2018
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

UnitedHealthcare Community Plan

Medicaid/Healthy Michigan Plan/MIChild 2018

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UnitedHealthcare®
Community Plan

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.

Click the following links to access different manuals:

- UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual-go to uhccommunityplan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in this manual using the following steps:

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

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

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.

Dear Care Provider,

Welcome to UnitedHealthcare Community Plan and thank you for your participation. We value our positive relations with those professionals who provide care to our members. We promise to continue to do all we can for your ongoing support.

This care provider manual is intended as a resource for the management of our Medicaid Program and Healthy Michigan Plan/MIChild. If you are unable to find what you are looking for, please feel free to contact your provider or hospital and facility advocate. If you do not know the name of your advocate, contact Customer Service at 800-903-5253. UnitedHealthcare Community Plan staff is available in person during normal business hours of 8:30 a.m. to 5:30 p.m., Monday through Friday.

In addition, we have designed a portion of our website specifically for you, our valued provider, at **UHCCommunityPlan.com**. It is here that you can access printable versions of the provider manual, provider directories, provider newsletters, clinical practice guidelines, drug formularies and so much more useful information.

Again, welcome to UnitedHealthcare Community Plan's Medicaid/Healthy Michigan Plan/MIChild Provider Manual and website. We look forward to your efforts in delivering quality healthcare!

Yours in good health,
UnitedHealthcare Community Plan

In the event of a conflict of information between your agreement and this manual, the manual controls unless the agreement dictates otherwise.

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Section 1: PROVIDER OFFICE PROCEDURES

1.1 MEMBER INFORMATION

Membership/Eligibility

Membership in UnitedHealthcare Community Plan is limited to Michigan Medicaid/Healthy Michigan Plan/MIChild enrollees who reside in our service area.

The state has the sole authority for determining whether individuals or families meet the eligibility requirements as specified for enrollment with a managed health care plan. Based on a combination of financial and non-financial factors, there are groups that must enroll, groups that may voluntarily enroll and groups that are excluded from enrollment in managed health care plans.

The Michigan Department of Health & Human Services (MDHHS) contracts with Michigan Enrolls (888-367-6557 or 800-975-7630), an Enrollment Services contractor to educate Medicaid Enrollees about managed care and to enroll, disenroll and change enrollment for these beneficiaries.

UnitedHealthcare Dual Complete (HMO SNP)

For information regarding UnitedHealthcare Dual Complete, please see the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products at UHCprovider.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Administrative Guide.

Provider/Member Relationship

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 provider and UnitedHealthcare Community Plan with a member.

Enrollment in a Health Plan

Once an enrollee is determined to be eligible for enrollment in a managed health care plan, the enrollee must decide within 30 days in which plan they wish to enroll. If a selection is not made, Michigan Enrolls automatically assigns the beneficiary to a plan within the beneficiary's county of residence.

Medicaid enrollees are locked into a health plan for 12 months. The Centers for Medicare & Medicaid Services (CMS) requires beneficiaries to have the opportunity to change health plans once a year. The last digit of the case number will designate the open enrollment month for each enrollee on the same case. For example, if the case number ends in two, the designated open enrollment month is every February. When the designated open enrollment month occurs during the 90-day Medicaid Health Plan (MHP) change period, the beneficiary will not receive an open enrollment letter. The next open enrollment period for these beneficiaries will be 12 months from the date of their last open enrollment letter, or in their designated month in the following year, whichever date results in the beneficiary receiving a letter notifying them of when they can change plans at least once during each 12-month period. When an Enrollee's case number changes, they may have two open enrollment periods in a 12-month period. During November and December each year, open enrollment letters will be mailed to cases that did not receive a notice to change plans within the past 12-month period.

UnitedHealthcare Community Plan is not able to directly enroll, disenroll or change a beneficiary's

enrollment. Beneficiaries must contact Michigan Enrolls (888-367-6557 or 800-975-7630) to request changes.

Beneficiaries disenrolled from UnitedHealthcare Community Plan because they are no longer eligible for Medicaid, and who are found eligible again within three months, are reassigned to UnitedHealthcare Community Plan by Michigan Enrolls.

Please note that neither our care providers nor we can request that a member be disenrolled because of an adverse change in their health or because of a health condition.

Pregnancy/Newborn Enrollment

Individuals who attain eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 60 days post-partum or post-loss of pregnancy.

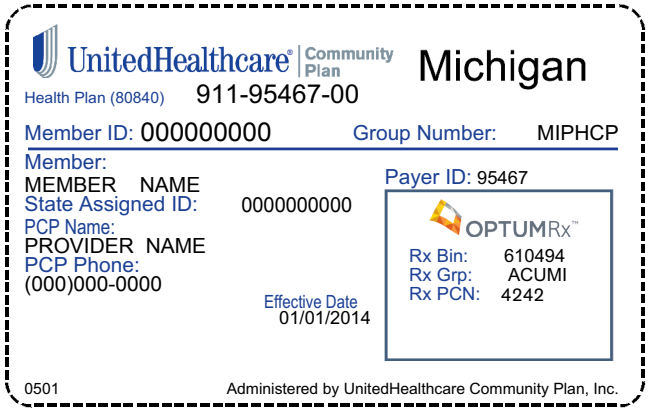
Newborns are automatically assigned to the health plan in which the mother was enrolled in at the time of the baby's birth. At a minimum, newborns are eligible for Medicaid coverage for the month of their birth and may be eligible for up to one year or longer.

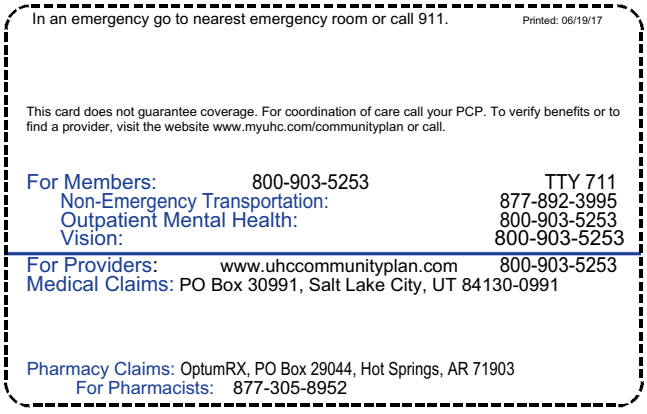
How to Verify Membership

Our members receive two forms of Medicaid identification. The State of Michigan issues each eligible Beneficiary a plastic "MIhealth" Medicaid identification card. Each eligible member receives his/her own UnitedHealthcare Community Plan identification card during the first week of enrollment. The cards identify beneficiaries as members of our plan. Please verify eligibility before providing services. For Medicaid members "Medicaid" will be displayed on the front of the ID card in the lower right corner above our corporate name.

Please note that coverage can change monthly. Check the member's eligibility each time the member seeks care. Enrollment and eligibility can be verified through the following methods:

- Review the member's "MIhealth" Medicaid identification card and UnitedHealthcare Community Plan identification card.
- Access Netwerkes website at **netwerkes.com**.
- Access UnitedHealthcare Community Plan's secure online Provider Portal, **UHCprovider.com**.





- Call our automated eligibility system at 800-903-5253. This option allows you to also receive a fax confirmation. Call UnitedHealthcare Community Plan's Customer Service department.

Changing Primary Care Provider

Members may request to change their primary care provider (PCP). The decision to change a PCP must be voluntary and initiated by the member. Changes are effective the day of the request. Capitation reimbursement will be pro-rated for members that change their PCP mid-month. We allow members to change their PCP one time per month, unless there are extenuating circumstances.

PCP changes can be requested by using the **PCP Change Form**. After the form is completed and signed by the Member, please fax the form to our Customer Service department 801-994-1348.

Provider Termination

Provider contracts stipulate your responsibility when intending to terminate the contractual relationship with UnitedHealthcare Community Plan. Most contracts indicate 90 days notice prior to termination without cause, or 30 days prior to termination with cause. Notification must be sent to your provider or hospital and facility advocate. If you do not know the name of your advocate, call Customer Service at 800-903-5253. This can be faxed to:

United Healthcare Community Plan Attn:
Provider Service
26957 Northwestern Highway, Suite 400
Southfield, MI 48033

If the affiliation between a PCP/group and UnitedHealthcare Community Plan terminates, the PCP should provide written notice of this termination within 15 days after the PCP becomes aware of the termination to each member who has chosen the care provider as his or her PCP. UnitedHealthcare Community Plan will notify the members affected by the PCP/group termination and assign the members to a new PCP.

Where the provider is a specialist/specialist group and the provider/group initiates the agreement termination, it is the specialist's responsibility to notify affected UnitedHealthcare Community Plan members prior to the effective date of termination. Affected UnitedHealthcare Community Plan members are those who have had at least three visits to the specialist in a one year period and/or who have a chronic condition such as COPD, ESRD or Diabetes whom the specialist has seen at least three times in the previous 12 month period.

If a member is in an ongoing course of treatment with any other provider who is affiliated with UnitedHealthcare Community Plan and the affiliation between the provider and UnitedHealthcare Community Plan terminates, the provider may provide written notice of the termination to the member within 15 days after the provider becomes aware of the termination.

UnitedHealthcare Community Plan permits the member to continue an ongoing course of treatment with the terminating provider: (a) if the member is in her second or third trimester of pregnancy at the time the provider's termination, through postpartum care directly related to the pregnancy, (b) if the member is determined to be terminally ill prior to a provider's termination or knowledge of the termination and the provider was treating the terminal illness before the date of termination or knowledge of the termination.

By continuing treatment, the terminating provider agrees to accept reimbursement from UnitedHealthcare Community Plan at applicable Medicaid rates as payment in full. The provider also agrees to adhere to UnitedHealthcare Community Plan's standards for quality, information submission and policies and procedures, including but not limited to, those concerning utilization review, referrals, prior authorizations, and treatment plans.

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 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 providers to ensure that all participants understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours, seven days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician 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.

Language Interpretation Services

We want to help ensure accurate communication between members, health care providers and our plan staff. We provide free translation service to members and providers. We use the AT&T Language Line and can provide interpretation services for over 130 languages.

For more information about the AT&T Language Line, please contact Customer Service at **800-903-5253** regarding use of an interpreter.

1.2 PROVIDER ACCESS REQUIREMENTS

Access to Primary Care and Services

We recognize the importance of reasonable access to PCPs to obtain primary care. As such:

- All PCPs must have 24-hour on-call service for emergency and after hours care with arrangements for back-up coverage as needed. PCPs must notify their provider advocate of coverage arrangements.
- All PCPs must be available to see UnitedHealthcare Community Plan members 20 hours per week per practice location.
- All practitioners must offer hours of operation to Medicaid members that are no less than those offered to commercial members.

We developed the following standards for PCP appointment availability and monitors provider compliance annually:

- Routine, preventive health care (check-ups) available within 30 days.
- Urgent care available the same day.
- Non-urgent or symptomatic care available within three days or less.
- Office hours: care providers must offer office hour of operation to Medicaid members no less than those offered to commercial members.

PCP Telephone Accessibility

- For any absences, PCPs must have coverage by a participating PCP. PCPs must notify their provider advocate of the covering PCP.
- Practice hours of the PCP must be documented and communicated to members.
- The PCP should notify their provider advocate if their practice is not accepting new patients.

Waiting Time

PCPs are expected to monitor waiting room times.

- Members should be taken to the exam room within 15 minutes of appointment time.

OB/GYN Access

UnitedHealthcare Community Plan established the following standards and measurement for sites that provide maternity care:

- First trimester: within 10 business days of request.
- Second trimester: within five business days of request.
- Third trimester: within four business days of request.
- High-risk pregnancies: within 24 hours of identification of high risk or immediately if an emergency exists.

UnitedHealthcare Community Plan Telephone Access

Follow the established telephone access standards:

- The average seconds to answer (ASA) must be 30 seconds or less.
- The abandonment rate must be 5% or less.

1.3 CAPITATION

Capitation Payment Reports

A Capitation Payment Report is included with the capitation payment made to all PCPs paid at a capitated rate. The capitation payment is prorated on a daily basis and computed from the member's effective date of eligibility with the PCP. Newborns are prorated from their date of birth. If a member were to change PCPs at any time during a month, each PCP will receive capitation for each day the member was assigned to him/her.

The Capitation Report is comprised of four sections:

1) CR1010: Capitation Check – This is the monthly capitation check.

2) CR1020: Capitation Remittance Statement – This section contains summary level information regarding:

- total capitation amount
- total retroactive capitation applied
- total manual adjustments applied
- total member months
- negative balance applied net payment

3) CR1030: Capitation Provider Medical Group Report – This section identifies the:

- line of business
- care provider name and, per care provider, the
  - state program
  - current and retro member months
  - total member months
  - current capitation
  - retro capitation
  - manual adjustments
  - total cap paid

4) CR1040: Capitation Adjustment Detail – This section identifies the:

- line of business
- Per adjustment, the:
  - adjustment description
  - member name and id for the adjustment
  - cap period for the adjustment
  - member months adjusted
  - adjusted amount
- This report also includes a total adjustment amount

5) CR1050a: Capitation Member Detail – This section identifies the:

- line of business
- per adjustment, the
  - member name, id, gender, age and zip code
  - provider name and id tied to the member
  - cap period
  - member count
  - cap amount
- This report also includes for current and retro the total:
  - Member count
  - Cap paid per member
  - Retro add count and cap payment
  - Retro term count and cap payment
  - Total member count and total cap payment

1.4 VFC/MCIR

Registration for Vaccines for Children (VFC) Program

Michigan Medicaid requires that participating providers register with the federal VFC program to obtain free vaccines for Michigan Medicaid beneficiaries. You benefit from involvement in VFC.

- Reduces your out-of-pocket costs because you do not have to buy vaccine with your own money.
- Covers all ACIP recommended vaccines.

- Enhances all services you provide relative to well child care.
- You can help ensure that your patients are getting needed vaccines before leaving your office.

Over the past decade, both general and immunization specific pediatric "best practices" include the administering of a child's immunizations in their "medical home" or with the child's PCP.

For more information on the VFC program, visit the Centers for Disease Control website at cdc.gov or call the State of Michigan Division of Communicable Disease and Immunizations at 517-335-8159.

Michigan Childhood Immunization Registry (MCIR)

All health care providers in Michigan who provide immunization services to a child born after December 31, 1993, are required by law to report each immunization to MCIR. Data from MCIR may only be used for immunization purposes, and all data is to be deleted upon the child reaching the age of 20.

MCIR consists of an electronic database into which health care providers submit data relative to the immunizations they provide. The data may be submitted electronically, or in the form of paper records by fax or mail. Those providers submitting their data electronically may submit records individually through an interactive client server interface, or in groups through a batch transfer.

An optional Vaccine Inventory Module has been developed to assist providers with management of their vaccine inventory and generates the reports needed for documentation of the VFC program.

MCIR may be accessed only by authorized professionals to determine which immunizations are due for the children they see. Immunization providers can determine the immunization level of their practice or community. Health care providers may access a child's record to determine the completeness of his or her immunizations. Providers have direct real-time access to the MCIR through either a modem, direct line, or a fax-back system. For more information, please visit the MCIR website at mcir.org.

1.5 COMMUNICABLE DISEASES

Reporting Requirements

You are required to report communicable diseases within the time frames specified by the Michigan Department of Health & Human Services (MDHHS).

Report Immediately:

Any unusual occurrence, outbreak, or epidemic of any disease, condition and/or nosocomial infection.

Report Within 24 Hours:

AIDS	Granuloma inguinale	Plague
Anthrax	H. influenzae (meningitis or epiglottitis)	Poliomyelitis
Botulism	Hepatitis B in a pregnant woman	Rabies (human)
Chancroid	Lymphogranuloma	Venereum Syphilis
Cholera	Measles	Tuberculosis
Diphtheria	Meningococcal disease (Meningitis or meningococcemia)	Viral hemorrhagic fevers
Gonorrhea	Pertussis	Yellow fever

Report Within Three Working Days:

Amebiasis	Hemolytic-uremic syndrome	Rocky Mountain spotted fever
Blastomycosis	Hepatitis	Rubella
Brucellosis	Histoplasmosis	Rubella (congenital syndrome)
Campylobacter enteritis	Kawasaki disease	Salmonellosis
Chlamydia (genital)	Legionellosis	Shigellosis
Coccidioidomycosis	Leprosy	Staphylococcal disease (first 28 days postpartum mother of child)
Cryptococcosis	Leptospirosis	Streptococcal, invasive Group A (normally sterile sites)
Cryptosporidiosis	Listeriosis	Tetanus
Cyclosporiasis	Lyme disease	Toxic Shock syndrome
Dengue fever	Malaria	Trachoma
E.coli disease (only shiga toxin producers)	Meningitis (bacterial & viral)	Trichinosis
Ehrlichiosis	Mumps	Tularemia
Encephalitis, viral	Psittacosis	Typhoid fever
Giardiasis	Qfever	Typhus
Guillain-Barre' syndrome	Reye's syndrome	Yersinia enteritis
Hantavirus pulmonary syndrome	Rheumatic fever	

Report Within One Week:

Chicken pox (aggregate numbers), HIV infection, Influenza (aggregate numbers).

How to Report:

Mail, call, or fax your local health department with the patient demographics, diagnosis and onset date.

For questions, forms, or information call:

Michigan Department of Community Health
Communicable Disease Epidemiology Division
201 Townsend St. 5th Floor
Lansing, MI 48913
Phone: 517-335-8165
Fax: 517-335-8121
After hour EMERGENCY calls only:
517-335-9030

1.6 TRANSPORTATION

Non-emergency medical transportation is provided at no cost to members for all covered medical services through National MedTrans Network.

To arrange for transportation services, please call:

- **844-714-2219**, 24 hours a day, seven days a week

We request that members call, at a minimum, four days in advance for routine appointments; however, occasionally National MedTrans Network can accommodate requests that are made with less than four days lead time.

You are encouraged to assist members in securing transportation services for necessary appointments. Transportation is provided to and from the following:

- Doctor's appointments, including PCP and specialty providers
- Dialysis clinics
- UnitedHealthcare Community Plan vision providers (MARCH® Vision Care) for eye exam or to pick up glasses
- Health departments
- Any family planning clinic
- Hospital (non-emergency only)
- Durable medical equipment (DME) provider to obtain equipment
- Radiology and MRI centers
- Physical therapy offices
- Urgent care facilities (non-emergency only)

Important information to remember about the transportation benefit:

- Transportation is available for the member only, unless the member is a child or an adult in need of assistance.
- Transportation to a pharmacy from the member's residence is not covered. However, pharmacy stops can be made when the pharmacy is on the route between the provider's office and the member's return destination.
- Transportation for dental appointments or methadone clinics should be arranged through the member's Department of Human Services (DHS) worker.
- Issues or problems that arise related to transportation should be communicated to your provider advocate as soon as possible.

