2017

UnitedHealthcare Community Plan
Health Care Professional, Facility
and Ancillary

Care Provider Manual
Welcome

Welcome to the UnitedHealthcare Community Plan of Missouri 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 additional electronic tools are available on our website at UnitedHealthcareOnline.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.
- West Capitated Administrative Guide, or go to uhcwest.com > Provider, click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- A different Community Plan manual-go to uhccommunityplan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

You may easily find information in the (guide/manual) using the following steps:

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

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

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

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

Important Information regarding the use of this manual

In the event of a conflict between your agreement and this 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 operational policies change.
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Chapter 1: Introduction

UnitedHealthcare Community Plan of Missouri provides benefits and value added services to our members.

If you have questions about the information or material in this manual, or about any of our policies or procedures, please do not hesitate to call Provider Services.

Our Approach to Health Care

The Whole Person Care Model (WPC):
The Whole Person Care program philosophy and structure helps ensure member needs are addressed in a holistic manner. Medical, behavioral and social/environmental concerns are targeted by engagement of members, hospitals and care providers working together. The primary goal is to help ensure the person receives the right care from the right care providers in the right place and at the right time. At a member level, this WPC program targets those individuals who have a higher persistency of healthcare utilization and may have chronic and complex emerging risk. The goal is to focus interventions on members with complex medical, behavioral, social, pharmacy and specialty needs, which results in; better quality of life for members, improved access to healthcare, and reducing expenses. The WPC program assesses the member, provides an integrated team for member care management/coordination with the goal to increase member engagement in the healthcare process provide resources to fill gaps in care and develop individualized goals toward a common outcome using evidence-based clinical guidelines. Improving the care experience and member outcomes guides our commitment to whole person care, essential to improving the health and wellbeing of individuals, families and communities.

The Whole Person Care program seeks to empower members, care providers and our community partners to improve care coordination and improve outcomes for individuals who are enrolled in Medicaid programs and have chronic complex conditions by providing:

- Integrated care team, including Community Health Worker (CHW), Registered Nurse (RN), and Behavioral Health Advocate (BHA). We work with the extended care team, including primary care provider (PCP), pharmacist, Medical Director, and Peer Support Specialist. Specialized staff, including Maternity RN serve as an extension of the core care team.
- CHAs employ field based interventions to locate and engage members, connecting them to needed resources, care and services.
- Assistance with appointments with Primary Care Provider and coordinating appointments as necessary. The CHA refers members to an RN, Behavioral Health Advocate or other specialists as required for complex needs.
- Tools and techniques for helping members engage with care providers, such as appointment reminders, transportation assistance, etc.
- CHAs work with the member to remove barriers to care, improve access to community resources and enhance the ability for the member to access care.
- Focus on individuals who are high and emerging risk members, with medical, BH, Social, RX and Specialty needs, at risk for future services.
- An integrated Community Care Team as the primary connection and bridge for the members to a broad array of healthcare and social support services.
- Foundation to build trust and relationships with difficult to engage members.

The goals of the WPC program are to:

- Reduce avoidable admissions and unnecessary ER visits
- Measured outcomes by IP admission and ER rates
- Improve access to PCP & other needed services
- Measured by number of PCP visits rates within identified time frames
- Identify and address Behavioral Health needs
- Measured by number of BH care provider visits within identified time frames
- Improve access to pharmacy
Chapter 1: Introduction

- Identify and remove social and environmental barriers to care
- Improve health outcomes
- Measured by improved HEDIS and STARS metrics
- Empower the individual member to become successful in managing their complex/chronic disease or condition and care transitions
- Improve coordination of care through assignment of dedicated staff to facilitate access to care and community resources to meet unique needs
- Engage a system of care that engages with community and care provider networks to assure access to affordable care and the appropriate utilization of services

Specialty Care Managers include:

- Maternal and Child Health Care Managers, who follow pregnant women in the Healthy First Steps® program. A care manager coordinates the member’s care, including health education and outreach from the onset of pregnancy through the postpartum checkup.
- Care Managers for members that have qualifying conditions including elevated lead levels.
- Care Managers for children/adolescents in foster care
- Care Managers for members requiring Private Duty Nursing.
- Disease management

We will be offering disease management programs for:

- Major depression
- Asthma
- Obesity
- Diabetes
- Hypertension
- Attention Deficit Hyperactivity Disorder (ADHD)

UnitedHealthcare Community Plan offers several options to support care providers who require assistance.

Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member for WPC, call Member Services. You may also call Provider Services and they will transfer you to the correct phone number.

Secure Care Provider Website

All online transactions for UnitedHealthcare Community Plan members are accessible through Link at UnitedHealthcareonline.com. If you are not registered, you may do so directly on the home page. This secure portal offers an innovative suite of online health care management tools. Use of this website is intended for Community Plan providers, facilities and medical administrative staff and offers the convenience of online support anytime.

The provider portal can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

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

On the secure care provider website, you may:

- Verify member eligibility including secondary coverage
- Review benefits and coverage limit
- Check prior authorization status
- Submit claims
- Check claim status
- View your panel roster
- Access remittance advice and review recoveries
- Review your preventive health measure report
- Access the EPSDT toolset
- Submit demographic profile change
- Reduce your time on the phone

Care Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialist care providers, medical facilities, allied health professionals, and ancillary service providers.
Care Provider Services
This is the primary point of contact for care providers who require assistance. Provider Services is staffed with Provider Service Representatives trained specifically for UnitedHealthcare Community Plan.

Provider Services can assist you with questions on MO HealthNet benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc.

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

Network Management Department
Within UnitedHealthcare Community Plan, the Network Management Department is the point of contact for care providers who require assistance with their contract, credentialing and in–services. The Network Management Department is staffed with Network Account Managers and Provider Advocates who are available for visits, contracting, credentialing, and specific issues in working with UnitedHealthcare Community Plan.

If you need to speak with a Network Contract Manager at any time for assistance with credentialing status or contracting, please feel free to contact our Network Management Phone Team.

Cultural Competency Resources
To assist you in meeting membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively impact access to health care. You must cooperate with UnitedHealthcare Community Plan in meeting this obligation.

UnitedHealthcare Community Plan offers the following support services:

- Language Interpretation Line – Use this service in your office free of charge for translation needs other than English. You can access the language interpretation line by contacting UnitedHealthcare Community Plan Member Services.
- Culturally competent member materials – Materials designed to meet the needs of our members including simplified materials for members with limited English proficiency, additional languages for members who speak language other than English or Spanish, or alternative formats including materials for visually impaired members

Care Provider Privileges
To help our members get access to appropriate care and minimize out-of-pocket costs, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.
## How to Contact Us

**Important Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Details</th>
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<tbody>
<tr>
<td>Benefits</td>
<td>866-815-5334</td>
<td>Call to confirm a member’s benefits and/or prior authorization.</td>
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<tr>
<td></td>
<td>Fax: 844-881-4772</td>
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<tr>
<td>Cardiology Prior Authorization</td>
<td>866-889-8054</td>
<td>To request prior authorization of the procedures and services outlined</td>
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<td>in the prior authorization requirements of this manual</td>
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<tr>
<td>Case Management</td>
<td>866-815-5334</td>
<td>To refer high-risk members (e.g., asthma, diabetes, obesity) and members</td>
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<tr>
<td>Person-Centered Care Model (Care Management/Disease Management) also known as Whole Person Care program</td>
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<td>who need private duty nursing</td>
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<tr>
<td>Chiropractic/Adult Pain Management</td>
<td>myoptumhealthphysicalhealth.com</td>
<td>To inquire about chiropractic services</td>
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<td></td>
<td>or 800-873-4575</td>
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<td></td>
<td>Fax: 844-881-4772</td>
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<td>Claims questions:</td>
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<td></td>
<td>866-815-5334</td>
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<td>Claims</td>
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<td>To inquire about the status of a claim or to ask questions about</td>
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<td>proper completion or submission of claims</td>
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<td>Online:</td>
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<td>Use the LINK Provider Portal at UnitedHealthcareOnline.com</td>
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<td></td>
<td>Mailing address:</td>
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<tr>
<td></td>
<td>UnitedHealthcare Community Plan P.O. Box 5240</td>
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<tr>
<td></td>
<td>Kingston, NY 12402-5240</td>
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<td></td>
<td>For FedEx (use for large packages/over 500 pages)</td>
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<tr>
<td></td>
<td>UnitedHealthcare Community Plan 1355 S 4700 West, Suite 100</td>
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<td></td>
<td>Salt Lake City, UT 84104</td>
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<td>Name</td>
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<td>Claim Disputes</td>
<td>866-815-5334&lt;br&gt;Online: Go to Link at <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> to process online&lt;br&gt;Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240 Fax: 801-994-1224&lt;br&gt;Appeals mailing address: Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364 Fax: 801-994-1082</td>
<td>Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
</tr>
<tr>
<td>Claim Overpayments</td>
<td>866-815-5334&lt;br&gt;See the Overpayment section for requirements before sending your request.&lt;br&gt;UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</td>
<td>Inquire about claim overpayments</td>
</tr>
<tr>
<td>Behavioral Health Disputes</td>
<td>Optum Appeals and Grievances P.O. Box 30512 Salt Lake City, UT 84130-0512 Fax: 855-312-1470 Phone: 866-556-8166</td>
<td>Inquire about appeals and grievances for behavioral health.</td>
</tr>
<tr>
<td>Dental Services</td>
<td>855-934-9818&lt;br&gt;<a href="https://www.uhcproviders.com">uhcproviders.com</a></td>
<td>Inquire about dental services.</td>
</tr>
<tr>
<td>Electronic Data Intake (EDI) Claim EDI Log-on Issues</td>
<td>800-210-8315&lt;br&gt;<a href="mailto:ac_edi_ops@uhc.com">ac_edi_ops@uhc.com</a> 800-842-1109 Information also available at <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
<td>Call to inquire about claims issues or questions.</td>
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<td>Name</td>
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<tr>
<td>Eligibility</td>
<td>866-815-5334</td>
<td>To confirm member eligibility</td>
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<td>To access the app, sign in to <strong>UnitedHealthcareOnline.com</strong> to access Link, then select the UnitedHealthcare Online app <strong>emomed.com</strong></td>
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<tr>
<td>Enterprise Voice Portal</td>
<td>877-842-3210</td>
<td>The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>866-242-7727</td>
<td>To notify us of suspected fraud or abuse on the part of a provider or member</td>
</tr>
<tr>
<td>Missouri Fraud Control Unit Fraud and Abuse Hot line</td>
<td>800-286-3932</td>
<td>To contact the state’s fraud unit directly.</td>
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<tr>
<td>Healthy First Steps/ OB Referral</td>
<td>800-599-5985 Fax 877-353-6913</td>