1.7 LABORATORY SERVICES

Laboratory Service Agreement

All outpatient laboratory services must be processed through UnitedHealthcare Community Plan's contracted providers which include:

- Joint Venture Hospital Laboratories (JVHL)
- Laboratory Corporation of America (Lab Corp)
- Regional Labs

- DMC's URL Laboratories
- Detroit Bio Medical Laboratories (Detroit Bio)

If your office is not currently set up with a JVHL network hospital, you can contact JVHL at 800-445-4979 for assistance in setting up services with a JVHL or UnitedHealthcare Community Plan Hospital provider. For questions on how to establish a service relationship with LabCorp, call 888-522-2677.

1.8 PHARMACY PROGRAMS

Preferred Drug List (PDL)

- The UnitedHealthcare Community Plan's formulary, or Preferred Drug List (PDL), is provided as reference and an educational tool to assist in the selection of cost-effective therapies.
- Included for coverage in our prescription benefit are some over-the-counter (OTC) products. The covered OTC products can be found in the complete PDL.
- We communicate updates through mailings to prescribers and updates to the PDL are added to our website monthly.
- To obtain the UnitedHealthcare Community Plan PDL, please contact your provider advocate or click here to view the **UnitedHealthcare Community Plan PDL**.

Requests to Add Medications to the PDL

- If you wish to propose PDL suggestions, send the information to the UnitedHealthcare Community Plan Director of Pharmacy at:

  Attn: Director of Pharmacy Services
  UnitedHealthcare Community Plan Unison Plaza
  1001 Brinton Road
  Pittsburgh, PA 15221
  Fax: 866-940-7328

- You should furnish adequate clinical documentation, such as documentation of clinical necessity as well as therapeutic advantages over current PDL products.
- Suggestions received by UnitedHealthcare Community Plan will be reviewed by the Pharmacy and Therapeutics Committee at the subsequent P & T meeting.

Prescription Guidelines

- Prescriptions may cover up to a maximum 30-day supply of medication.
- Refills are permitted as medically necessary, but will only be dispensed if the member is eligible with UnitedHealthcare Community Plan.
- Prior authorization or exception requests can be submitted to UnitedHealthcare Community Plan National Intake by completing a Prior Authorization form by fax to 855-225-9847.
- A prior authorization or exception request can also be called in to **800-310-6826**.
- All medications (prescription and OTC) require a valid prescription (written or telephone) from the prescribing provider.
- The member must first have tried and failed listed PDL agent(s) prior to authorization being reviewed for non-PDL agents.
- All prescriptions must comply with state and federal regulations.
- UnitedHealthcare Community Plan is always considered the secondary payor in the event the member has additional insurance coverage. In situations where members have additional insurance coverage, UnitedHealthcare Community Plan covers prescription co-pays from other insurance carriers.

Pharmacy Authorizations

Health care providers may request a pharmacy Prior Authorization (PA) or a Medical Exception for a non-PDL medication. Pharmacy prior authorization forms can be found on the UnitedHealthcare Community Plan website.

Healthcare providers should fax a completed Prior Authorization form to the UnitedHealthcare Community Plan National Intake at **855-225-9847** and help ensure the following information is included:

- Member name, Member ID# and date of birth
- Care provider name and telephone number
- Drug name, strength and directions for use
- Diagnosis and history of trial PDL agent(s)
- Other clinical documentation as requested by UnitedHealthcare Community Plan

Prior authorization or exception requests can be submitted to Pharmacy Services by completing a Prior Authorization form by fax to 866-940-7328. A prior authorization or exception request can also be called in to **800-310-6826**.

Upon approval, Pharmacy Services places an override in the system to allow the claim to pay online at the UnitedHealthcare Community Plan participating pharmacy if authorized.

If the request does not meet criteria for the requested medication, Pharmacy Services faxes a notification to the requesting provider. The notification will include Member appeal rights.

Injectable Outpatient Chemotherapy Drugs

Prior authorization is required for injectable outpatient chemotherapy drugs given for a cancer diagnosis.

Pharmacy Appeal Requests

Decisions of UnitedHealthcare Community Plan may be appealed by the member or the member's health care provider on behalf of the member, if the member has given the provider power of attorney. Providers may mail appeal requests to the UnitedHealthcare Community Plan Medical Director:

UnitedHealthcare Community Plan
Attn: Medical Director
26957 Northwestern Highway, Suite 400
Southfield, MI 48033

1.9 PROVIDER APPEAL PROCEDURES

An appeal may be filed in the event that a health care provider receives a payment denial relating to:

- Inpatient days or other services
- Prior authorization requests
- Covered Services

Please refer to the following information before filing an appeal. Following the instructions and criteria facilitates efficient and timely processing of provider appeals. Appeal decisions are based on state and provider contracts, medical necessity screening criteria, and company policy and procedure. UnitedHealthcare Community Plan is committed to resolving provider disputes in a fair and timely manner.

How to File an Appeal

In order to file an appeal, the claim which is the subject of the appeal, must be in the UnitedHealthcare Community Plan claims payment system and must be either paid or denied. If services were rendered, providers must submit an initial claim with the medical documentation. Initial claims submitted with the medical documentation are processed, in order to establish claim activity, based on the initial decision

of our UR department. The case is then presented to the appropriate reviewer for a decision following the steps below. A provider request for appeal must include the following information:

- A letter from the requesting entity clearly detailing the issue in dispute and what specifically is being appealed.
- The name, address and telephone number of the person responsible for filing the appeal. This facilitates communication between UnitedHealthcare Community Plan and the person responsible for filing the appeal in the event of any questions.
- Supporting documentation such as proof of timely filing, proof of authorization or innocent victim status, medical records, or other information to support the appeal.

Reconsiderations should be filed within 12 months of the claim process date. A first level appeal must be filed within 180 days from the claim reconsideration letter. A second level appeal must be filed within 60 days of the level one appeal notice. Any submissions received beyond these time frames will not be considered.

The first step of the appeal process is to file a claims reconsideration. Please see Section 5 for details on how to submit a claims reconsideration.

Level 1 Appeal

UnitedHealthcare Community Plan:

- Conducts an initial review of the documentation to help ensure that all pertinent information is received.
- Denies the file as "unclean" if information is missing or incomplete.
- Sends an acknowledgement letter to the appeal contact.
- Reviews the case and makes a determination.
- Mails the appeal decision to the appeal contact using the Appeal Submission Form or cover letter
- Forwards the claim to UnitedHealthcare Community Plan's Claims department for processing if the appeal is approved.
- Notifies the appeal contact on the appeal denial and rights for further appeal.

Providers dissatisfied with a denial of a Level 1 appeal decision may request a Level 2 Appeal. Further appeal rights are included in appeal determination letters.

Level 2 Appeal

- UnitedHealthcare Community Plan must receive a Level 2 Appeal within 60 days of receipt of the Level 1 decision. The requesting party must include additional information or documentation that could affect the Level 1 decision. UnitedHealthcare Community Plan will not accept a letter requesting a review of the information submitted with the Level 1 Appeal.
- Level 2 Appeals are the final level available within UnitedHealthcare Community Plan.

Mail all UnitedHealthcare Community Plan Provider Appeal requests to:

Provider Appeals Department UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

Discussion with Care Provider Reviewer

UnitedHealthcare Community Plan care provider reviewers are available to discuss adverse determinations with care providers. Please contact UnitedHealthcare Community Plan at **800-903-5253** to speak with a UnitedHealthcare Community Plan care provider reviewer; a care provider, depending on the case type of case involved, concerning an adverse determination.

Post-Payment Audit Appeals

Appeals related to post-payment audits are resolved through a separate appeal process. Post-payment appeal decisions cannot be further appealed through the standard appeal process defined above.

1.10 FRAUD, WASTE AND ABUSE

Legal Responsibility

Federal and state governments regulate the business operations of UnitedHealthcare Community Plan, a Michigan Medicaid Managed Care Organization (MCO). As a government contractor, UnitedHealthcare Community Plan is responsible for preventing, detecting, investigating, and reporting fraud, waste and abuse.

A provider commits health care fraud, waste or abuse by:

- Balance billing – federal and state law prohibits billing Medicaid beneficiaries for Medicaid covered benefits. Information about Medicaid covered benefits can be found at their website: michigan.gov/mdhhs
- Inflating bills for services provided
- Double billing
- Improper coding (upcoding and unbundling)
- Billing for services never rendered

UnitedHealthcare Community Plan has a legal responsibility to report such incidents to the Centers for Medicare and Medicaid Services (CMS) and the Office of Health Services Inspector General. Providers who suspect any fraud, waste or abuse of the Medicaid program are requested to call or send correspondence to either of the following:

Compliance Officer
UnitedHealthcare Community Plan
26957 Northwestern Highway, Suite 400
Southfield, MI 48033
800-903-5253

Office of Inspector General
by calling 855-643-7283,
online at michigan.gov/fraud,
or in writing to:

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

The reporting party may choose to remain anonymous when reporting fraud, waste or abuse.

The reporting party needs to identify: WHAT was observed, WHEN it was observed it, WHO was present, AND any further information that may be of assistance.

1.11 BLOOD LEAD TESTING

The CDC reported in 1997 that almost 900,000 U.S. children have blood lead levels (BLL) high enough to cause adverse effects on their ability to learn (>=10 ug/dl). In April 2004, Michigan legislature passed a law requiring that all Michigan Medicaid children be tested at age 12 and 24 months or between 36 and 72 months if not tested previously for blood lead poisoning. All labs are required to submit a copy of the results of the blood lead level analysis to the Michigan Lead Registry. UnitedHealthcare Community Plan provides three convenient methods for obtaining specimens in the provider office. This helps ensure greater member compliance.

Care providers may use the convenience of MedTox filter paper kits, Quest's Micro Container or the Michigan Department of Community Health filter paper kit.

The MedTox method uses two drops of fingerstick blood to obtain a quantitative blood lead screen. Once collected using a free collection kit supplied by MedTox, care providers send the samples to the MedTox laboratory in prepaid envelopes through the U.S. mail. MedTox faxes results back to provider offices and reports results electronically to MDHHS usually within 48 hours of sample receipt at the MedTox laboratory.

MedTox Pediatric Lead Testing Supplies

MedTox provides the following filter paper lead supplies to the provider at no charge:

- Pediatric Lead Requisition
- MedTox Blood Sample Card
- Ziploc bag
- Standard pre-paid envelope
- Lancets, upon request
- Large pre-paid envelope, upon request
- Pre-assembled, comprehensive collection kits are also available upon request

It is important to fill out all information on the laboratory requisition form. All patient information must be provided in order to be in compliance with state lead reporting guidelines. Accurate billing information must also be provided so MedTox can bill UnitedHealthcare Community Plan directly.

Please contact MedTox for further details at **877-725-7241**.

Quest Diagnostics provides microtainer tubes for lead testing.

MDHHS Filter Paper Lead Testing

The Statewide Lead Screening/Lead Testing Plan that was fax blasted to all UnitedHealthcare Community Plan providers in 2005 stated clearly that there is no requirement that the initial blood test for lead be a venous sample. A capillary specimen is acceptable. Capillary specimens for blood lead can be obtained by performing a finger or heel stick and collecting the blood in a micro tube or onto filter paper. UnitedHealthcare Community Plan offers MedTox filter paper kits free to our providers in an effort to facilitate in-office blood lead draws. The MDHHS Bureau of Laboratories accepts micro tube samples and now also offers providers caring for Medicaid eligible children the option of obtaining and submitting filter paper blood lead samples for processing through the state lab. Filter paper blood lead collection kits or other lead collection supplies can be obtained free from MDHHS by calling 517-335-9867. Additional information on lead testing, filter paper and the proper sample collection technique can be found on the MDHHS website at **michigan.gov**.

1.12 PROVIDER INTENT TO WITHDRAW MEDICAL SERVICE FROM A PATIENT CASE

Non-compliance with treatment recommendations may not be adequate reason for a member to be transferred out of a provider's practice. It is UnitedHealthcare Community Plan's responsibility to work with the PCP to help coordinate care.

Member Transfer Request Guidelines

UnitedHealthcare Community Plan PCPs may request that a member be transferred out of their practice for the following reasons:

- The member exhibits violent or life threatening behavior involving physical acts of violence, physical or verbal threats of violence against a PCP or PCP staff, threats or violence at a provider's location, or when the member is determined to be an excessive menace to a PCP or PCP's staff.
- UnitedHealthcare Community Plan and/or the UnitedHealthcare Community Plan PCP has documented evidence of fraud or misrepresentation involving alteration or theft of prescriptions, misrepresentations of UnitedHealthcare Community Plan membership or unauthorized use of benefits.
- Other non-compliance situations involving the repeated failure to follow treatment plans, repeated use of non- contracted providers, repeated emergency room use and other situations that impede care.

Procedure

- Member transfer requests must be submitted in writing. Documentation must outline specific concerns including prior warning notice(s) to the member that a continued behavior may result in a PCP transfer request. PCPs are required to send certified notification to the member as well as mailing the request and supporting documentation to:

  UnitedHealthcare Community Plan
  Attn: Customer Service
  P.O. Box 30991
  Salt Lake City, UT 84130

- UnitedHealthcare Community Plan reviews and responds to all requests within five business days from receipt.
- If a request is determined to be inadequate because it either does not meet the policy guidelines stated above or does not include necessary supporting documentation, UnitedHealthcare Community Plan returns the request to the provider with an explanation for the denial of transfer request.

Please note that neither UnitedHealthcare Community Plan nor its providers can request that a member be disenrolled because of an adverse change in their health or because of a health condition.

1.13 MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

- To be treated with respect, consideration, and recognition of their dignity and right to privacy no matter what their race, religion, color, age, sex, health condition, familial status, height, weight, disability, or veteran's status.
- To receive information about all health services including a clear explanation of how to obtain services.
- To choose a personal doctor from our list of UnitedHealthcare Community Plan Primary Care Providers (PCPs).
- To file a grievance, to request a fair hearing, or have an external review, under the Patient's Right to Independent Review Act.
- To voice grievances or appeals about UnitedHealthcare Community Plan or the care it provides.

- To make recommendations regarding UnitedHealthcare Community Plan's members rights and responsibilities policies.
- To expect that their medical records and communications will be treated in a confidential manner as required by law.
- To expect UnitedHealthcare Community Plan staff and providers to comply with all enrollee rights requirements.
- To seek a second opinion in network. If not available in network, the member must go through the prior authorization process for out of network.
- To receive full information from their PCP or health care provider as to the nature and consequence of any treatment, test, or procedure that may be involved in their health care.
- To participate in decisions involving their health care and make decisions to accept or refuse medical treatment or surgical treatment from their health care provider.
- To candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To ask for and receive information about UnitedHealthcare Community Plan, its services, its organization, UnitedHealthcare Community Plan providers and practitioners who provide health care services.
- To ask if UnitedHealthcare Community Plan has special financial arrangements with UnitedHealthcare Community Plan providers that can affect the use of referrals and other services they might need. To get information, the Member may call UnitedHealthcare Community Plan and ask for information about our care provider payment arrangements.
- To see any UnitedHealthcare Community Plan OB/GYN for well woman exams or obstetrical care without a referral from their PCP.
- To see any UnitedHealthcare Community Plan Pediatrician if they are under the age of 18 without a referral from their PCP.
- To get a copy of these rights and responsibilities or have them explained if they have any questions.

Member Responsibilities

- To be an informed member. Read their handbook and call UnitedHealthcare Community Plan if they have any questions.
- To understand health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To call UnitedHealthcare Community Plan for approval of all hospitalizations, except for emergencies or for urgently needed services.
- To inform UnitedHealthcare Community Plan of any other health insurance coverage, so that medical bills may be considered appropriately.
- To tell their PCP their complete health history. To tell the truth about any changes in their health. To supply information (to the extent possible) that UnitedHealthcare Community Plan and its' providers need in order to provide care.
- To listen to and follow their PCP's advice for care they have agreed on. To help plan what treatment will work best for them.
- To know the name(s) of their medication(s). To know what they are for and how to use them.
- To report any emergency treatment within 48 hours to their PCP. Report an emergency stay at a hospital soon after.

- To always carry their UnitedHealthcare Community Plan ID Card.
- To respect the rights of other patients, doctors, office staff and staff at UnitedHealthcare Community Plan.
- To tell UnitedHealthcare Community Plan if they move or change phone numbers.
- To tell us about changes that affect their health, like childbirth.

2.1 REFERRAL / CERTIFICATION PROCESS

General Information

- Care providers may call UnitedHealthcare Community Plan at **800-903-5253** between 8:30 a.m. and 5:30 p.m., Monday through Friday, to obtain prior authorization and to request copies of Utilization Management (UM) criteria.
- Care providers may fax prior authorization requests to UnitedHealthcare Community Plan National Intake department at 855-225-9847 24 hours a day, seven days a week.
- Any routine service performed by the PCP in his/her office does not require authorization.
- Pediatric members may self-refer to any UnitedHealthcare Community Plan participating Pediatrician.
- Female members may self-refer to any UnitedHealthcare Community Plan contracted OB/GYN for well-woman care.
- All Glucometer referrals should be directed to the designated UnitedHealthcare Community Plan pharmacy vendor with a prescription.
- PCPs that are not board certified in Cardiology should refer to an appropriate UnitedHealthcare Community Plan specialist when ordering advanced cardiac and cardiovascular studies, as well as cardiac or pulmonary rehabilitation services. PCPs that are not board certified in Neurology should refer to an appropriate UnitedHealthcare Community Plan specialist when ordering nerve conduction studies (NCVs), and/or electromyograms (EMGs).

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

Paperless Referrals

UnitedHealthcare Community Plan does not require a hard copy referral form when a UnitedHealthcare Community Plan member is referred to another participating UnitedHealthcare Community Plan provider. It is important to note that non-participating UnitedHealthcare Community Plan providers must contact UnitedHealthcare Community Plan at **800-903-5253** to obtain prior approval. Either the specialist or the referring PCP can contact UnitedHealthcare Community Plan for prior approval.

It is the responsibility of the specialist to:

- Verify member eligibility prior to rendering the service.
- Communicate outcomes back to the referring PCP to help ensure coordination of care.

Obstetrics & Gynecology

- The member may self-refer for all routine OB/GYN services to a participating OB/GYN care provider.
- Pregnancy care requires notification to UnitedHealthcare Community Plan by the attending OB/GYN care provider by phone or fax as soon as the pregnancy is confirmed. Global authorization for pregnancy covers all prenatal visits, ultrasounds as medically necessary, delivery and post-partum care. Additional ultrasounds and non-stress test (NST) services do not require pre-certification. You must notify UnitedHealthcare Community Plan if a member's pregnancy is determined to be high risk for intervention by UnitedHealthcare Community Plan's prenatal case manager.
- Document prenatal care on a nationally recognized prenatal and post-partum form such as a Hollister form. For more information about these specific forms, please call the Quality Improvement department at **800-903-5253**.