<td>To refer high-risk OB members. To fax initial prenatal visit form</td>
</tr>
<tr>
<td>LabCorp for Providers</td>
<td>888-522-2677</td>
<td>LabCorp is the preferred lab provider</td>
</tr>
<tr>
<td>Member Services</td>
<td>866-292-0359</td>
<td>Monday through Friday, from 8:00 a.m. to 5:00 p.m. Central Time, except state designated holidays</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse Optum Behavioral Health</td>
<td>866-815-5334 Fax: 844-881-4772</td>
<td>To refer members for behavioral health services (a PCP referral is not required)</td>
</tr>
<tr>
<td>Missouri Department of Social Services/HealthNet</td>
<td>573-751-3425 dss.mo.gov&gt;mhd&gt;providers</td>
<td>Members may call this number to contact Medicaid directly. Website for more provider information</td>
</tr>
<tr>
<td>Multilingual and Interpreter Services</td>
<td>866-292-0359</td>
<td>Monday through Friday, from 8:00 a.m. to 5:00 p.m. Central Time, except state designated holidays</td>
</tr>
<tr>
<td>National Credentialing Center (VETTS line)</td>
<td>877-842-3210</td>
<td>Self-service functionality to update or check credentialing information.</td>
</tr>
<tr>
<td>National Plan and Provider Enumeration System (NPPES)</td>
<td>800-465-3203 nppes.cms.hhs.gov</td>
<td>To apply for a National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>Network Management Phone Team</td>
<td>800-284-0626</td>
<td>Contracting and provider services information</td>
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<td>Name</td>
<td>Contact Information</td>
<td>Details</td>
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<tr>
<td>NurseLine</td>
<td>866-351-6827</td>
<td>Available 24 hours a day/seven days a week</td>
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<td>Obstetrician Referral</td>
<td>Healthy First Steps: 800-599-5985, Fax 877-353-6913</td>
<td>Baby Blocks: <a href="#">UHCBabyBlocks.com</a></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Contact MO HealthNet Pharmacy Services: 800-392-2161 or 573-751-6527</td>
<td>Prescription medication received at the pharmacy is covered by MO HealthNet. Durable medical equipment (DME) received at a pharmacy is covered under UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Prior Authorization/Notification of Health Services</td>
<td>866-815-5334, Fax: 844-881-4772</td>
<td>Submit PA online: <a href="#">UnitedHealthcareOnline.com</a> &gt; Notifications/ Prior authorizations &gt;Notification/Prior Authorization submission  &lt;br&gt; PA Fax form: <a href="#">UHCCommunityPlan.com</a> &gt; Provider Information&gt;Missouri&gt; Prior Authorization and Notification  &lt;br&gt; To request authorization of procedures and services outlined in the prior authorization/ notification requirements section of this manual.  &lt;br&gt; For a complete and current list of prior authorizations visit <a href="#">UHCCommunityPlan.com</a> &gt; Radiology tab</td>
</tr>
<tr>
<td>Care Provider Service</td>
<td>866-815-5334, Fax: 844-881-4772</td>
<td>Available 8 a.m. to 5 p.m. Central Time Monday through Friday</td>
</tr>
<tr>
<td>Radiology Prior Authorization</td>
<td>866-889-8054, <a href="#">UHCCommunityPlan.com</a> &gt; Radiology tab</td>
<td>To request prior authorization of the procedures and services outlined in the prior authorization requirements of this manual  &lt;br&gt; For a complete and current list of CPT Codes that require prior authorization, visit <a href="#">UHCCommunityPlan.com</a> &gt; Radiology tab</td>
</tr>
<tr>
<td>Telecommunication Device for the Deaf (TDD) Services</td>
<td>711</td>
<td>Deaf services</td>
</tr>
<tr>
<td>Tobacco Free Quit Line</td>
<td>800-784-8669</td>
<td>Inquire about services for quitting tobacco/smoking</td>
</tr>
<tr>
<td>Transportation/MTM</td>
<td>UnitedHealthcare Community Plan Member Services: 866-292-0359</td>
<td>Call to schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance. Members must call between Monday through Friday 8:00 a.m. to 5:00 p.m. Central Time to schedule transportation.</td>
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<tr>
<td>Name</td>
<td>Contact Information</td>
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<tr>
<td>Utilization Management</td>
<td>866-815-5334</td>
<td>UM helps avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. You may request a copy of our UM guidelines or request information about the program.</td>
</tr>
<tr>
<td>Vaccines for Children program</td>
<td>800-219-3224 or 573-751-6124 Fax: 573-526-5220 <a href="http://health.com.gov%3Eliving%3Ewellness%3Eimmunizations%3Evfc-providers.php">health.com.gov&gt;living&gt;wellness&gt;immunizations&gt;vfc-providers.php</a></td>
<td>MO HealthNet enrolled providers must participate in the VFC Program administered by the Missouri Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified MO HealthNet eligible children. Providers are required to enroll as VFC providers with DHSS in order to bill for the administration of the vaccine.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>MARCH Vision Care 844-616-2724</td>
<td>Prior confirmation is required for all routine eye exams and hardware. Obtain confirmation from MARCH Vision Care.</td>
</tr>
</tbody>
</table>
Missouri Care Provider
Quick Reference Guide
Our Claims Process

To help ensure prompt payment for services:

1. **Review and copy** both sides of the member’s UnitedHealthcare Community Plan ID card and their MO HealthNet Medicaid ID card.

2. **Notify** Health Services of planned procedures and services on our Prior Authorization list and/or if the member does not have their Medicaid ID card. Document the card verification in the member’s medical record.

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

4. **Submit** claims electronically — sign in to UnitedHealthcareOnline.com to access Link, then select the UnitedHealthcare Online app. Be sure to use our electronic payer ID number (86050) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315.

If you do not have access to internet services, you may mail the completed claim to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

**Complete Claims**
A complete claim includes the following:

- Referring care provider’s name (if applicable).
- Information about other insurance coverage, including job-related, auto or accident information, if available.
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers.
- Attach an anesthesia report for anesthesia claims submitted.
- Attach documentation, such as operative report, office notes, etc., of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable).
- Include the exact NDC that appears on the product administered.

**IMPORTANT:** Submit claims within timely filing limit.

**UHCCommunityPlan.com**

This website allows you to get updated provider information that includes:

- Newsletters
- Administrative manual
- Clinical practice guidelines
- Bulletins
- Reimbursement policies
Missouri Care Provider Quick Reference Guide
Additional Contact Information

Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. Tool developed using CMS General Equivalence Mappings (GEMs) as a baseline.

Notify Health Services Within the Following Time Frames:

- **Emergency Admission** – One business day if an emergency or urgent admission
- **Admission After Ambulatory Surgery** – One business day of an inpatient admission
- **Non-Emergency Care (except maternity)** – At least 14 calendar days prior to non-emergent non-urgent facility admissions and/or outpatient services
- Call 866-815-5334 or fax prior authorization to 844-881-4772

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

Evidence-Based Clinical Review Criteria and Guidelines
UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for determinations of appropriateness of care.
Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

This manual is written for in-network and/or out-of-network care providers approved to treat our members for specific services. Out-of-network care providers should follow the policies within this manual for those services.

Non Discrimination

You cannot refuse an enrollment/assignment or disenroll a member or otherwise discriminate against them solely based on age, sex, race, physical or mental handicap and national origin, type of illness or condition, except when that illness or condition can be better treated by another care provider type.

Communication between Care Providers and Members

The health care program requires a two-way communication between primary care providers (PCP) and other participating care providers to help ensure both quality and cost-effective health services are provided to UnitedHealthcare Community Plan members.

UnitedHealthcare Community Plan does not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member’s health status, medical care or treatment options including any alternative that may be self-administered or providing any information the member needs to decide among all relevant treatment options.

All care provider and provider agreements executed by UnitedHealthcare Community Plan contain language, which encourages you to discuss treatment options and their associated risks and benefits with members, regardless of whether the treatment is covered under the member’s benefit contract. Nothing in the UnitedHealthcare agreement is intended to interfere with your relationship with members as patients, or with UnitedHealthcare Community Plan’s ability to administer its quality improvement, utilization management or credentialing programs.

UnitedHealthcare Community Plan members and/or their representative(s) have the right to actively participate in the planning and implementation of their care. In order to help ensure members and/or their representative(s) are afforded this opportunity, UnitedHealthcare Community Plan has developed a policy which requires you to:

1. Educate patients, and/or their representative(s) regarding their health needs.
2. Share findings of history and physical examinations.
3. Discuss potential treatment options (without regard to plan coverage), side effects of treatment and management of symptoms.
4. Recognize members (and/or their representative) have the right to choose the final course of action among clinically acceptable choices.
5. Collaborate with the Plan Care Manager in developing a member specific Plan of Care for members enrolled in High Risk Care Management.

Provide Official Notice

You must notify us of the following events, in writing, within 10 calendar days of your knowledge of their occurrence:

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

You may use the care provider and provider demographic change submission form for demographic changes or to update NPI information for care providers in your office. This form is located at UnitedHealthcareOnline.com > Tools & Resources > Forms.

Transition Member Care Following Termination of Your Participation

If your network participation terminates for any reason, you are required to participate in the transition of your patient toward timely and effective care. This may include providing service(s) for a reasonable time, at our contracted rate. Provider Services is available to help you and our members with the transition.
**Arrange Substitute Coverage**
If you are unable to provide care and are arranging for a substitute, we ask that you try to arrange for care from other care providers and health care professionals who participate with UnitedHealthcare Community Plan.

**For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCCommunityPlan.com.**

To cover services under the member’s in-network benefit plan, you need to apply for participation and, if accepted, sign a participation agreement.

**Administrative Terminations for Inactivity**
Up-to-date directories are a critical element of providing our members with the information they need to manage their health. In an effort to accurately reflect care providers who are actively treating UnitedHealthcare Community Plan members in our directories, UnitedHealthcare Community Plan takes the following actions:

1. Administratively terminate provider agreements for care providers who have not submitted claims for a period of one year on the basis they are not actively treating UnitedHealthcare Community and State members, and have voluntarily ceased participation in our network.

2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year on the basis they are not in active use. This is not a termination of the agreement with the provider. Providers may contact UnitedHealthcare Community Plan to reactivate an inactivated TIN.