Perinatal Education

- UnitedHealthcare Community Plan emphasizes preventive medicine and member education as an approach to attain member wellness.
- A woman instructed in nutrition, drug abuse, anatomy, reproduction, sexually transmitted diseases, and child care will have improved perinatal outcomes and more effective parenting skills.
- An outgrowth of this education may also decrease unanticipated pregnancies.
- Referrals to local maternal and infant support providers are expected, as well as referrals to the Women, Infants & Children (WIC) Program. Information regarding community based support programs such as WIC, perinatal education classes, and others are available by contacting UnitedHealthcare Community Plan.
- Educational services provided by any provider must be documented in the member's medical record.

Vision

- Members may self-refer to participating optometrists MARCH® Vision Care for covered vision services.
- Vision services are coordinated through the MARCH® Vision Care provider network. The MARCH® Vision Care Provider Directory can be found online at marchvisioncare.com.
- Claims should be directly submitted to MARCH® Vision Care, not to UnitedHealthcare Community Plan.
- It is the responsibility of the optometry providers to verify eligibility and benefit coverage by contacting MARCH® Vision Care at 800-903-5253 or online at marchvisioncare.com when a member presents for services.
- Diabetic members may obtain a retinal eye exam annually.
- PCPs should help ensure that assigned members with diabetes obtain a dilated eye exam every year.
- UnitedHealthcare Community Plan also contracts with ophthalmologists for management of non-routine eye diseases and conditions to which PCPs may refer to care and services.

2.2 SPECIALIST REFERRAL / AUTHORIZATION PROCESS

Specialist Referral Process

- Specialists should evaluate, and then treat the specific condition for which the PCP refers the member.
- Specialists may perform additional diagnostic testing as medically necessary within the specialist's scope of practice without obtaining additional authorization unless the service is listed on the plan's Prior Authorization/Pre-Certification List.
- If it is determined that a member needs to be referred to additional specialists, the referral process should be coordinated with the PCP.
- UnitedHealthcare Community Plan encourages the specialist to communicate outcomes back to the referring PCP.
- UnitedHealthcare Community Plan does not require a hard copy referral form when a UnitedHealthcare Community Plan member is referred to another contracted UnitedHealthcare Community Plan provider.

Pre-Certification Requirements

UnitedHealthcare Community Plan reserves the right to add or delete required pre-certification procedures. Additions and deletions will be posted on uhccommunityplan.com/health-professionals/mi.html.

- All services requiring pre-certification must have a certification number from UnitedHealthcare Community Plan before services are rendered.
- For services that require pre-certification, specialists and PCPs must call or fax requests(s) to UnitedHealthcare Community Plan no less than three business days prior to the planned service date.
- Please call United Healthcare Community Plan Monday to Friday at **800-903-5253**, from 8:30 a.m. to 5:30 p.m.
- You may also fax your pre-certification request to 855-225-9847. UnitedHealthcare Community Plan will begin processing the request.
- If services will be performed within 48 hours of the request for pre-certification, the request must be called in to UnitedHealthcare Community Plan at **800-903-5253**.
- Providers requesting pre-certification services by phone receive a certification number based on clinical information supporting the request at the time of call.
- Providers requesting pre-certification services by telephone will receive a reference number for requests that have to be pended for clinical review. For requests that can be approved immediately, a pre-certification number will be provided at the time of call.

Referred Provider Responsibilities

- UnitedHealthcare Community Plan requires that participating specialists send a written report to the referring PCP within 10 days after the service, or communicate immediately when medically necessary.
- It is the PCP's ultimate responsibility to obtain the specialist's consultation report and help ensure the recommendations are implemented.

Sterilization

Voluntary Sterilizations - An informed consent to sterilization form must be completed and signed 30 days prior to all voluntary sterilizations. An informed consent to sterilization form may be obtained through the State of Michigan Medical Services Administration by calling **800-292-2550**. Fax the completed consent form prior to claim submission

along with the UnitedHealthcare Community Plan's Consent Submission Form to (855) 237-1213 or mail your claim with completed consent form attached to:

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

All informed consent to sterilization form must be completed and signed 30 days prior to all voluntary sterilizations.

Hysterectomy

Hysterectomies are covered and reimbursed when medically indicated. A hysterectomy is not covered for the purpose of sterilization. Medicaid form DSS-2218 must be signed by the member and practitioner, and be on file with UnitedHealthcare Community Plan at the time of claims processing. Fax the completed consent form prior to claim submission along with the UnitedHealthcare Community Plan's Consent Submission Form to (855) 237-1213 or mail your claim with completed consent form attached to

UnitedHealthcare Community Plan
P.O. Box 30991
Salt Lake City, UT 84130-0991

A form is not required when the patient is already sterile, or a life-threatening emergency exists. If medical necessity is not clearly indicated, UnitedHealthcare Community Plan requires a second opinion. The sterilization/hysterectomy consent form must be complete and compliant with all guidelines stipulated on the form.

Medicaid Mental Health

Overview

- The Michigan Medicaid managed care mental health benefit for Medicaid recipients is designed for brief intervention approaches, which address mild or moderate concerns.
- UnitedHealthcare Community Plan contracts with OptumHealth Behavioral Solutions (OBH), a managed behavioral health care organization, to manage outpatient services and a network of behavioral health specialists.
- Members may self-refer for services at any in-network OBH mental health provider.

Care Coordination for Mental Health Visits:

For assistance coordinating mental health benefits, please contact OBH at **800-903-5253**.

- It is the care provider's responsibility to verify member eligibility prior to rendering services.

Referring to CMH:

- A member with a chronic condition meeting the MSA criteria for Serious and Persistent Mental Health Illness (SPMI-adults), or Severe Emotional Disturbance (SED-children) may be referred to the Community Mental Health (CMH) agency in the member's county of residence.
- Treatment for substance abuse disorders is the direct responsibility of the Substance Abuse Coordinating Agency in the member's county of residence (see below). County contact numbers for SPMI and substance abuse referrals are as follows:

County	CMH (SA & MH) Agency	CMH (SA & MH Phone)
Alcona	NORTHERN MI REGIONAL ENTITY	231-487-9144
Allegan	LAKESHORE REGIONAL ENTITY	231-342-3379
Alpena	NORTHERN MI REGIONAL ENTITY	231-487-9144
Antrim	NORTHERN MI REGIONAL ENTITY	231-487-9144
Arenac	MID-STATE HEALTH NETWORK	517-253-7525
Barry	SW MI BEHAVIORAL HEALTH	269-979-9132
Bay	MID-STATE HEALTH NETWORK	517-253-7525
Benzie	NORTHERN MI REGIONAL ENTITY	231-487-9144
Berrien	SW MI BEHAVIORAL HEALTH	269-979-9132
Branch	SW MI BEHAVIORAL HEALTH	269-979-9132
Calhoun	SW MI BEHAVIORAL HEALTH	269-979-9132
Cass	SW MI BEHAVIORAL HEALTH	269-979-9132
Charlevoix	NORTHERN MI REGIONAL ENTITY	231-487-9144
Cheboygan	NORTHERN MI REGIONAL ENTITY	231-487-9144
Clare	MID-STATE HEALTH NETWORK	517-253-7525
Clinton	MID-STATE HEALTH NETWORK	517-253-7525
Crawford	NORTHERN MI REGIONAL ENTITY	231-487-9144
Eaton	MID-STATE HEALTH NETWORK	517-253-7525
Emmet	NORTHERN MI REGIONAL ENTITY	231-487-9144
Genesee	REGION 10	810-966-7803
Gladwin	MID-STATE HEALTH NETWORK	517-253-7525
Grand Traverse	NORTHERN MI REGIONAL ENTITY	231-487-9144
Gratiot	MID-STATE HEALTH NETWORK	517-253-7525
Hillsdale	MID-STATE HEALTH NETWORK	517-253-7525
Huron	MID-STATE HEALTH NETWORK	517-253-7525
Ingham	MID-STATE HEALTH NETWORK	517-253-7525
Ionia	MID-STATE HEALTH NETWORK	517-253-7525
Iosco	NORTHERN MI REGIONAL ENTITY	231-487-9144
Isabella	MID-STATE HEALTH NETWORK	517-253-7525
Jackson	MID-STATE HEALTH NETWORK	517-253-7525
Kalamazoo	SW MI BEHAVIORAL HEALTH	269-979-9132

County	CMH (SA & MH) Agency	CMH (SA & MH Phone)
Kalkaska	NORTHERN MI REGIONAL ENTITY	231-487-9144
Kent	LAKESHORE REGIONAL ENTITY	231-342-3379
Lake	LAKESHORE REGIONAL ENTITY	231-342-3379
Lapeer	REGION 10	810-966-7803
Leelanau	NORTHERN MI REGIONAL ENTITY	231-487-9144
Lenawee	CMH PARTNERSHIP OF SE MI	734-222-3818
Livingston	CMH PARTNERSHIP OF SE MI	734-222-3818
Macomb	MACOMB CO CMH SERVICES	586-469-5275
Manistee	NORTHERN MI REGIONAL ENTITY	231-487-9144
Mason	LAKESHORE REGIONAL ENTITY	231-342-3379
Mecosta	MID-STATE HEALTH NETWORK	517-253-7525
Midland	MID-STATE HEALTH NETWORK	517-253-7525
Missaukee	NORTHERN MI REGIONAL ENTITY	231-487-9144
Monroe	CMH PARTNERSHIP OF SE MI	734-222-3818
Montcalm	MID-STATE HEALTH NETWORK	517-253-7525
Montmorency	NORTHERN MI REGIONAL ENTITY	231-487-9144
Muskegon	LAKESHORE REGIONAL ENTITY	231-342-3379
Newaygo	MID-STATE HEALTH NETWORK	517-253-7525
Oakland	OAKLAND CO CMH AUTHORITY	248-858-1210
Oceana	LAKESHORE REGIONAL ENTITY	231-342-3379
Ogemaw	NORTHERN MI REGIONAL ENTITY	231-487-9144
Osceola	MID-STATE HEALTH NETWORK	517-253-7525
Oscoda	NORTHERN MI REGIONAL ENTITY	231-487-9144
Otsego	NORTHERN MI REGIONAL ENTITY	231-487-9144
Ottawa	LAKESHORE REGIONAL ENTITY	231-342-3379
Preque Isle	NORTHERN MI REGIONAL ENTITY	231-487-9144
Roscommon	NORTHERN MI REGIONAL ENTITY	231-487-9144
Saginaw	MID-STATE HEALTH NETWORK	517-253-7525
Sanillac	REGION 10	810-966-7803
Shiawassee	MID-STATE HEALTH NETWORK	517-253-7525
St Clair	REGION 10	810-966-7803
St Joseph	SW MI BEHAVIORAL HEALTH	269-979-9132
Tuscola	MID-STATE HEALTH NETWORK	517-253-7525
Van Buren	SW MI BEHAVIORAL HEALTH	269-979-9132
Washtenaw	CMH PARTNERSHIP OF SE MI	734-222-3818
Wayne	DETROIT WAYNE MH AUTHORITY	313-833-2500
Wexford	NORTHERN MI REGIONAL ENTITY	231-487-9144

2.3 HOSPITAL ADMISSIONS

General Information

- Hospital admissions should be based on medical necessity and appropriateness.
- UnitedHealthcare Community Plan uses nationally recognized MCG to guide medical necessity determinations. UnitedHealthcare Community plan also uses the Michigan Association of Health Plan (MAHP) Bariatric Surgery Guidelines to guide decisions concerning gastric procedures for weight management control. The guidelines used to make determinations are available upon request to providers by calling **800-903-5253**. UnitedHealthcare Community Plan staff will read the criteria over the phone or fax the specific criteria related to the case in questions.
- It is the responsibility of the hospital/admitting facility to verify that UnitedHealthcare Community Plan authorized an admission.
- Please call UnitedHealthcare Community Plan Monday to Friday, at **800-696-8735**; staff is available from 8:30 a.m. to 5:30 p.m.
- You may also fax your hospital review to 855-225-9847. UnitedHealthcare Community Plan will begin processing the request.
- Fax clinical information related to the admission to 800-882-1105. Clinical information and will be routed to a nurse reviewer.

Elective Admissions

- All elective admissions must be prior authorized by UnitedHealthcare Community Plan.
- Inpatient and Outpatient Elective Procedures/ Surgeries require authorization if they are listed on the **Precertification/Authorization List**. Please call no later than 72 hours in advance.
- All non-emergent surgery patients must be admitted on the day of surgery unless pre-op days are medically necessary and authorized by UnitedHealthcare Community Plan's Health Services department in advance.
- All diagnostic and laboratory tests should be performed prior to admission. Results and copies of pertinent medical records should accompany the member to the hospital.

Hospital Admission Notification by the PCP

When the condition of a member necessitates hospitalization, the admitting provider should obtain authorization for admission by calling the UnitedHealthcare Community Plan.

- The member's name and birth date
- The member's ID number
- The admitting care provider and facility
- The admitting diagnosis
- Pertinent medical information, including the member's medical history
- Date of admission
- Treatment plan and planned procedures or surgeries
- Known problems that may affect the outcome of the member's hospital stay

UnitedHealthcare Community Plan requires that participating providers observe the following utilization management requirements concerning inpatient admissions:

- The hospital or attending care provider must contact UnitedHealthcare Community Plan for each admission.

- In the event that the clinical information is not available or the provider notifies UnitedHealthcare Community Plan after normal business hours, UnitedHealthcare Community Plan pends the admission and provides a tracking number until clinical information is received. NOTE: A tracking number does not guarantee payment of the claim.
- UnitedHealthcare Community Plan informs the facility or care provider of the date that the clinical information must be received. If the clinical information is not received by phone or fax within the requested time frame, UnitedHealthcare Community Plan denies payment.
- If the member requires the care of specialists while inpatient, UnitedHealthcare Community Plan requires that the attending provider make a referral to providers in UnitedHealthcare Community Plan specialty network where available.
- Discharge Summaries must be placed in the member's inpatient medical record and a copy also sent to the member's PCP for inclusion in the member's ambulatory record.

Hospital Admission Notification by the Hospital

It is the responsibility of the facility to verify eligibility. All hospitals must contact UnitedHealthcare Community Plan for all inpatient admissions within 24 hours or the next business day. The following information is necessary:

- The member's name and birth date
- The member's ID number
- The admitting care provider and facility
- The admitting diagnosis
- Date of admission
- Clinical information to support the need for admission

Upon receipt of the required information, UnitedHealthcare Community Plan either approves the admission with an initial assigned length of stay or refers the case to the UnitedHealthcare Community Plan Medical Director for review and determination. UnitedHealthcare Community Plan provides the review decision information to the caller.

- UnitedHealthcare Community Plan only authorizes additional days when the hospital contacts UnitedHealthcare Community Plan for Concurrent Review prior to the exhaustion of the initial or approved length of stay. This may be done by phone or by fax.
- The hospital must contact UnitedHealthcare Community Plan with discharge information by phone or fax to help ensure coordination of care between health care settings.
- UnitedHealthcare Community Plan requires that the facility notify UnitedHealthcare Community Plan when a UnitedHealthcare Community Plan member is transferred to another facility.

Birth Related Admissions and Requirements

Emergency Room labor checks do not require prior authorization. A labor check is considered to be any stay for maternity purposes of less than six hours duration.

Delivery and birth-related admissions may proceed without prior authorization.

UnitedHealthcare Community Plan requires that the facility provide UnitedHealthcare Community Plan with the following clinical information within 24 hours of the birth, or the next business day using the **Delivery Admission Review Form** as a guide to requested information. This form can be found in the Appendix.

- The date & time of birth.
- Method of delivery.
- Birth weight & sex.
- Apgar scores and discharge date if known.

Concurrent Review is necessary for:

- Pregnant members requiring inpatient hospitalization for any pregnancy related complications.
- Vaginal deliveries that require hospitalization longer than two days.
- C-section deliveries that require hospitalization longer than four days.
- Newborns remaining hospitalized after mother's discharge.

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient 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 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 uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Discharge Planning

- Discharge planning starts the day of admission. This is to assure the member's needs at home will be anticipated and met in an efficient, timely manner. Therefore, it is important that the facility Discharge Planner notify the UnitedHealthcare Community Plan Health Services department of any issues that may affect discharge. This may include:
  - Member's ability to care for self after discharge including ability to understand instructions
  - Member's support system at home (family, chore worker)
  - Member's home situation (house, apartment, shelter, street, stairs, etc.)
  - Member's social situation (drug abuse, other abuse)
  - Equipment needed for discharge (or equipment already at home)

  - Services needed for discharge (Home Health, Infusion, SNF, Rehab)
  - Previous non-compliance or failure to follow-up with the PCP
  - Discharge medications
- When needed, the UnitedHealthcare Community Plan Health Services department assists the facility in making outpatient care plans, such as case management for catastrophic illnesses or injuries or difficult placements.
- Some post hospital outpatient services, such as home health, home IV infusion, etc., must be pre-authorized.
- Use UnitedHealthcare Community Plan's contracted providers when available.
- UnitedHealthcare Community Plan's Health Services department is available to assist providers in making arrangements for discharge.

Financial Incentives

UnitedHealthcare Community Plan UM decisions are based only on the appropriateness of care and service and benefit coverage. Further, UnitedHealthcare Community Plan does not specifically reward providers or other individuals for issuing denials of coverage, service or care. Lastly, UnitedHealthcare Community Plan financial incentives for UM decision makers do not encourage decisions that result in underutilization.

2.4 MATERNAL INFANT HEALTH PROGRAM (MIHP)

Recommendations for Prenatal Care

- Prenatal care is a preventive, wellness health service providing a series of comprehensive visits throughout the pregnancy.
- The goal of prenatal care is to help ensure, as much as possible, an uncomplicated pregnancy and the delivery of a thriving, healthy infant.
- UnitedHealthcare Community Plan requires that UnitedHealthcare Community Plan providers screen all pregnant members to determine if they qualify for MIHP. Providers are asked to fax a copy of the completed screening tool to the MIHP provider (please refer to the sample MIHP Screening Tool included in the Appendix).

Pregnancy Clinical Practice Guidelines

UnitedHealthcare Community Plan fully adopts Michigan Quality Improvement Consortium (MQIC) guidelines for Routine Prenatal and Postnatal Care. Please refer to Section 3.1 Preventive Health and Clinical Practice Guidelines for these guidelines.

PCP Responsibilities

- Document pregnancy and referral to Obstetrician.
- Complete a referral follow-up to help ensure the prenatal care is initiated and to help ensure that pertinent information regarding the pregnancy and birth are obtained from the Obstetrician and placed in the patient's medical record.
- Mail or fax a signed and completed MIHP Screening Tool to the MIHP provider.

Obstetrician Responsibilities

- Send a care summary to the referring PCP.
- Mail or fax a signed and completed MIHP Screening Tool to the MIHP provider.

MIHP

The MIHP programs' goal is to reduce infant mortality and morbidity. MIHP providers work with expecting mothers to alleviate social and psychological

problems, educate regarding health status, address transportation needs, and contribute to the delivery of a healthy, full-term baby. These programs were established to supplement the routine prenatal care provided by obstetricians, nurse providers, and certified nurse mid-wives, and are not intended to in any way replace those services.

Pregnant women on Medicaid can qualify for MIHP at any time during their pregnancy. Newborns may qualify as early as birth for MIHP. The services for both programs include:

- Psychosocial and Nutritional Assessment
- Plan of Care Development
- Professional Intervention of a team consisting of a qualified:
  - Social Worker
  - Nutritionist
  - Nurse
  - Infant Mental Health Specialist (when available)
- Transportation (managed by the MIHP)
- Referral to community services
- Coordination with medical care providers
- Childbirth classes or parenting education classes

Referrals to a contracted MIHP provider are encouraged if any of the following conditions exist:

- Homelessness or dangerous living situation
- Negativity or ambivalence towards the pregnancy
- Mother younger than the age of 18 with no family support
- Need for assistance to care for self or infant
- Mother with cognitive, emotional, or mental impairment
- Nutrition problem
- Abuse of alcohol, drugs or nicotine
- Need for transportation to keep medical appointments
- Need for childbirth education classes

At least one of the above criteria must be met for the member to qualify for services.

Referrals to a contracted MIHP provider are encouraged if any of the following situations exist:

- Abuse of alcohol or drugs (especially use of cocaine) or smoking
- Mother under the age of 18 with no family support
- Family history of child abuse or neglect
- Failure to thrive
- Low birth weight (<2500 grams)
- Mother with cognitive, emotional, or mental impairment
- Homelessness or dangerous living situation
- Any condition that may place the infant at risk for death, illness, or significant impairment when indicated by a care provider

A listing of contracted MIHP providers can be found at our on-line provider directory.

2.5 CASE & DISEASE MANAGEMENT PROGRAMS

Introduction

UnitedHealthcare Community Plan's mission is to improve member health through information-based medicine. To fulfill this mission, in collaboration with our health care provider partners, UnitedHealthcare Community Plan has several programs designed to promote optimal health and health outcomes for our members.

Case Management

The goal of UnitedHealthcare Community Plan's Case Management Program is to facilitate the organization and sequencing of appropriate health care services for our medically complex and high-risk members.

Case Management involves:

1) Coordinating all of the member's health care services, including home health care.

2) Educating the member and his/her family on the illness, maintaining wellness and preventing acute episodes.

3) Reducing exacerbations and resulting in emergency room visits and hospital readmissions and thus health care costs.

4) Care coordination is performed by case managers and outreach specialists.

The process of Case Management is most successful in achieving desired outcomes when:

- Medically complex and high-risk members are identified early and UnitedHealthcare Community Plan Case Managers, in collaboration with the member's health care providers, can initiate interventions as soon as possible.

If you have a UnitedHealthcare Community Plan patient who you believe can benefit from this program, please call our Customer Service department at **800-903-5253**.

Healthy First Steps

UnitedHealthcare Community Plan is proud to provide OB case management services to our high risk ante- partum/post-partum members and their doctors through an exciting case management program called Healthy First Steps.

UnitedHealthcare Community Plan's Quality Outreach department and dedicated OB Case Managers administer the Healthy First Steps Program. The Healthy First Steps Program provides intensive phone support, education and community resources to some members of UnitedHealthcare Community Plan who are expecting a baby, or who have recently delivered a baby.

For additional information, please call **800-903-5253**.

Disease Management Programs

UnitedHealthcare Community Plan developed disease management programs to meet the needs of our members with chronic illnesses and to support your efforts for member self management and optimal health status. These programs are all based on nationally recognized and evidence-based clinical practice guidelines.

UnitedHealthcare Community Plan has four programs; there is no cost to UnitedHealthcare Community Plan members to be enrolled in these programs.

- Diabetes
- COPD
- CHF
- Asthma

UnitedHealthcare Community Plan automatically enrolls members who we identify as having one of these diagnoses, but you may also refer a newly diagnosed patient for enrollment by calling **800-903-5253**. Ask to speak with a Disease Management Nurse. You'll need the patient's:

- Name
- ID number
- Phone number

- Specific care needs

UnitedHealthcare Community Plan provides our members enrolled in disease management programs with:

- Information about their conditions
- Assessment and assistance with immediate needs
- One-on-one health information including education on risk factors, healthy lifestyles and adherence to evidence- based treatment
- Follow-up, education on or compliance with treatments you have ordered
- Smoking cessation information
- Notification of needed tests, abnormal lab values or significant changes
- Reminders for missed tests or screens
- Direction to online patient education that support patient decisions and management
- Information on depression in people with chronic illnesses and where to get help

For you, UnitedHealthcare Community Plan provides you with:

- Tools and resources about specific chronic conditions
- Names of members who need tests or who have significant changes

3.1 PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

UnitedHealthcare Community Plan takes an active interest in the preventive health and wellness of its membership. We are also committed to partnering with our providers to help ensure that the members receive quality health care. In accordance with our commitment to preventive health, wellness and quality, UnitedHealthcare Community Plan is participating with the Michigan Quality Improvement Consortium (MQIC) for purposes of developing, updating and implementing both preventive health and clinical practice guidelines.

MQIC Preventive Health Guidelines (PHGs) and Clinical Practice Guidelines (CPGs) are established through the collaborative efforts of participating Michigan health plans, medical societies/associations, and other involved organizations seeking to achieve consistent delivery of evidence-based services and better health outcomes. Each PHG and CPG is reviewed minimally every two years for changes or revisions in evidence-based national standards of care and updated as is appropriate.

UnitedHealthcare Community Plan realizes that clinical decisions about patient care should always be tailored to each individual's medical and psychosocial needs. Our goal is to provide our care provider network with resources that support clinical practices that are consistent with the nationally recognized recommendations. Therefore, adherence to the MQIC guidelines may lead not only to improved outcomes but also to a better quality of life for each patient.

Clicking on **mqic.com** will take you to MQIC Guidelines. Providers may obtain a paper copy of the guidelines by contacting your provider or hospital and facility advocate. If you do not know the name of your Advocate, contact Customer Service at **800-903-5253**.

Child Immunization Schedule

Follow the link for the recommended **Childhood Immunization Schedule**.

Well Child and Adolescent Care

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21 years. EPSDT, also known as "well child care or adolescent care" was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. The EPSDT program is based on the American Academy of Pediatrics' (AAP) recommendations for preventive pediatric health care. It is imperative that UnitedHealthcare Community Plan network providers who accept children and adolescents into their member panel adhere to the requirements of this program. EPSDT supports two goals:

1) Assuring the availability and accessibility of required health care resources.

2) Helping Medicaid recipients and their parents or guardians effectively use these resources.

EPSDT elements include:

- Health and developmental history
- Height and weight measurements and age appropriate head circumference
- Blood pressure for children age three years and over

- Age appropriate unclothed physical examination
- Age appropriate screening, testing and vaccinations
- Immunization review and administration
- Blood lead testing for children under six years of age
- Developmental/behavioral assessment
- Nutritional assessment
- Hearing, vision and dental assessments
- Health education including anticipatory guidance
- Interpretive conference and appropriate counseling for parents or guardians

Providers need to make appropriate referrals for diagnostic and treatment services determined to be necessary.

- Oral screening should be part of a physical exam; however, each child must have a direct referral to a dentist after age two.
- Children should also be referred to a hearing and speech clinic, optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services as necessary.
- Referral to a community mental health services or a UBH participating behavior health specialist also may be appropriate.
- Children at risk should be tested according to the American Academy of Pediatrics (AAP) guidelines. Problems found or suspected during an EPSDT/well care exam must be diagnosed and treated as appropriate. Referrals must be made based on standards of good practice and AAP's recommendations for preventive pediatric health or presenting need.

For example, if a child is found to have elevated blood lead levels in accordance with standards disseminated by the Michigan Department of Community Health, then a referral should be made for follow-up services that may include an epidemiological investigation to determine the source of blood lead poisoning. UnitedHealthcare Community Plan encourages providers to provide these essential services even when a child or adolescent presents with an illness, not doing so is a missed opportunity that may not avail itself again.

UnitedHealthcare Community Plan, in collaboration with other Michigan Medicaid health plans, worked with Michigan State University's Institute for Healthcare Studies to develop provider resources useful in providing care to children and adolescents. Providers may link to this information that includes information on: EPSDT/Well Child Exam forms, Billing Codes, Developmental Screening tools, Immunization Tools and Resources for Women, Infants & Children (WIC) by clicking on: **ihp.msu.edu**.

UnitedHealthcare Community Plan conducts outreach services to remind members who are due or overdue for EPSDT/well child visits.

Billing of EPSDT/Well Child Care

CPT indicates the following under the preventive medicine service section of CPT: If an abnormality(ies) is encountered or a preexisting problem is addressed in the process of performing the preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant separately identifiable. Evaluation and

Management service was provided by the same care provider on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

If you have additional questions regarding this notice, please contacting your provider or hospital and facility advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.

Lead Screening/Lead Testing Guidelines

The State of Michigan requires all Medicaid eligible children be tested for lead at 12 and 24 months of age; or between 36 and 72 months if not tested previously. Effective August 2005 MDHHS released the Statewide Lead Screening/Lead Testing Provider Guidelines aimed at clarifying the following:

- Testing - requires a blood specimen
- Screening - is asking exposure related questions
- Initial blood test - does not need to be a venous specimen, it can be capillary
- When to retest - is based on the blood lead level (BLL) results of a prior test
- Cues - for asking about potential ethnic exposures to lead
- Actions - Required by providers and LHD staff are outlined by specific blood lead levels
- Clinical Evaluation Components - conducted on a child who is lead poisoned
- Additional information on lead testing and lead poisoning can be found on the Michigan Department of Community Health site at michigan.gov.

Pain Management

In 2003, members of the Michigan Board of Medicine and Michigan Board of Osteopathic Medicine and Surgery finalized and adopted "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain". UnitedHealthcare Community Plan adopted these guidelines and conducts medical record review periodically to monitor for compliance.

The guidelines state that patients should have access to appropriate and effective pain relief that will serve to improve the quality of life for those who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Boards advise that medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and nonpharmacological modalities. Further, that pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Care providers should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

MDHHS advises that care providers should be diligent in preventing the diversion of drugs for illegitimate purposes. These guidelines are available at the Michigan Department of Health & Human Services website at michigan.gov or available as a hard copy by contacting your provider advocate. If you do not know the name of your Advocate, call Customer Service at **800-903-5253**.

Section 4: QUALITY IMPROVEMENT

4.1 QUALITY IMPROVEMENT PROGRAM

UnitedHealthcare Community Plan is committed to its founding mission to improve member health through information-based medicine. UnitedHealthcare Community Plan achieves this by adhering to the principles regarding delivery of valuable services to our customers and participating providers in addition to providing our employees with an environment that supports high standards of performance. UnitedHealthcare Community Plan' s Quality Improvement (QI) Program establishes standards that encompass all quality management activities within the plan. UnitedHealthcare Community Plan considers all QI activities privileged and confidential, which are consistent with state and federal laws

To achieve desired performance outcomes, UnitedHealthcare Community Plan's QI Program is guided by important objectives:

A) Improve the health status of the plan's members through:

- Implement programs that address the priority health care needs of UnitedHealthcare Community Plan's membership. These programs include preventive health disease management and care management.
- Monitor care outcomes against national practice guidelines and local and national outcomes measures.
- Use a multi-disciplinary approach to include primary and specialty care providers as well as community resources to improve services and care delivery opportunities.
- Oversee delegated health improvement programs.

B) Provide for an effective monitoring and evaluation process that helps ensure care and services provided to the plan's members meets acceptable medical practice standards and contractual performance expectations and is positively perceived by members, MDHHS and health care professionals.

- Review and distribute nationally recognized guidelines of medical practice and preventive care.
- Develop medical care administrative services related to quality management activities, access/ availability, credentialing/recredentialing, peer review, confidentiality, etc.
- Annually survey members and providers as to satisfaction with UnitedHealthcare Community Plan service quality.
- Acquire and maintain data systems appropriate and adequate to support UnitedHealthcare Community Plan QI activities.

C) Help ensure prompt identification and analysis of barriers to desired performance improvement opportunities, subsequent improvement interventions and follow-up.

- Identify and assess important issues and concerns of health care services provided to UnitedHealthcare Community Plan members ensuring coordination and continuity of care across and between general medical and behavioral care services, sites and providers.
- Continually improve UnitedHealthcare Community Plan's QI Program and help ensure responsiveness to revised minimum performance levels as established by accreditation and regulatory bodies.

- Provide periodic feedback and education to network providers and customers/members regarding status of quality management initiatives and applicable measurements.

D) Encourage patient safety.

- Distribute information to members which improves their knowledge about medication safety.
- Facilitate informed decision-making.
- Collaborate with network providers/providers and the greater health care community, as appropriate, to establish mechanisms to support and promote safe clinical practices.

The UnitedHealthcare Community Plan Board of Directors has overall responsibility for the QI Program. Responsibility for the broad range of activities associated with the QI Program has been delegated to the Chief Medical Officer and Director of Quality Management. A Quality Management Committee (QMC), composed of participating providers and senior staff, oversees the QI Program. The health plan President chairs the QMC, which meets at least ten times a year and has oversight responsibility for issues affecting health services delivery. The QMC reports its recommendation to the UnitedHealthcare Community Plan Board of Directors.

Responsibilities of the QMC include:

- Review and approve the QI Program description, annual evaluation and annual work plan.
- Assure that system-wide trends are identified and analyzed, and that focused interventions are implemented to improve performance.
- Recommend areas for study.
- Review and approve the development, implementation, and evaluation of benchmarks.
- Review and approve clinical practice guidelines, medical record documentation standards and preventive health guidelines.
- Assure that QI efforts are prioritized, consist of appropriate resources and that resolution occurs.
- Review reports from standing subcommittees.
- Report to the Board of Directors on program quality.
- Review recommendations for delegation of QI, Utilization Management, credentialing/recredentialing and make recommendations to the Executive Committee. The Executive Committee retains the authority to authorize delegation.

The QMC has five standing subcommittees:

- Credentialing Committee credentials/recredential of providers and facilities and reviews performance of same.
- Pharmacy and Therapeutics Committee reviews and updates appropriate accessibility, availability, and utilization of drugs to reflect the evolving standard of practice in medicine and drug therapy. This committee also implements the UnitedHealthcare Community Plan formulary.
- Health Services Committee reviews statistics on utilization and provides feedback on Utilization Management and Case Management policies.
- Member Appeal Committee reviews member complaints and grievances and tracks and notes trends and timeliness of resolution.

- Service Improvement Committee reviews service quality and customer satisfaction data and recommends initiatives to improve service to members and providers.

Care providers who are interested in serving on any subcommittee of the QMC should contact their provider advocate. If you do not know the name of your Advocate, call Customer Service at 800-903-5253. To be considered for membership, the provider must meet the following criteria:

- Contracted with UnitedHealthcare Community Plan.
- Board certified.
- Demonstrated compliance with UnitedHealthcare Community Plan quality standards.

All care providers are required to participate in and cooperate with the UnitedHealthcare Community Plan QI Program. Care providers who are interested in learning more about any of the QI processes or initiatives, or who wish to obtain a copy of the QI Program Description, should contact their provider advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.

QI Program elements include, but are not limited to:

- Annual access to care evaluation.
- Annual availability of provider's evaluation.
- Annual medical record review and evaluation.
- Clinical practice guideline development, implementation and evaluation.
- Preventive health services guideline development, implementation and evaluation.
- Care continuity and coordination evaluation.
- Annual HEDIS reporting.
- Annual member satisfaction survey (CAHPS).
- Annual provider satisfaction survey.
- Ongoing monitoring of member complaints and appeals, quality of care concerns and annual evaluation thereof.
- Provider profiling.
- Delegation oversight.
- Member safety.
- Disease management programs.
- Care management.

Peer Review

Peer review is a supportive process designed to improve the quality of care UnitedHealthcare Community Plan's members receive from our practitioner network. The process is governed by applicable Michigan and federal law and is protected by the immunity and confidentiality provisions of those laws. Peer reviews examine the medical necessity and quality of health care services and outcomes. The evaluations are conducted by UnitedHealthcare Community Plan providers of the Credentialing Committee. A provider who is dissatisfied with the peer review findings may appeal a peer review recommendation. A provider may submit a written request to the Credentialing Committee stating the reasons for the disagreement and may ask to present at the Credentialing Committee.

Provider Criteria

The following table outlines UnitedHealthcare Community Plan's credentialing and re-credentialing criteria for providers.

The ability of a provider to meet credentialing criteria does not guarantee acceptance as a UnitedHealthcare Community Plan participating provider. UnitedHealthcare Community Plan reserves the right to accept or deny any provider application, with or without cause.

Criteria	Means of Validation	Frequency of Validation
Current Michigan State License to practice and Michigan Controlled Substance License (if applicable)	Verification with Michigan Department Commerce License Verification Unit (MDCLVU)	Initial credentialing, every three years at re-credentialing and on an ongoing basis
Current Federal Drug Enforcement Agency License (DEA) (if applicable)	Visual inspection of license and/or verification with DEA (NTIS) registration file	Initial credentialing and every three years at re-credentialing
Completion of appropriate medical education and post-graduation training (internship and/or residency program), including Board Certification (if applicable)	Primary source verification with certifying entity ABMS, AMA/AOA, ECFMG as necessary or verification from professional school and hospital	Initial credentialing
Current malpractice coverage as required by UnitedHealthcare Community Plan	Visual inspection of the malpractice image facesheet	Initial credentialing and every three years at re-credentialing
Acceptable malpractice claims history	NPDB/HIPDB and information from malpractice carrier, application information	Initial credentialing and every three years at re-credentialing
Privileges at UnitedHealthcare Community Plan participating hospital(s) (if applicable)	Primary source verification with hospital(s)	Initial credentialing and every three years at re-credentialing
Appropriate work history of professional activity	Information submitted on credentialing application and/or Curriculum Vitae	Initial credentialing and every three years at re-credentialing and on an ongoing basis
Free of any sanctions and/or restrictions through state, federal, and local authorities	Disclosure information on credentialing application, NPDB/HIPDB information; verification with MDCLVU	Initial credentialing and every three years at re-credentialing and on an ongoing basis
Acceptable clinical measures, cost effectiveness measures, service measures, quality of care, performance improvement activities and administrative compliance	Site Review, Medical Records Review, focused quality of care review, utilization review, member services complaints and/or appeals, and provider network compliance	
Initial credentialing	A site review and medical record review performed (if applicable); review of all areas performed every three years at re-credentialing	
Access and Availability	Credentialing application and site review	Initial credentialing and every three years at re-credentialing

Facility Criteria

UnitedHealthcare Community Plan credentials hospitals, free standing surgical centers, skilled nursing facilities and home healthcare agencies. Specific criteria vary based upon the type of facility that is being reviewed. The general criteria for contracting with hospitals and ancillary sites are as follows:

- Acceptable accreditation, certification or compliance with UnitedHealthcare Community Plan established standards
- In good standing with Federal and State regulatory agencies
- Current State license, if applicable
- Appropriate insurance coverage
- On-site facility review, if not accredited

4.2 MONITORING AND IMPROVING HEALTH CARE AND SERVICE QUALITY

The UnitedHealthcare Community Plan QI Program implements a comprehensive set of activities to help ensure that providers deliver accessible, appropriate, high quality care in a timely and respectful manner. Processes used to monitor and improve quality include the following:

- A thorough and rigorous credentialing process which includes primary source verification of a provider's credentials; accessing the National Provider's Data Bank and state agencies, onsite reviews of medical record documentation practices, on-site review of provider facilities and as well as access and availability.
- A recredentialing process designed to help ensure that the circumstances under which the provider was originally credentialed have not changed, and that there is documented evidence of the provision of quality care based on audits of the provider's records.
- Tracking and trending member complaints, grievances, and corrective action plans.
- Bi-annual on-site chart audits of PCPs and high volume specialists to help ensure compliance with Medical Records and Charting Standards, as well as key aspects of clinical guidelines adopted by UnitedHealthcare Community Plan (see Section 3.1 Preventive Health and Clinical Practice Guidelines). Audit tools are included in the Appendix.
- Annual measurement of clinical outcomes through production and submission of HEDIS.
- Annual member satisfaction survey.
- Ongoing review of drug prescribing patterns.
- Continual monitoring of utilization information to identify potential quality of care concerns.
- Conduct special studies regarding clinical care for specific high risk, high frequency conditions and populations.
- Trending of aggregated performance data in order to identify opportunities for improvement.
- Evaluation of health outcomes and quality of care processes against standards and benchmarks.
- Distribution of PCP profiles, contrasting individual PCP utilization patterns to other similar participating care providers.

4.3 UNITEDHEALTHCARE COMMUNITY PLAN OVERSIGHT OF SUBCONTRACTED PROGRAMS

UnitedHealthcare Community Plan has arranged for selected services to be provided by subcontractors, outpatient behavioral health benefits, vision benefits and pharmacy benefits management. All of these "delegated" activities are subject to quality management review. UnitedHealthcare Community Plan expects subcontractors to maintain a written quality management plan and to have processes in place for quality monitoring and improvement. UnitedHealthcare Community Plans' QMC reviews these plans, and the Quality Management department monitors compliance with the plans through periodic reviews.

4.4 PROVIDER COOPERATION WITH QUALITY IMPROVEMENT ACTIVITIES

General Information

Providers are required to cooperate with all quality improvement activities, including, but not limited to investigations of member complaints and quality of care issues.

Providers also must cooperate and participate in focused quality studies conducted by UnitedHealthcare Community Plan, such as medical record data abstraction, review of phone response times, or accessibility of provider offices.

UnitedHealthcare Community Plan may request provider input and participation in special education and outreach projects, such as child immunizations or pregnancy outreach.

Providers are encouraged to initiate quality improvement activities within their offices. Documentation of those activities may be reviewed by UnitedHealthcare Community Plan as a part of contracting, credentialing and quality improvement processes.

Corrective Action Plans

UnitedHealthcare Community Plan may ask providers or other health care providers who are not in compliance with UnitedHealthcare Community Plan standards or do not cooperate with quality improvement initiatives to submit a corrective action plan.

Required corrective actions may include changes in policies, practices or providing written verification of compliance with standards.

The Quality Management department reviews all corrective action plans and is available to assist providers in developing and implementing the plans.

Any findings or requests for corrective action plans may be appealed through written correspondence to the UnitedHealthcare Community Plan CMO.

Access to Records

Providers must allow representatives from UnitedHealthcare Community Plan or its designee to access medical records for the purpose of quality improvement activities, in accordance with the terms of the provider contract. If you use Electronic Medical Records (EMR) access systems, you allow UnitedHealthcare Community Plan to automatically access your EMR system for any member treated at your facility to help ensure our quality assurance and obligations.

Providers are not required to obtain prior consent from the member in order to share medical records with UnitedHealthcare Community Plan. State law MCL 400.111b(7) permits state contracted qualified health plans to obtain medical records of Medicaid enrollees for quality of care and utilization management purposes.

Providers may not charge UnitedHealthcare Community Plan any fees for the copying of records for quality improvement studies.

Any other disclosure of medical records by the provider to an outside party should be consistent with applicable laws.

Confidentiality

UnitedHealthcare Community Plan's members have the right to confidentiality with regard to their medical records and information about their health care.

All information in a member's medical record will remain confidential and may be disclosed to authorized personnel only.

Any and all information gathered by UnitedHealthcare Community Plan for the purposes of quality improvement, including individual provider performance data, will remain strictly confidential.

Quality of Care Case Referral

In the event that a provider suspects a quality concern, the provider should report these incidences to the UnitedHealthcare Community Plan Quality Management department, which will thoroughly investigate these concerns with strict confidentiality. The provider can call the Quality Management department at 800-903-5253 to report concerns, or submit your concerns in writing or by facsimile to:

UnitedHealthcare Community Plan
Quality Management Department
26957 Northwestern Highway, Suite 400
Southfield, MI 48033
Facsimile: 248-331-4519

4.5 CREDENTIALING AND RECREDENTIALING

We are dedicated to providing our customers with access to effective health care and, as such, we periodically review the care and services delivered to our customers. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use the CAQH Universal Provider Data Source (UPD) for gathering credentialing data for care providers and other health care professionals. The CAQH process is available to care providers and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing care providers and other health care professionals to make updates online.
We have 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 recredentialing are instructed on the paper method for accessing the CAQH UPD.

Rights Related to the Credentialing Process

Care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at **877-842-3210**.

While current board certification is not a requirement for network participation, it is a requirement for designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application.

Care providers can view the Credentialing and Recredentialing Plan at **UHCprovider.com** > Menu > Resource Library > Join Our Network & Credentialing.

Provider Office Reviews

UnitedHealthcare Community Plan may conduct site reviews of all PCPs, obstetrics and gynecology offices, to determine compliance with UnitedHealthcare Community Plan standards where potential concerns are identified.

- UnitedHealthcare Community Plan may conduct a site visit in response to complaints or as part of performance monitoring.
- Site visits include a review of office procedures, office environment, safety, accessibility and medical record keeping practices.

4.6 DOCUMENTATION GUIDELINES

Important Medical Record Documentation Requirements

UnitedHealthcare Community Plan requires PCPs to maintain medical record systems in a manner that is current, detailed and organized to effect prompt retrieval of information, effect privacy of protected health information, help ensure medical record accessibility and permit effective and confidential patient care and quality review. UnitedHealthcare Community Plan requires that providers make medical records or copies of medical records available to UnitedHealthcare Community Plan, agents of the Michigan Department of Community Health, Michigan Office of Financial and Insurance Regulation, Centers for Medicare and Medicaid Services and any external quality review organization for purposes of accreditation and assessing the quality of care rendered. UnitedHealthcare Community Plan requires providers to retain medical records for at least seven years from the date of the most recent entry.

UnitedHealthcare Community Plan establishes the following basic requirements for an acceptable medical records system:

- Medical records are stored in a manner to protect the privacy of protected health information.
- If a computerized medical records system is utilized, the PCP establishes and enforces policies and procedures for saving, storing, securing, protecting and retrieving medical records.
- Medical records are organized in a logical manner, by individual patient or other medical records filing system

Periodically, UnitedHealthcare Community Plan performs medical record documentation review on a sample of member records. Where 80% of the records sampled vary substantially from the

established standards, UnitedHealthcare Community Plan will work collaboratively with the provider and his/her office staff to help ensure medical record documentation and record keeping practices comply with established expectations.

Providers may not charge UnitedHealthcare Community Plan any fees for the copying of records for quality improvement studies. Please click the following for UnitedHealthcare Community Plans' **Medical Record Documentation Review Guidelines**.

Documentation Standards

UnitedHealthcare Community Plan expects that all primary care provider medical record documentation standards and practices will comply with the following requirements:

- Each page in the record contains the patient's full name or ID number.
- Biographical/personal data includes:
  - Date of birth
  - Current address
  - Work/home telephone numbers as applicable
  - Employer, as applicable
  - Marital status if age 18 or older
- Legibility - The record is legible to someone other than the writer.
- All entries are signed and dated - All entries in the medical record contain the author's identification. Signature can be in the form of the provider's initials, it may be a written or a unique electronic signature. Stamped signatures are not acceptable.
- Advance directives discussion - Chart must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children have been given information regarding advance directives.
- Medication list - Can be a separate form or can be found within the progress notes. List prescribed medications, including dosages and dates of initial or refill prescriptions. List over-the-counter and sample medications and dosages.
- Problem list* - Using either a separate sheet or listing in the progress notes, include a list of all significant illnesses and active medical conditions.
- Cultural and linguistic needs - Document the member's cultural and linguistic needs.

History

- Medical history - Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (6 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
- Family history - Minimally include pertinent medical history of parents and/or siblings.
- Social history - Minimally include pertinent information such as occupation, education, and living situation.
- Allergies and/or adverse reactions are noted or NKA is noted - All agents causing some type of negative response must be clearly and easily identified.
- Preventive services and screenings offered and provided in accordance with protocols
  - Child and adolescent immunization record, current
  - Age/gender appropriate preventive health services

Problem Evaluation/Management

- Pertinent subjective and objective information of presenting complaints - History, onset and duration of present illness.
- Physical exam.
- Plans/actions* must be consistent with findings/diagnosis
  - Timeframe for follow-up visit, as appropriate
  - Appropriate use of referrals/consultations, studies, tests
  - Follow-up for all abnormal diagnostic tests, procedures, consultation reports
- Lab and other studies ordered as appropriate with evidence of follow-up.
- Test, lab results and consultant summaries are included in the medical record with evidence of provider review, if applicable.
- Evidence of continuity and coordination of care between primary care site and specialists and between primary care sites and facilities - Minimally medical records contain consultant reports, ER reports, and facility discharge reports as applicable.
- Unresolved issues from previous visits are addressed in subsequent visits.
- "No shows" or missed appointments are documented along with follow-up efforts to reschedule the appointment.
- Evidence of patient education - Reference to written material provided or verbal education/counseling.

* Critical Element: All providers are expected to be fully compliant with the critical elements. Providers who fail to meet one or more critical element(s) will receive written feedback and may be individually contacted by UnitedHealthcare Community Plan staff for further consultation, review, and/or corrective action as needed.

Electronic Medical Records (EMR) Access

EMR is any type of electronic medical information management system. It improves efficiency and quality inpatient care through integrated decision support, which allows better information storage, retrieval and data sharing capabilities. EMR systems allow you to access and share information smoothly and quickly, enable you to work more efficiently and make better quality decisions. EMR systems will follow these documentation guidelines.

Section 5: BILLING TO UNITEDHEALTHCARE COMMUNITY PLAN

5.1 BILLING INSTRUCTIONS FOR CMS-1500

Billable services may be submitted electronically or on a standard CMS-1500 claim form. Other types of billing forms will not be accepted and will be returned.

A health care professional must submit claims using the data elements on the CMS-1500 paper form consistent with the Medical Service Administration's CMS Uniform Billing Guidelines. These guidelines can be found in the **Michigan Medicaid Provider Manual**.

Note: The appropriate segments must be completed for electronic claims following the HIPAA guidelines as required for an 837 v.4010A1 professional claims submission.

At a minimum, each claim must include the following detailed information:

- The patient's unique Medicaid Recipient Identification Number, the patient's name, address, and date of birth.
- The day, month, and year the service was provided. Effective June 1, 2017, all services performed by a contracted provider must be billed to UnitedHealthcare Community Plan within 180 days of the date of service. However if your contract with UnitedHealthcare Community Plan identifies a longer time frame to file claims, UnitedHealthcare Community Plan and the provider will abide by the terms of the contract.
- The name, appropriate tax identification number, location of service and National Provider ID (NPI) of the provider rendering the service. If you do not have your PIN, please contact UnitedHealthcare Community Plan's Customer Service department.
- Description of the covered service rendered using the universal identifying procedure code, as designated by the State of Michigan Department of Insurance and Financial Services (DIFS). The database(s) of codes can be found at the **Michigan Department of Health & Human Services (MDHHS)** website.
- The form must also contain a valid ICD-9 diagnosis code.
- Provider certification required by MCL 400.111b(17) and identifying information required by MCL 400.111b(21). This certification allows the provider to file Medicaid claims.
- Substantiation of medical necessity and appropriateness of service as required by UnitedHealthcare Community Plan.
- An applicable authorization number when required by UnitedHealthcare Community Plan.
- Any additional documentation when required by UnitedHealthcare Community Plan. Additional documentation may include, but is not limited to medical records.
- Please note that all provider claims are checked for completeness and proper authorization before processing. Claims that do not meet the above criteria will be delayed and possibly rejected.

Other Procedural Requirements

UnitedHealthcare Community Plan contracted providers are responsible for determining any requirements that UnitedHealthcare Community Plan may have concerning the prior authorization of services and information required on a claim form. DIFS has established the following procedures as a standard to follow even before a claim is filed:

- All providers are responsible for knowing what services are covered by UnitedHealthcare Community Plan's benefits. Claims submitted with questions concerning whether or not the services are covered will not be considered clean claims for purposes of MCL 400.111i.

Section 5: BILLING TO UNITEDHEALTHCARE COMMUNITY PLAN

- Care providers must verify eligibility for covered services before providing the service, as prior eligibility verification is required by UnitedHealthcare Community Plan. If eligibility is not verified when required before submission of the claim, the claim will not be considered a clean claim.
- The care provider is required to verify that the Medicaid member is a legitimate member of UnitedHealthcare Community Plan before the claim is submitted. If no verification is done, the claim will not be considered a clean claim.
- Claims submitted for Medicaid members for whom another known payment source is available are not considered to be clean claims until the provider has exhausted all other sources of payment before billing UnitedHealthcare Community Plan.
- All claims must be computer generated or typed. Hand writing, white-out and/or correction tape are not acceptable on the claim form. Claims submitted with these items will be returned to the provider.

UnitedHealthcare routinely updates fee schedules in response to changes published by the state, such as fee amount changes. UnitedHealthcare will use reasonable efforts to implement the fee schedule changes in our system within 30 days after the final publication and make them effective in our system on the effective date of the change as defined by the state. Claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless the change goes beyond 30 days. Claims will be processed from day 31 and after.

Date of Receipt

- UnitedHealthcare Community Plan encourages providers to submit claims electronically. For information about electronic claim submissions, please contact your provider or hospital and facility advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.
- In order for a claim to be considered clean, it must be submitted to UnitedHealthcare Community Plan electronically, unless the provider does not currently have the EDI capability.
- For claims incurred after June 1, 2001, only claims filed electronically by the provider will have the access to claims adjudication under the timely claims processing and payment procedure pursuant to MCL 400.111i.
- UnitedHealthcare Community Plan will pay a clean claim within 45 days after receipt of the claim, unless otherwise stated in your contract with UnitedHealthcare Community Plan.

For Electronically Submitted Claims

- If a provider uses a clearinghouse for UnitedHealthcare Community Plan claims processing (i.e. Netwerkes) the date of receipt by UnitedHealthcare Community Plan will be the date UnitedHealthcare Community Plan or UnitedHealthcare Community Plan's clearinghouse receives control of the claim from the provider's clearinghouse.
- If the provider's clearinghouse returns the claim for incorrect or incomplete information, the provider will not consider the claim as received by UnitedHealthcare Community Plan and will not begin the 45-day count for turnaround.
- Upon receipt of a claim, UnitedHealthcare Community Plan has 30 days from that date to identify in writing to the provider any defects in the claim. If the claim is defective due to failure to comply with any of the established Medicaid clean claim requirements, the claim does not qualify as a clean claim. The required 45 day payment timeline for clean claims no longer applies. UnitedHealthcare Community Plan's written notice to the provider of the claim defect may be either through electronic transmission or on paper.
- The care provider is subject to initial filing limit for first claim received by UnitedHealthcare

Community Plan. Once the first claim is on file at UnitedHealthcare Community Plan, the provider must resubmit the corrected claim within 12 months of date of service. Please follow the instructions provided in the Claims Resubmission document at the end of this section to avoid having your resubmitted claim rejected as duplicate.

- UnitedHealthcare Community Plan has 30 days from the date of receipt of the corrected claim to pay, if the corrected claim meets the definition of a clean claim.

Further Claim Requirements

- If a corrected claim that is returned to UnitedHealthcare Community Plan is still defective for the same or another reason, UnitedHealthcare Community Plan has 30 days from the date it receives the corrected claim to notify the provider of the remaining defect.
- UnitedHealthcare Community Plan is also required to notify the Commissioner of the defect on a quarterly basis.
- Upon receipt of any claim, if UnitedHealthcare Community Plan determines that one or more covered services listed on a claim are payable, UnitedHealthcare Community Plan will pay for those covered services and will not deny the entire claim.
- The care provider must allow UnitedHealthcare Community Plan at least 30 days to provide notice of any reason for not paying the claims. If a nonpayment notice has not been sent within 30 days, the provider may assume payment will be made 45 days from the date of receipt by UnitedHealthcare Community Plan.
- If the claim or a service listed on a claim form becomes the subject of an adverse determination on payment, the provider may request an external review as outlined in MCL 400.111i(4) and (5).

All Medicaid clean claim disputes that come before DIFS will be reviewed using these standards:

- DIFS will not review any timely claim payment disputes for Medicaid services rendered before October 1, 2000.
- DIFS will not review any timely claim payment disputes other than Medicaid claims filed with UnitedHealthcare Community Plan.
- If the party filing the grievance is also found to have violated any of the timely claims payment procedures, penalties due under these procedures will be assessed at the discretion of DIFS.

CMS-1500 Claim Form Billing Instructions: Required Criteria

The following criteria are required by UnitedHealthcare Community Plan to be completed on the CMS-1500 form:

- Member Demographics
- ICD-9-CM diagnosis codes: The ICD-9-CM codes must be used for the diagnosis, conditions or other reasons for the encounter or visit. All providers must code to the highest level of specificity. One diagnosis code is required but can include up to four codes in order of priority (primary, secondary condition, etc.) to accurately describe the reason for the services.
- CPT or HCPCS procedure codes that describe services performed.
- Correct place of service codes. This item indicates where the services were rendered or an item was utilized. Box 24B on the CMS-1500 claim form must reflect the place of service codes.
- Providers NPI and Federal Tax identification number.
- All claims must be computer generated or typed. No written or highlighted information is accepted and will be returned.

Ancillary and Professional Services - Inpatient and Outpatient

- Professional services should be billed on a CMS-1500 claim form.
- There are services provided by a specialist or ancillary provider that may need to be authorized by UnitedHealthcare Community Plan. Please refer to Section 1 Provider Office Procedures for services that require authorization.

How to Fill Out the CMS-1500 Claim Form

Listed below are sections of the CMS-1500 claim form that are required to be filled out.

Box 1a: Insured's I.D. Number

- Medicaid member's recipient I.D. number

Box 23: Prior Authorization Number

- Indicate authorization number issued by UnitedHealthcare Community Plan if available

Box 24B: Place of Service

- Indicate the two-digit place of service codes as follows:

CMS Place of Service Codes:

03 School	25 Birthing Center	55 Res Sub Abuse TX Facility
11 Office	31 Skilled Nursing Facility	56 Psych Resid TX Center
12 Home	32 Nursing Facility	61 Compreh IP Rehab Facility
17 Walk In Retail Health Clinic	34 Hospice	65 End Stage Renal TX Facility
20 Urgent Care Clinic	41 Ambulance-Land	71 State or Local Pub Health
21 Inpatient Hospital	42 Ambulance-Air or Water	72 Rural Health Clinic
22 Outpatient Hospital	51 IP Psych Facility	81 Independent Lab
23 Emergency Room Hosp.	52 Psych Fac Partial Hosp	99 Other Unlisted Facility
24 Ambulatory Surgical Ctr.		

Box 24D: Procedures, Services or Supplies

- Enter the CPT or HCPCS code that is applicable for the services, procedures or supplies rendered. Include CPT/HCPCS modifiers when necessary. The codes and modifiers selected must be supported by medical documentation in the patient's record.

Box 31: Signature of Care Provider or Supplier of Services

- Must be completed.

Box 32: Name and Address of Facility Where Services Were Rendered

Box 33: Care Provider's Supplier's Billing Name, Address, Zip Code and Phone Number

- The provider's NPI must be entered in the NPI Number Section in Box 33. The address in Box 33 is where payment will be sent.
- All other fields must be filled out in accordance to the HCFA guidelines.

Other Billing Instructions:

Billing Codes

- Reimbursement is based upon the provider's contract.
- All CPT or HCPCS codes that are non-specific will be rejected as "unclean". This includes most codes ending in 99 and others such as A4649, E1399, J3490, and J7799. If you feel these codes must be utilized for services delivered, you must submit supporting documentation as an attachment to your claim. National Drug Codes (NDC) codes are required for drugs.
- For surgical services using the above non-specific codes, operative notes must be submitted to UnitedHealthcare Community Plan's Medical Director for review.
- Not otherwise classified (NOC) codes will be paid at 20% of billed charges unless the health plan and care provider mutually agree to other payment terms before the service is rendered. Care providers should simply ask to negotiate a rate through the authorization intake process.
- All Durable Medical Equipment (DME) codes that are non-specific will require manufacturer's invoice to determine pricing. Claims will be rejected as unclean claims if the invoice is not submitted.
- For further information regarding use of appropriate billing codes, please refer to your contract or contact your provider advocate. If you do not know the name of your advocate, call Customer Service at 800-903-5253.

Anesthesia

- Anesthesia claims must be billed using CPT anesthesia code along with the appropriate modifier. If a claim is submitted without the appropriate modifier, the claim will be rejected.
- The anesthesia time should be reported in actual minutes in Box 24G. Care providers and CRNAs should report a quantity of "1" for each minute of anesthesia time. For example, if anesthesia time is 37 minutes, the quantity would be reported as 37.

Maternity Care

Antepartum care, delivery and postpartum care visits must be billed separately using the following codes:

Antepartum Visits

All prenatal visit dates, along with last menstrual period (LMP) or expected due date (EDD)/expected date of confinement (EDC), must be included with the claim.

- 59425: Antepartum Care Only, four - six visits, **OR**
- 59426: Antepartum Care Only, seven or more visits

*HEDIS & ACOG Guidelines state the first prenatal care visit must be completed in the first trimester or the first 42 days the member is enrolled in a health plan.

Postpartum Visit

- 59430: Postpartum Care Only, completed 21-56 days after delivery.
- If less than four visits were performed, use the appropriate Evaluation and Management codes. The date(s) of service should be the actual date(s) the visit(s) occurred.
- Provider has six months from the date of delivery to bill antepartum care.

Newborns

- Newborns must be billed separately from the mother, using the newborns Medicaid I.D. Number.
- The name should be designated as 'last name' and either 'baby boy' or 'baby girl'.
- If the newborn is a well-baby, the claim should be

billed with the baby's authorization number, and baby's Medicaid I.D. Number.

- If the newborn is a sick baby or boarder baby, the claim should be billed under the baby's Medicaid I.D. Number, with the authorization number that is given by UnitedHealthcare Community Plan upon newborn admission.

Durable Medical Equipment (DME)

- All DME authorization requests must be accompanied by a care provider's order/prescription. The prescription must contain the type of DME, duration and if it is a rental or purchase. If the initial claim includes all necessary information outlined above, subsequent claims need not include additional prescription copies. The care provider's order/prescription is not required to accompany the claim for reimbursement.
- All DME codes that are non-specific will require the manufacturer's invoice to determine pricing. Claims will be rejected if the invoice is not submitted.

Newborns

- UnitedHealthcare Community Plan requires all capitated providers to submit a CMS-1500 with the appropriate codes for all health care services provided to UnitedHealthcare Community Plan members.
- UnitedHealthcare Community Plan requires all capitated providers to complete the CMS-1500 in the same manner as used when billing for the same services on a fee-for-service basis.
- Early Periodic Screening and Diagnostic Testing (EPSDT) must be reported by completing field 24H (EPSDT Family Plan) on the CMS-1500 claim form.
- UnitedHealthcare Community Plan denotes "payment" on the remittance advice with an explanation code of "CAP" (capitated service) with a zero dollar amount.

Fee for Service

- There are services that a PCP may provide for a member that are not listed as a capitated service. Some of these may require pre-certification from UnitedHealthcare Community Plan.
- See Section 2 – Medical Management for details of the pre-certification guidelines. These services must be billed using the CMS-1500 claim form. Failure to obtain an authorization for services requiring pre-certification will result in the claim being rejected.

5.2 BILLING INSTRUCTIONS FOR UB-04

Billing Requirements

Billable services may be submitted electronically or on a UB-04 claim form; other types of billing forms will not be accepted and will be returned..

A health professional must submit claims using the data elements on the UB-04 paper form consistent with the Medical Service Administration's UB-04 Uniform Billing Guidelines. A health facility must use the data elements of the UB-04 or any successor format that becomes the industry standard for filing facility claims in the future.

Note: Complete the appropriate segments for electronic claims following the HIPAA guidelines as required for an 837 v.401A1 professional claims submission.

Section 5: BILLING TO UNITEDHEALTHCARE COMMUNITY PLAN

At a minimum, each claim must include the following detailed information:

- The patient's unique Medicaid Recipient Identification Number and the patient's name, address, and date of birth.
- The day, month, and year the service was provided. Effective June 1, 2017, all services performed by a contracted provider must be billed to UnitedHealthcare Community Plan within 180 days after the date of service or the date of discharge from the health facility. However, if your contract with UnitedHealthcare Community Plan identifies a longer time frame to file claims, UnitedHealthcare Community Plan and the provider will abide by the terms of the contract.
- The name, appropriate tax identification number, the National Provider ID (NPI) (of the facility rendering the service), and location of service.
- Description of the covered service rendered using the universal identifying procedure code, as designated by the State of Michigan Department of Insurance and Financial Services (DIFS).
- The form must also contain the ICD-9 diagnosis code.
- Provider certification required by MCL 400.111b(17) and identifying information required by MCL 400.111b(21). This certification allows the provider to file Medicaid claims.
- Substantiation of medical necessity and appropriateness of service as required by UnitedHealthcare Community Plan.
- An applicable authorization number when required by UnitedHealthcare Community Plan.
- Any additional documentation when required by UnitedHealthcare Community Plan. Additional documentation may include, but is not limited to medical records.
- Please note that all provider claims are checked for completeness and proper authorization before processing. Claims that do not meet the above criteria will be delayed and possibly rejected.

Other Procedural Requirements

UnitedHealthcare Community Plan's contracted providers are responsible for determining any requirements that UnitedHealthcare Community Plan may have concerning the authorization of services and information required on a claim form. DIFS has established the following procedures as a standard to follow even before a claim is filed:

- All providers are responsible for knowing what services are covered by UnitedHealthcare Community Plan's benefits. Claims submitted with questions concerning whether or not the services are covered will not be considered clean claims for purposes of MCL 400.111i.
- Care providers must verify eligibility for covered services before providing the service, if prior eligibility verification is required by UnitedHealthcare Community Plan. If eligibility is not verified when required before submission of the claim, the claim will not be considered a clean claim.
- The care provider is required to verify that the Medicaid member is a legitimate member of UnitedHealthcare Community Plan before the claim is submitted. If no verification is done, the claim will not be considered a clean claim.
- Claims submitted for Medicaid members for which another known payment source is available are not considered to be clean claims until the provider has exhausted all other sources of payment before billing UnitedHealthcare Community Plan.

Section 5: BILLING TO UNITEDHEALTHCARE COMMUNITY PLAN

Date of Receipt

- For a claim to be considered clean, you must submit it to UnitedHealthcare Community Plan electronically, unless the provider does not currently have the capability.
- For claims incurred after June 1, 2001, only claims filed electronically by the provider will have access to claims adjudication under the timely claims processing and payment procedure pursuant to MCL 400.111i.
- UnitedHealthcare Community Plan pays a clean claim within 45 days after receipt of the claim unless otherwise stated in your contract with UnitedHealthcare Community Plan.

For Electronically Submitted Claims

- If a provider uses a clearinghouse for UnitedHealthcare Community Plan claims processing, i.e. Netwerkes, the date of receipt by UnitedHealthcare Community Plan will be the date UnitedHealthcare Community Plan or UnitedHealthcare Community Plan's clearinghouse receives control of the claim from the provider's clearinghouse.
- If the care provider's clearinghouse returns the claim for incorrect or incomplete information, the provider will not consider the claim as received by UnitedHealthcare Community Plan and will not begin the 45-day count for turnaround.
- Upon receipt of a claim, UnitedHealthcare Community Plan has 30 days from that date to identify in writing to the provider any defects in the claim. If the claim is defective due to failure to comply with any of the established Medicaid clean claim requirements, the claim does not qualify as a clean claim. The required written notice to the provider of the claim defect may be either through electronic transmission or on paper.
- The care provider has 30 days from the date of receipt of the notice of defective claim to correct the defect and resubmit the corrected claim to UnitedHealthcare Community Plan.
- UnitedHealthcare Community Plan has 30 days from the date of receipt of the corrected claim to pay, if the corrected claim meets the definition of a clean claim.

Further Claim Requirements

- If a corrected claim that is returned to UnitedHealthcare Community Plan is still defective for the same or another reason, UnitedHealthcare Community Plan has 30 days from the date it receives the corrected claim to notify the provider of the remaining defect.
- UnitedHealthcare Community Plan is also required to notify the Commissioner of the defect on a quarterly basis.
- Upon receipt of any claim, if UnitedHealthcare Community Plan determines that one or more covered services listed on a claim are payable, UnitedHealthcare Community Plan will pay for those covered services and will not deny the entire claim.
- The care provider must allow UnitedHealthcare Community Plan at least 30 days to provide notice of any reason for not paying the claims. If a nonpayment notice has not been sent within 30 days, the provider may assume payment will be made 45 days from the date of receipt by UnitedHealthcare Community Plan.
- If a care provider resubmits a claim before the 45 days elapsed, it will not be considered clean.

- If the claim or a service listed on a claim form becomes the subject of an adverse determination on payment, the provider may request an external review as outlined in MCL 400.111i(4) and (5).

All Medicaid Clean Claim disputes that come before DIFS will be reviewed using these standards:

- DIFS will not review any timely claim payment disputes for Medicaid services rendered before October 1, 2000.
- DIFS will not review any timely claim payment disputes other than Medicaid claims filed with UnitedHealthcare Community Plan.
- If the party filing the grievances is also found to have violated any of the timely claims payment procedures, penalties due under these procedures will be assessed at the discretion of DIFS.

UB-04 Claim Form Billing Instructions:

All inpatient and outpatient facility services must be billed to UnitedHealthcare Community Plan on a UB-04 claim form.

Required Criteria

- Member demographics
- ICD-9-CM diagnosis and procedure codes: The ICD-9-CM codes must be used for the diagnosis, conditions or other reasons for the encounter or visit. All providers must code to the highest level of specificity. Principal diagnosis code is required to accurately describe the reason for the services. Other diagnosis codes are required, if applicable.
- For outpatient claims, CPT or HCPCS procedure codes that describe services performed.
- All other required fields in accordance with UnitedHealthcare Community Plan Clean Claim Guidelines and the Michigan Uniform Billing Guidelines. Please refer to the MSA Bulletin-Hospital 00-06 for further clarification.
- All claims must be computer generated or typed. No handwritten information is accepted and will be returned.

How to Fill Out the UB-04 Claim Form

Below you will find some highlights of the required fields.

Field 4: Type of Bill: This indicates the specific type of facility, bill classification and frequency

Field 5: Federal Tax I.D. Number: The provider's numeric identification number assigned by the federal government Field 42: Revenue Code

Field 43: Description
Field 44: CPT/HCPCS codes

Field 51: Provider Number

Other Billing Instructions:

Billing Codes

- Reimbursement is based upon the provider's contract.
- All CPT or HCPCS codes that are non-specific will be rejected as "unclean". This includes most codes ending in 99 and others such as A4649, E1399, J3490, and J7799. If you feel these codes must be utilized for services delivered, you must submit supporting documentation as an attachment to your claim. National Drug Codes (NDC) codes are required for drugs.
- For surgical services using the above non-specific codes, operative notes must be submitted to

UnitedHealthcare Community Plan Medical Director for review.

- Not otherwise classified (NOC) codes will be paid at 20% of billed charges unless the health plan and care provider mutually agree to other payment terms before the service is rendered. Care providers should simply ask to negotiate a rate through the authorization intake process.
- All Durable Medical Equipment (DME) codes that are non-specific will require manufacturer's invoice to determine pricing. Claims will be rejected as unclean claims if the invoice is not submitted.
- For further information regarding use of appropriate billing codes, please refer to your contract or contact your provider advocate. If you do not know the name of your advocate, call Customer Service at 800-903-5253.

Guidelines for Hospital Emergency Services

Revenue Code 0450 should be used for emergency services billing and always reflect a quantity of 1. A member's emergency medical condition must be fully documented in order to support the manner in which the claim was coded.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Periodically, UnitedHealthcare Community Plan will exercise its contract authority to conduct a retrospective review to assure claims for emergency room services have been paid appropriately.

UnitedHealthcare Community Plan encourages all of its providers to contact their provider advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.

Newborns

- Bill newborns separately from the mother, using the newborns Medicaid I.D. Number.
- With the recipient I.D., there should be a full name.
- If the newborn is a well-baby, the claim should be billed with the baby's Medicaid I.D. Number and full name.
- If the newborn is a sick or boarder baby, the claim should still be billed under the baby's Medicaid Recipient I.D. Number and full name, with the authorization number issued by UnitedHealthcare Community Plan upon newborn admission.
- Neonatal Intensive Care Unit (NICU) services are billed with revenue codes 0174 and require an authorization from UnitedHealthcare Community Plan. NICU services rendered to severely ill newborns that are billed under revenue code 0174 are subject to the following guidelines:
  - The facility must have a Certificate of Need (CON) for its NICU.
  - The facility's neonatologist must order any placement into the NICU.

- Medical documents need to support a level of severity sufficient to warrant reimbursement under revenue code 0174.

Series Billing

- Series type services should be billed on a monthly basis.
- All dates of service must be itemized on the claim forms. An itemization of charges is required either by submitting each date of service individually in form locator 45 or by listing the dates of service in form locator 84. Following is a list of services that may be billed using series billing:
  - Chemotherapy
  - Physical Therapy
  - Hemodialysis
  - Peritoneal Dialysis
  - Occupational Therapy
  - Radiation Therapy
  - Speech Therapy

5.3 COORDINATION OF BENEFITS (COB)

Some Medicaid members have dual insurance coverage.

- In this case, the other insurance company should be billed because it is always considered the primary insurance.
- All professional and ancillary services that are considered a benefit with the primary insurance carrier will not require an authorization number from UnitedHealthcare Community Plan.
- Professional and ancillary services that are not covered by the primary insurance carrier require an authorization number from UnitedHealthcare Community Plan in order to be reimbursed for these services. Please refer to Section 2 Medical Management for a detailed listing of services requiring an authorization.
- All hospital admissions require notification with detailed clinical information to UnitedHealthcare Community Plan.
- For capitated services, the PCP will receive fee for service reimbursement from the other insurance company and their capitation rate from UnitedHealthcare Community Plan.
- For billable professional or ancillary services, the provider must submit the explanation of benefits (EOB) received from the primary carrier in order for the claim to be considered for additional payment by UnitedHealthcare Community Plan.
- If the member is treated for injuries sustained in an auto-related accident, or has a work-related injury or condition, the auto carrier and/or workers compensation must be billed for the services first.
- Injuries or conditions that are auto or work-related may have secondary coverage through UnitedHealthcare Community Plan. However, the provider must bill the primary payor before attempting to bill UnitedHealthcare Community Plan.
- A letter disputing the liability from the worker's compensation carrier must accompany any worker's compensation claim in order for the claim to be considered for payment by UnitedHealthcare Community Plan.
- When submitting a claim, an EOB from the primary carrier must accompany the claim in order to coordinate benefits.

- If other insurance coverage is in question, UnitedHealthcare Community Plan requires a letter or other appropriate documentation from the primary carrier that the coverage is no longer in effect. The documentation must include the termination date of the coverage.
- UnitedHealthcare Community Plan extends the filing limit for claims with another carrier's EOB when the primary carrier's EOB identifies payment or denial of the claim and the claim is received within six months from the notification date of the other carrier EOB and/or the claim is received within 18 months from the claim date of service.

5.4 CLAIMS PROCESS

Filing Limitations

Effective June 1, 2017, initial claim submissions for contracted providers must be within 180 days of the date of service unless the contract between the care provider and UnitedHealthcare Community Plan provides for a longer timeframe. Non-contracted providers may contact UnitedHealthcare Community Plan's Customer Service department for specific information related to filing limitations.

Mailing Address

Claims may be forwarded to the following address for processing:

UnitedHealthcare Community Plan Attention Claims
P.O. Box 30991
Salt Lake City, UT 84130-0991

Send behavioral health claims to:

OptumHealth Behavioral Solutions
P.O. Box 30760
Salt Lake City, UT 84130-0760

Submit Claims Electronically to UnitedHealthcare Community Plan through Electronic Data Interchange (EDI)

Would you like to save time and money, and receive payment for your claims faster than you are today? Submitting your claims electronically to UnitedHealthcare Community Plan can accomplish all of the above. EDI eliminates the need for your office staff to prepare claims manually or rekey repetitive transaction information. In fact, there are no paper forms, no envelopes and no stamps. Your staff can work more efficiently, saving you time and money. With EDI, claims are processed quickly, efficiently and more accurately. Fewer rejected claims means better cash flow for your practice.

Research has indicated that providers can save up to $1.50 per claim using EDI instead of paper. Electronic claims can be delivered to the payor much more quickly than mail. Mail service can range from two to five days, while EDI claims can be submitted the same day that they are entered. UnitedHealthcare Community Plan would like to encourage providers to submit their claims electronically. Have your clearinghouse send claims electronically to payer ID 95467.

UnitedHealthcare Community Plan Online for Efficient, Prompt Service

Register at UHCprovider.com, 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's policies, products and processes. UHCprovider.com.

Contact UnitedHealthcare Community Plan About EDI/Electronic Remittance Advices Electronic Fund Transfers

If you have any questions about submitting claims to UnitedHealthcare Community Plan electronically or are interested in receiving electronic remittance advices or fund transfers, please contact your software vendor or clearinghouse or you may enroll using our clearinghouse, OptumInsight by calling 800-341-6141, option 3 or contact your provider or hospital and facility advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.

Requesting a Status of a Claim

Inquiries regarding claims are welcome 60 days after the initial claims submission. Several options are available to obtain claim status information needed:

- Online: Claim status and eligibility is available online. Register for access to our provider portal on UHCprovider.com/claims or contact your provider or hospital and facility advocate. If you do not know the name of your advocate, call Customer Service at **800-903-5253**.
- Care providers may also contact the UnitedHealthcare Community Plan Customer Service department at **800-903-5253** to discuss concerns regarding claims submissions.

Claims Payment

- A remittance advice is sent with the claims decision.
- Explanation of the payment codes may be found on the last page of the remittance advice.
- Providers are paid according to their contracted rates.
- Non-contracted providers are paid the published Medicaid Fee Screen rates applicable on the date of service.
- Contact your provider advocate for general questions about the remittance advice.
- For detailed claims issues contact the Customer Service department at **800-903-5253**.

Medicaid Payment in Full

Please note that UnitedHealthcare Community Plan's payment of covered Medicaid services is considered payment in full.

- It is against the law to bill a Medicaid member.
- Any attempt to collect money from a Medicaid enrollee for covered services rendered in excess of the payment for such services may result in immediate termination from the UnitedHealthcare Community Plan network.

Claim Correction

Corrected claims must be submitted within one year of the date of service if the original claim was received within the care provider's filing limit.

For claim corrections submitted on a CMS-1500:

- Box 22 on the CMS-1500 is a split field labeled as "Medicaid Resubmission Code/Original Ref. No." In order to submit corrections to a previously processed claim, providers are required to enter "7" in the area for the resubmission code. The original

reference number area should be populated with the 12-digit claim number assigned to the claim being corrected. This number can be found on the UnitedHealthcare Community Plan remittance advice, or by contacting Customer Service.

For claim corrections submitted on a UB-04:

- Form Locator 4 on the UB-04 form is labeled "Type of Bill". A three digit code is required on all claim submissions. The third digit is what will indicate the frequency of the claim.
- For claim submission that have corrections to the service line items, a "7" should be indicated as the third digit to replace a prior claim submission with corrected information. Form Locator 84 "Remarks" should indicate the reason for resubmission.
- Voiding Claims: A claim that was billed in error, and that does not require correction, must be billed with the frequency reported as "8". Please note that it is inappropriate for voided claims to be followed by a claim coded with a "7" for resubmission.

For both UB-04 resubmission types listed above, field 37 must be populated with the 12 digit claim number assigned to the previous submission being addressed. This number can be found on the UnitedHealthcare Community Plan remittance advice, or by contacting Customer Service.

Claim Reconsideration (step one of dispute)

What is it?

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

When to use:

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

Timeframe

Claim reconsiderations must be submitted within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law (or your Participation Agreement), along with a completed UnitedHealthcare Claim Reconsideration Request Form.

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on Link.
- **Phone:** Call Provider Services at 866-815-5334 or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
  - Note: Claims can be aggregated online if you have a request that involves 20 or more paid or denied claims and attachments aren't required. Go to UHCprovider.com/claims.
- **Mail:** A Claim Reconsideration Request Form can be found at UHCprovider.com/claims > Submit a Claim Reconsideration > Single Paper Claim Reconsideration Form.
  - Please note: the address may differ based on product. Please see the applicable plan supplement section in your care provider manual or on our care provider website for specific contact information.
- **Fax:** Send the Claim Reconsideration Request Form to 801-994-1224.

Submit a claim reconsideration request for a denied claim which is requesting medical documentation using one of the following ways:

- **Electronically:** Use the claimsLink application on Link.
- **Mail:**
  - Complete the Claim Reconsideration Request Form and check "Previously denied/closed for Additional Information" as your reason for request.
  - Provide a description of the documentation being submitted along with all relevant documentation. To prevent processing delays it is important to include the member name and health care ID number as well as the care provider name, address and TIN on the Claim Reconsideration Form.

Submit a claim reconsideration request for a denied claim due to not timely filing using one of the following ways:

1. **Electronic claims:** include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
2. **Paper claims:** include a screen print copy from your accounting software to show the date you submitted the claim. All proof of timely filing requests must also include documentation that the claim is for the correct member and date of service.

Appeals (step two of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

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

Timeframe

Claim appeals must be submitted to us within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA), or as required by law or your Participation Agreement.

A first level claim appeal must be submitted within 180 days from the date of the reconsideration decision letter. A level two appeal must be submitted within 60 days from the first level appeal decision letter.

Medical Records Request Submission Timeframe

If medical records are requested to process an appeal (which may include providing a copy of the denial notice), information is due according to the below timeframes:

- **Expedited appeals:** within 2 hours of receipt of the request.
- **Standard appeals:** within 24 hours of receipt of the request.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Include information you wish to have included in the appeal review that supplements your prior claim adjustment submission.

Send your information electronically, by mail or fax.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. Include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim. You may upload attachments.
- **Mail:** The address may differ based on product. Please see the applicable plan supplement section in your care provider manual or on our care provider

website for specific contact information.

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

We will render our decision based on the materials available at the time of formal appeal review. If you are appealing a claim that was denied due to not timely filing:

- **Electronic claims:** include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
- **Paper claims:** include a screen print copy from your accounting software to show the date you submitted the claim.

We have a one-year timely filing limitation to complete all steps in the reconsideration and appeal process. It starts on the date of the first EOB.

Appendix 1: Forms

Click on the name below to view the form.

Claims Inquiry Status Form

Delivery Admission Review Form

Diabetes Checklist - MQIC

Prenatal Notification Form

Medical Prior Authorization Form

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Child/Adolescent Care

Well-Child Visits in the First 15 Months of Life [Commercial, Medicaid]	*Codes to identify Well-Child Visits 0-15 Months*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99381, 99382, 99391, 99392, 99461		G0438, G0439	V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life [Commercial, Medicaid]	*Codes to identify Well-Child Visits 3-6 Years*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99382, 99383, 99392, 99393		G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Adolescent Well-Care Visits (ages 12-21) [Commercial, Medicaid]	*Codes to identify Adolescent Well-Care Visits*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99383-99385, 99393-99395		G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Childhood Immunization Status (by age 2) [Commercial, Medicaid]	*Codes to identify Childhood Immunizations**			*Codes for evidence of disease*
	CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-9-CM Diagnosis**
4-DTaP	90698, 90700, 90721, 90723		99.39	
3-IPV	90698, 90713, 90723		99.41	
1-MMR	90707, 90710		99.48	
Measles and rubella	90708			
Measles	90705		99.45	055
Mumps	90704		99.46	072
Rubella	90706		99.47	056
3-HiB	90645-90648, 90698, 90721, 90748			
3-Hepatitis B	90723, 90740, 90744, 90747, 90748	G0010		070.2, 070.3, V02.61
1-VZV	90710, 90716			052, 053
4-Pneumococcal conjugate	90669, 90670	G0009		
1-Hepatitis A	90633			070.0, 070.1
2-Rotavirus (two-dose schedule)	90681			
3-Rotavirus (three-dose schedule)	90680			
2-Influenza	90655, 90657, 90661, 90662	G0008	99.52	
	*Pediatric immunization administration codes are: 90460 and 90461 (for each additional). Please show CPT code for VFC vaccines at $0 so that appropriate credit can be applied. When an evaluation and management service (other than a preventive medicine service) is provided on the same date as a prophylactic immunization, Modifier-25 may be appended to the code for the evaluation and management service.			
	EXCLUSIONS:	**ICD-9-CM Diagnosis**		
	Anaphylactic reaction	999.42	See complete guide for other exclusions and related codes by vaccine, as applicable.	

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Child/Adolescent Care-continued

Immunizations for Adolescents [Commercial, Medicaid]	*Codes to identify Immunizations*								
	CPT	**ICD-9-CM Procedure**		**EXCLUSIONS:**		**ICD-9-CM Diagnosis**			
Meningococcal [ages 11-13]	90733, 90734			Anaphylactic reaction		999.42			
Tdap [ages 10-13]	90715	99.39		See complete guide for other contraindication codes by vaccine, as applicable.					
Td [ages 10-13]	90714, 90718								
Tetanus [ages 10-13]	90703	99.38							
Diphtheria [ages 10-13]	90719	99.36							
HPV (3) [ages 9-13]	90649, 90650								
Lead Screening in Children (by age 2) [Medicaid]	*Codes to identify Lead Tests*								
	CPT	**LOINC**							
	83655	5671-3, 5674-7, 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3							
Children and Adolescents' Access to Primary Care Practitioners (12 months-19 years) [Commercial, Medicaid]	*Codes to identify Ambulatory or Preventive Care Visits*								
	Office or other outpatient services		Home services	Preventive medicine		General medical examination			
	CPT		**CPT**	**CPT/HCPCS**		**ICD-9-CM Diagnosis**			
	99201-99205, 99211-99215, 99241-99245		99341-99345, 99347-99350	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429/G0438, G0439		V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (ages 3-17) [Commercial, Medicaid]	*Codes to identify Outpatient Visits*			*Codes to identify BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity*					
	CPT		**UB Revenue**	**BMI Percentile**	**Nutrition Counseling**	**Physical Activity Counseling**			
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456		051x, 0520-0523, 0526-0529, 0982, 0983	ICD-9-CM Dx: V85.5	ICD-9-CM Dx: V65.3, HCPCS: G0270-G0271, S9449, S9452, S9470, G0447, CPT: 97802-97804	ICD-9-CM Dx: V65.41, HCPCS: S9451, G0447			
	EXCLUSIONS:		**ICD-9-CM Diagnosis**						
	Pregnancy		630-679, V22, V23, V28						

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Child/Adolescent Care-continued

Chlamydia Screening (ages 16-24) [Commercial, Medicaid]	*Codes to identify Chlamydia Screening*			
	CPT	**LOINC**		
	87110, 87270, 87320, 87490-87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2		
	EXCLUSIONS:	**CPT**	**UB Revenue**	**LOINC**
	Pregnancy test	81025, 84702, 84703	925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 45194-8, 55869-2, 55870-0, 56497-1
		WITH		
	Diagnostic radiology	70010-76499	032x	
	Retinoid	Isotretinoin prescription		

Source: HEDIS 2013 Technical Specifications
Allowable codes may vary by state. Reimbursement for these services will be per the terms of your agreement.

HEDIS Code Quick Reference Guide–Disease Management Services

Respiratory Conditions

Appropriate Testing for Children With Pharyngitis (ages 2-18) [Commercial, Medicaid]	*Codes to identify Outpatient Visit Type*		*Codes to identify Group A Streptococcus Tests*	
	CPT	**UB Revenue**	**CPT**	**LOINC**
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983	87070, 87071, 87081, 87430, 87650-87652, 87880	626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9, 60489-2, 68954-7
Appropriate Treatment (no antibiotic) for Children With Upper Respiratory Infection [Commercial, Medicaid]	Antibiotics should NOT be prescribed for children 3 months-18 years diagnosed with ONLY upper respiratory infection diagnosis.			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis [Commercial, Medicaid]	Antibiotics should NOT be prescribed for adults 18-64 years of age with a diagnosis of acute bronchitis.			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (ages 40+) [Commercial, Medicaid, Medicare]	*Codes to identify Spirometry Testing*	*Codes to identify Outpatient Visit*		*Codes to identify COPD*
	CPT	**CPT**	**UB Revenue**	**ICD-9-CM Diagnosis**
	94010, 94014-94016, 94060, 94070, 94375, 94620	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983	491, 492, 493.2, 496
Pharmacotherapy Management of COPD Exacerbation [Commercial, Medicaid, Medicare]	Adults 40 and older who had an acute inpatient discharge or ED encounter for COPD exacerbation should be dispensed the following medications: 1. A systemic corticosteroid within 14 days of discharge; and 2. A bronchodilator within 30 days of discharge.			
Use of Appropriate Medications for People With Asthma [Commercial, Medicaid]	Children and adults ages 5-64 diagnosed with persistent asthma should be dispensed at least one asthma controller medication. Asthma controller medications include: antiasthmatic combinations, antibody inhibitor, inhaled steroid combination, inhaled corticosteroid, leukotriene modifier, mast cell stabilizer, methylxanthines.			
Medication Management for People With Asthma [Commercial, Medicaid]	Children and adults ages 5-64 who were identified as having persistent asthma and were dispensed appropriate medications must remain on an asthma controller for at least 75% of the treatment period. Controller medications include: antiasthmatic combinations, antibody inhibitor, inhaled steroid combination, inhaled corticosteroid, leukotriene modifier, mast cell stabilizer, methylxanthines.			
Medication Ratio for People With Asthma [Commercial, Medicaid]	Children and adults 5-64 years who were identified as having persistent asthma should have a ratio of controller medications to total asthma medications of 0.50 or greater during the year.			

HEDIS Code Quick Reference Guide–Disease Management Services

Cardiovascular Conditions

Cholesterol Management for Patients With Cardiovascular Conditions (ages 18-75) [Commercial, Medicaid, Medicare]	*Codes to identify Outpatient Visit Type*		*Ischemic Vascular Disease (IVD)Codes*	*Percutaneous Coronary Interventions (PCI) Codes*	*Codes to identify LDL-C Screening*		
	CPT	**UB Revenue**	**ICD-9-CM Diagnosis**	**CPT/ICD-9/HCPCS Procedure Codes**	**CPT**	**CPT Category II**	**LOINC**
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983	411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445	CPT: 92980, 92982, 92995; ICD-9-CM Proc: 00.66, 36.06, 36.07; HCPCS: G0290	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0
	AMI and CABG inpatient codes	Acute myocardial infarction (AMI)-ICD-9 Dx: 410x1; coronary artery bypass graft (CABG) CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, ICD-9 Procedure: 36.1, 36.2, HCPCS: S2205-S2209					
Controlling High Blood Pressure [Commercial, Medicaid, Medicare]	Document blood pressure at least once a year on members ages 18-85 who have a diagnosis of hypertension. Goal: <140/90mm Hg						
Persistence of Beta Blocker Treatment After a Heart Attack [Commercial, Medicaid, Medicare]	Adults 18 years and older who are discharged with a diagnosis of acute myocardial infarction should receive a beta-blocker treatment for 6 months: Noncardioselective beta-blockers, Cardioselective beta-blockers, Antihypertensive combinations.						

Musculoskeletal Condition Care

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis [Commercial, Medicaid, Medicare]	Adults 18 and older diagnosed with Rheumatoid Arthritis should be dispensed at least one prescription for a disease modifying anti-rheumatic drug (DMARD): 5-Aminosalicylates, Alkylating agents, Aminoquinolones, Anti-rheumatics, Immunomodulators, Immunosuppressive agents, Tetracyclines.		
Use of Imaging Studies for Low Back Pain [Commercial, Medicaid]	Adults ages 18-50 with a primary diagnosis of low back pain should NOT have an imaging study within 28 days of diagnosis unless clinically indicated.		
Osteoporosis Management in Women Who Had a Fracture [Medicare]	Women 67 and older who suffered a fracture should have a bone mineral density test or be dispensed a drug to treat or prevent osteoporosis within six months of the fracture. Osteoporosis Therapies: Biphosphonates, Estrogens, Other agents, Sex hormone combinations.		
	Codes to identify a Bone Mineral Density Test		
	CPT	**HCPCS**	**ICD-9-CM Procedure**
	76977, 77078-77083, 78350, 78351	G0130	88.98

HEDIS Code Quick Reference Guide–Disease Management Services

Diabetes Care

Diabetes Visit and Diagnosis (ages 18-75) [Commercial, Medicaid, Medicare]	*Codes to identify Outpatient Visit Type*									*Diabetes Dx*
	CPT					**UB Revenue**				**ICD-9-CM Diagnosis**
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456					051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983				250, 357.2, 362.0, 366.41, 648.0
	EXCLUSIONS			**ICD-9-CM Diagnosis**						
	Polycystic ovaries			256.4						
	Steroid induced			249, 251.8, 962.0						
	Gestational diabetes			648.8						
HbA1c Testing [Commercial, Medicaid, Medicare]	*HbA1c Levels*							*Codes to identify HbA1c Tests*		
	CPT Category II							CPT	CPT Category II	LOINC
	≤9%	3044F, 3045F	<8%	3044F	<7%	3044F		83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8,
	>9%	3046F	≥8%	3046F	≥7%	3045F, 3046F				
Retinal Eye Exams [Commercial, Medicaid, Medicare]	Refer diabetics for annual retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist).									
LDL-C Screening [Commercial, Medicaid, Medicare]	*Codes to identify LDL-C Screening*							*Codes to identify LDL-C Levels*		
	CPT		**CPT Category II**		**LOINC**			**CPT Category II**		
	80061, 83700, 83701, 83704, 83721		3048F, 3049F, 3050F		2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0			LDL-C <100mg/dL	3048F	LDL-C ≥100mg/dL	3049F, 3050F
Nephropathy Screening [Commercial, Medicaid, Medicare]	*Codes to identify Nephropathy Screening*									
	CPT		**CPT Category II**		**LOINC**					
	82042, 82043, 82044, 84156		3060F, 3061F		1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13705-9,13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1			
Evidence of Nephropathy	**CPT**			**HCPCS**	**ICD-9-CM Diagnosis**		**ICD-9-CM Procedure**	**UB Revenue**	**CPT Category II/ LOINC***	
Urine Macroalbumin Test	81000-81003, 81005								3062F/5804-0, 20454-5, 50561-0, 53525-2, 57735-3	
ACE Inhibitor/ARB Therapy									4009F	

HEDIS Code Quick Reference Guide-Disease Management Services

Diabetes Care-continued

	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	CPT Category II/ LOINC*
Evidence of Treatment for Nephropathy	36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, S9339	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6	0367, 080x, 082x-085x, 088x	3066F
	* A CPT Category II code indicates a positive result for urine macroalbumin; providers must use automated laboratory data to confirm a positive result for tests identified by CPT or LOINC codes.					
Blood Pressure [Commercial, Medicaid, Medicare]	Document blood pressure at least once a year for members ages 18-85 who have a diagnosis of hypertension. Goal: <140/80mm Hg or <140/90 mm Hg					

Behavioral Health

Antidepressant Medication Management (ages 18+) [Commercial, Medicaid, Medicare]	Adults 18 and older diagnosed with a new episode of depression should remain on an antidepressant medication for a minimum of 84 days (12 weeks) and optimally 180 days (six months.)				
Follow-Up Care for Children Prescribed ADHD Medication (ages 6-12) [Commercial, Medicaid]	*Codes to identify Follow-up Visits*				*Codes to identify Telephone Visits*
	CPT	**HCPCS**		**UB Revenue**	**ICD-9-CM Diagnosis**
	90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485		0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983	98966-98968, 99441-99443
	CPT			**POS**	
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	**WITH**		03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72	
	99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**		52, 53	
	EXCLUSION: Narcolepsy ICD-9-CM Dx: 347				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (ages 18-64) [Medicaid]	*Diabetes Glucose Screening*			*Bipolar Disorder*	*Schizophrenia*
	CPT	**LOINC**		**ICD-9-CM Diagnosis**	**ICD-9-CM Diagnosis**
	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	1518-0, 1554-5, 10450-5, 14995-5, 17865-7		296.0, 296.1, 296.4, 296.5, 296.6, 296.7	295
Diabetes Monitoring for People With Diabetes and Schizophrenia (ages 18-64) [Medicaid]	*Codes to identify HbA1c Tests*			*Codes to identify LDL-C Screening*			*Schizophrenia*
	CPT	**CPT Category II**	**LOINC**	**CPT**	**CPT Category II**	**LOINC**	**ICD-9-CM**
	83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4, 71875-9	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0	295

HEDIS Code Quick Reference Guide–Disease Management Services

Behavioral Health-continued

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (ages 18-64) [Medicaid]	*Codes to identify LDL-C Screening*			*Schizophrenia*
	CPT	**CPT Category II**	**LOINC**	**ICD-9-CM**
	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0	295
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (ages 19-64) [Medicaid]	Patients ages 19-64 with schizophrenia who were dispensed an antipsychotic medication should remain on the medication for at least 80% of their treatment period.			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (ages 13+) [Commercial, Medicaid, Medicare]	*Codes to identify Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*			
	CPT	**HCPCS**	**UB Revenue**	
	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983	
	CPT		**POS**	
	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	**WITH**	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	
	90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53	

Source: HEDIS 2013 Technical Specifications
Allowable codes may vary by state. Reimbursement for these services will be per the terms of your agreement.

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Child/Adolescent Care

Well-Child Visits in the First 15 Months of Life [Commercial, Medicaid]	*Codes to identify Well-Child Visits 0-15 Months*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99381, 99382, 99391, 99392, 99461		G0438, G0439	V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life [Commercial, Medicaid]	*Codes to identify Well-Child Visits 3-6 Years*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99382, 99383, 99392, 99393		G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Adolescent Well-Care Visits (ages 12-21) [Commercial, Medicaid]	*Codes to identify Adolescent Well-Care Visits*			
	CPT		**HCPCS**	**ICD-9-CM Diagnosis**
	99383-99385, 99393-99395		G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Childhood Immunization Status (by age 2) [Commercial, Medicaid]	*Codes to identify Childhood Immunizations**			*Codes for evidence of disease*
	CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-9-CM Diagnosis**
4-DTaP	90698, 90700, 90721, 90723		99.39	
3-IPV	90698, 90713, 90723		99.41	
1-MMR	90707, 90710		99.48	
Measles and rubella	90708			
Measles	90705		99.45	055
Mumps	90704		99.46	072
Rubella	90706		99.47	056
3-HiB	90645-90648, 90698, 90721, 90748			
3-Hepatitis B	90723, 90740, 90744, 90747, 90748	G0010		070.2, 070.3, V02.61
1-VZV	90710, 90716			052, 053
4-Pneumococcal conjugate	90669, 90670	G0009		
1-Hepatitis A	90633			070.0, 070.1
2-Rotavirus (two-dose schedule)	90681			
3-Rotavirus (three-dose schedule)	90680			
2-Influenza	90655, 90657, 90661, 90662	G0008	99.52	

*Pediatric immunization administration codes are: 90460 and 90461 (for each additional). Please show CPT code for VFC vaccines at $0 so that appropriate credit can be applied. When an evaluation and management service (other than a preventive medicine service) is provided on the same date as a prophylactic immunization, Modifier -25 may be appended to the code for the evaluation and management service.

EXCLUSIONS:	**ICD-9-CM Diagnosis**	
Anaphylactic reaction	999.42	See complete guide for other exclusions and related codes by vaccine, as applicable.

Immunizations for Adolescents [Commercial, Medicaid]	*Codes to identify Immunizations*				
	CPT	**ICD-9-CM Procedure**	**EXCLUSIONS:**	**ICD-9-CM Diagnosis**	
Meningococcal [ages 11-13]	90733, 90734		Anaphylactic reaction	999.42	
Tdap [ages 10-13]	90715	99.39	See complete guide for other contraindication codes by vaccine, as applicable.		
Td [ages 10-13]	90714, 90718				
Tetanus [ages 10-13]	90703	99.38			
Diphtheria [ages 10-13]	90719	99.36			
HPV (3) [ages 9-13]	90649, 90650				

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Child/Adolescent Care-continued

Lead Screening in Children (by age 2) [Medicaid]	*Codes to identify Lead Tests*				
	CPT	**LOINC**			
	83655	5671-3, 5674-7, 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3			
Children and Adolescents' Access to Primary Care Practitioners (12 months-19 years) [Commercial, Medicaid]	*Codes to identify Ambulatory or Preventive Care Visits*				
	Office or other outpatient services	Home services	Preventive medicine	General medical examination	
	CPT	**CPT**	**CPT/HCPCS**	**ICD-9-CM Diagnosis**	
	99201-99205, 99211-99215, 99241-99245	99341-99345, 99347-99350	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429/G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (ages 3-17) [Commercial, Medicaid]	*Codes to identify Outpatient Visits*		*Codes to identify BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity*		
	CPT	**UB Revenue**	**BMI Percentile**	**Nutrition Counseling**	**Physical Activity Counseling**
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 0982, 0983	ICD-9-CM Dx: V85.5	ICD-9-CM Dx: V65.3, HCPCS: G0270-G0271, S9449, S9452, S9470, G0447, CPT: 97802-97804	ICD-9-CM Dx: V65.41, HCPCS: S9451, G0447
	EXCLUSIONS:	**ICD-9-CM Diagnosis**			
	Pregnancy	630-679, V22, V23, V28			

Women's Health

Breast Cancer Screening (ages 40-69) [Commercial, Medicaid, Medicare]	*Codes to identify Breast Cancer Screening*				
	CPT	**HCPCS**	**ICD-9-CM Procedure**	**UB Revenue**	
	77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403	
	EXCLUSIONS:	**CPT**	**ICD-9-CM Procedure**		
	Bilateral mastectomy	Use Unilateral code WITH bilateral modifier .50 or 09950 to indicate the procedure was bilateral and performed during the same operative session.	85.42, 85.44, 85.46, 85.48		
	Unilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307 (Modifiers: Right=RT, Left=LT)	85.41, 85.43, 85.45, 85.47		
Cervical Cancer Screening (ages 21-64) [Commercial, Medicaid]	*Codes to identify Cervical Cancer Screening*				
	CPT	**HCPCS**	**ICD-9-CM Procedure**	**UB Revenue**	**LOINC**
	88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
	EXCLUSIONS:	**CPT**	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**	
	Hysterectomy	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47, V88.01, V88.03, 752.43	68.4-68.8	

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Women's Health-continued

Chlamydia Screening in Women (ages 16-24) [Commercial, Medicaid]	*Codes to identify Chlamydia Screening*			
	CPT	**LOINC**		
	87110, 87270, 87320, 87490-87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2		
	EXCLUSIONS:	**CPT**	**UB Revenue**	**LOINC**
	Pregnancy test	81025, 84702, 84703	925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 45194-8, 55869-2, 55870-0, 56497-1
	WITH			
	Diagnostic radiology	70010-76499	032x	
	Retinoid	Isotretinoin prescription		

Pregnancy Care

Postpartum Care [Commercial, Medicaid]	*Codes to identify Postpartum Visits*						
	CPT (Preferred Codes)	**CPT Category II**	**HCPCS**	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**	**UB Revenue**	**LOINC**
	57170, 58300, 59400,* 59410,* 59430, 59510,* 59515,* 59610,* 59614,* 59618,* 59622,* 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, 99501 (*Generally, these codes are used on the date of delivery. Code may be used only if the claim form indicates when postpartum care was rendered.)	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
Prenatal Care [Commercial, Medicaid]	*Basic Codes to identify Prenatal Care Visits*						
	CPT			**ICD-9-CM Diagnosis**			
	59400,* 59425,* 59426,* 59510,* 59610,* 59618* (* Generally, these codes are used on the date of delivery. Code is useful only if the claim form indicates when prenatal care was initiated.)		**WITH**	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22, V23, V28		
	CPT Category II						
	0500F, 0501F, 0502F						

Adult Care

Adult BMI Assessment (ages 18-74) [Commercial, Medicaid, Medicare]	*Codes to identify Outpatient Visits*			*Codes to identify BMI*
	CPT	**HCPCS**	**UB Revenue**	**ICD-9-CM Diagnosis**
	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402	051x, 0520-0523, 0526-0529, 0982, 0983	V85.0-V85.5
	EXCLUSIONS:	**ICD-9-CM Diagnosis**		
	Pregnancy	630-679, V22, V23, V28		

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Adult Care-continued

Adults' Access to Preventive/ Ambulatory Health Services (ages 20-65) [Commercial, Medicaid, Medicare]	*Codes to identify ambulatory or preventive care visit*				
	Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
	Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
	Home services	99341-99345, 99347-99350			
	Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
	Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
	Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439		
	Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
	General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Colorectal Cancer Screening (ages 50-75) [Commercial, Medicare, NY Medicaid]	*Codes to identify Colorectal Cancer Screening*				
	Description	**CPT**	**HCPCS**	**ICD-9-CM Procedure**	**LOINC**
	FOBT	82270, 82274	G0328		2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2
	Flexible sigmoidoscopy	45330-45335, 45337-45342, 45345	G0104	45.24	
	Colonoscopy	44388-44394, 44397, 45355, 45378-45387, 45391, 45392	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43	
	EXCLUSIONS:	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**
	Colorectal cancer		G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05	
	Total colectomy	44150-44153, 44155-44158, 44210-44212			45.8

Glaucoma Screening in Older Adults (ages 67+) [Medicare]	Refer Medicare members 65 years and older who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.

Care of Older Adults (ages 66+) [Medicare SNP]	*Codes to identify Care of Older Adults*			
	Category	**CPT Category II**	**HCPCS**	**CPT**
	Advance Care Planning	1157F, 1158F	S0257	
	Identify Medication Review	1160F (review),1159F (list)		90862, 99605, 99606
	Functional Status Assessment	1170F		
	Pain Screening	0521F, 1125F, 1126F		

Influenza Vaccine/Pneumonia Vaccine [Commercial, Medicare]	Annual Influenza vaccine of commercial adults 50-64 years of age. Annual Influenza vaccine of Medicare adults 65 years of age and older. Pneumococcal vaccination of Medicare members 65 years of age and older.	
	Influenza CPT	90654, 90656, 90660, 90662
	Pneumonia CPT	90732

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Adult Care-continued

Annual Monitoring for Persistent Medications (ages 18+) [Commercial, Medicaid, Medicare]	*Codes to identify Annual Monitoring for Persistent Medications*			
	Medications	**Description**	**CPT**	**LOINC**
	ACE inhibitors or ARBs, Digoxin, or Diuretics	Lab panel	80047, 80048, 80050, 80053, 80069	
		OR		
		Serum potassium (K+)	80051, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 29349-8, 32713-0, 39789-3, 39790-1, 41656-0, 51618-7
		AND		
		Serum creatinine (SCr)	82565, 82575	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3, 59826-8, 59834-2, 62425-4
		OR		
		Blood urea nitrogen (BUN)	84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 44734-2, 49071-4, 59570-2
		Drug serum concentration for phenobarbital	80184	3948-7, 3951-1, 10547-8, 14874-2, 34365-7, 60468-6
	Anticonvulsants	Drug serum concentration for phenytoin	80185, 80186	3968-5, 3969-3, 14877-5, 32109-1, 40460-8, 65361-8
		Drug serum concentration for valproic acid or divalproex sodium	80164	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4
		Drug serum concentration for carbamazepine	80156, 80157	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 47097-1
Medication Reconciliation Post Discharge [Medicare SNP]	Adults 66 years and older should have medications reconciled by outpatient provider within 30 days of discharge. Reconciliation can be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.			
Drug-Disease Interaction in the Elderly [Medicare]	Adults 65 years or older who have evidence of an underlying disease, condition or heath concern should NOT be dispensed an ambulatory prescription for a contraindicated medication.			
	1. Adults identified with falls or hip fractures should NOT be dispensed an ambulatory prescription for a tricyclic antidepressant or an antipsychotic or sleep agent.			
	2. Adults diagnosed with dementia or a dispensed dementia medication should NOT be dispensed an ambulatory prescription for a tricyclic antidepressant or anticholinergic agent.			
	3. Adults diagnosed with chronic renal failure should NOT be dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID.			
High-Risk Medications in the Elderly [Medicare]	Adults 66 years of age and older should not be dispensed high-risk prescriptions as identified in the Beers List.			
Aspirin Use and Discussion [Commercial, Medicaid, Medicare]	Discuss the risks and benefits of using aspirin in the following populations: – Women 56-79 years of age with at least two risk factors for cardiovascular disease. – Men 46–65 years of age with at least one risk factor for cardiovascular disease. – Men 66-79 years of age, regardless of risk factors.			
Medical Assistance With Smoking and Tobacco Use Cessation [Commercial, Medicaid, Medicare]	Provide cessation advise to adults 18 years of age and older who are current smokers or tobacco users, discuss or recommend cessation medications, and provide cessation methods or strategies.			

HEDIS Code Quick Reference Guide–Preventive/Ambulatory Services

Health Outcomes Survey Measures

The Medicare survey measures each member's physical and mental health status at the beginning and the end of a two-year period.	
Falls Risk Assessment [Medicare]	Discuss falls or problems with balance or walking with adults 75 years of age and older or 65–74 years of age with balance or walking problems, and provide fall risk intervention for these individuals.
Management of Urinary Incontinence in Older Adults [Medicare]	Discuss urine leakage problem with adults 65 years of age and older who reported having a problem with urine leakage in the past six months, and provide treatment for these individuals.
Osteoporosis Testing in Older Women [Medicare]	Women 65 years of age and older should receive a bone density test to check for osteoporosis.
Physical Activity in Older Adults [Medicare]	Speak with adults 65 years of age and older about their level of exercise or physical activity and provide advice to start, increase or maintain their level of exercise or physical activity.

Source: HEDIS 2013 Technical Specifications
Allowable codes may vary by state. Reimbursement for these services will be per the terms of your agreement.

HEDIS Code Quick Reference Guide–Women's Health Services

Women's Health

Breast Cancer Screening (ages 40-69) [Commercial, Medicaid, Medicare]

Codes to identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403

EXCLUSIONS:	CPT	ICD-9-CM Procedure
Bilateral mastectomy	Use Unilateral code WITH bilateral modifier .50 or 09950 to indicate the procedure was bilateral and performed during the same operative session.	85.42, 85.44, 85.46, 85.48
Unilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307 (Modifiers: Right=RT, Left=LT)	85.41, 85.43, 85.45, 85.47

Cervical Cancer Screening (ages 21-64) [Commercial, Medicaid]

Codes to identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue	LOINC
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

EXCLUSIONS:	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Hysterectomy	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47, V88.01, V88.03, 752.43	68.4-68.8

Chlamydia Screening in Women (ages 16-24) [Commercial, Medicaid]

Codes to identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490-87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2

EXCLUSIONS:	CPT	UB Revenue	LOINC
Pregnancy test	81025, 84702, 84703	925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 45194-8, 55869-2, 55870-0, 56497-1
WITH			
Diagnostic radiology	70010-76499	032x	
Retinoid	Isotretinoin prescription		

HEDIS Code Quick Reference Guide–Women's Health Services

Pregnancy Care

	Codes to identify Postpartum Visits						
	CPT (Preferred Codes)	**CPT Category II**	**HCPCS**	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**	**UB Revenue**	**LOINC**
Postpartum Care [Commercial, Medicaid]	57170, 58300, 59400,* 59410,* 59430, 59510,* 59515,* 59610,* 59614,* 59618,* 59622,* 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, 99501 (*Generally, these codes are used on the date of delivery. Code may be used only if the claim form indicates when postpartum care was rendered.)	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

	Basic Codes to identify Prenatal Care Visits		
	CPT		**ICD-9-CM Diagnosis**
Prenatal Care [Commercial, Medicaid]	59400,* 59425,* 59426,* 59510,* 59610,* 59618* (* Generally, these codes are used on the date of delivery. Code is useful only if the claim form indicates when prenatal care was initiated.)	**WITH**	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22, V23, V28
	CPT Category II		
	0500F, 0501F, 0502F		

Well Care

	Codes to identify Ambulatory or Preventive Care Visit				
	Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Adults' Access to Preventive/Ambulatory Health Services (ages 20-65) [Commercial, Medicaid, Medicare]	Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
	Home services	99341-99345, 99347-99350			
	Nursing facility care	99304-99310, 99315, 99316, 99318			
	Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
	Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439		
	Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
	General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

	Codes to identify Adolescent Well-Care Visits		
	CPT	**HCPCS**	**ICD-9-CM Diagnosis**
Adolescent Well-Care Visits (ages 12-21) [Commercial, Medicaid]	99383-99385, 99393-99395	G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source: HEDIS 2013 Technical Specifications
Allowable codes may vary by state. Reimbursement for these services will be per the terms of your agreement.