**To change an existing TIN or to add a health care provider,** please complete and fax the Provider Demographic Change Form and your W-9 form to the appropriate fax number listed on the bottom of the fax form.

The W-9 form and the Provider Demographic Change Form are available at UnitedHealthcareOnline.com > Tools & Resources > Forms.

Alternatively, you may submit detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. Fax this information to the fax number on the bottom of the demographic change request form.

**To update your practice or facility information**
You can make all other updates to your practice information by going to the Provider Data Management application on UnitedHealthcareOnline.com, Tools and Resources, Forms, then Provider Demographic Change Form. You may also submit your change by: (a) completing the Provider Demographic Change Form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our Enterprise Voice Portal.

**After-Hours Care**
While true emergencies and life-threatening situations require the immediate services of an emergency department, treatment after hours can be provided quickly and efficiently at an urgent care center where available, and appropriate for conditions such as infections, fever, symptoms of cold or flu. When your office is contacted by one of your patients after hours asking where to seek urgent care, please refer them to an urgent care center if you are not able to accommodate them in your schedule.

**Participate in Quality Initiatives**
You must cooperate with our quality assessment and improvement activities, and comply with our clinical guidelines, member safety (risk reduction) efforts, and data confidentiality procedures.

The guidelines upon which UnitedHealthcare Community Plan clinical quality initiatives are based define optimal delivery of health care for particular diseases and conditions as determined by United States government agencies and professional specialty societies. See Chapter 10 for more details about the Quality Initiatives, including information on Advance Directives.

**Provide Access to Your Records**
You must provide access to any medical, financial or administrative records related to the services you provide to UnitedHealthcare members within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Such records must be maintained for ten years, or longer if required by applicable statutes or regulations.

**Performance Data**
You must allow the plan to use care provider performance data.
Comply With Protocols
You must cooperate with, and are bound by, UnitedHealthcare Community Plan’s and Payer’s Protocols including those protocols contained in this Guide.

These protocols, as well as additional protocols, can be viewed at UHCCommunityPlan.com.

Office Hours
You must offer office hours of operation to UnitedHealthcare Community Plan members no less than those offered to commercial members.

Protect Confidentiality of Member Data
UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members’ health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. You will comply with applicable regulatory requirements, including but not limited to, those relating to confidentiality of member medical information.

You agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes passwords, screen saver, firewalls and other computer protection, along with shredding of information that includes PHI and all confidential conversations. All personnel are trained on HIPAA and confidentiality requirements.

Follow Medical Record Standards
Please reference Chapter 9 for specific Medical Record Standards.

Inform Members of Advance Directives
The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive.

Under the federal act, you must provide written information to members on state law about advance treatment directives, about members’ right to accept or refuse treatment, and about your own policies regarding advance directives.

To comply with this requirement, we also inform members of state laws on advance directives through our member handbooks and other communications.

If you have a concern or complaint about your agreement with us, send a letter containing the details to the address in your contract. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, you may file for arbitration.

If your concern or complaint relates to a matter administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Management process, follow the dispute procedures documented in your agreement. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described in your agreement.

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

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

You may locate the member’s handbook at uhccommunityplan.com.

Please also reference Chapter 12 of this manual concerning information on Provider Claim Disputes, Appeals and Grievances.
Role of the Primary Care Provider (PCP) and Specialists (i.e., Internal Medicine, Pediatrics, or OB/GYN) Serving in the PCP Role — Requirements

PCPs are an important partner in the delivery of care and Department of Social Services members have the freedom to seek services from any participating care provider. The Department of Social Services program does require members to be assigned to PCPs and members are encouraged to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a “medical home” that they can access to optimize their care.

The Primary Care Provider (PCP) plays a vital role as a care provider case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas – access, coordination, continuity, and prevention. The PCP is responsible for the provision of initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24-hours/seven days coverage and backup coverage when he or she is not available.

Provider types that can be PCPs are medical doctors (M.D.), doctors of osteopathy (DO), nurse practitioners (NPs)*, and physician assistants (PAs)* from any of the following practice areas:

- General Practice
- Internal Medicine
- Family Practice
- Pediatrics
- Obstetrics/Gynecology

Nurse practitioners are allowed to enroll with the state as solo providers, but physician assistants cannot. They must be part of a group practice.

*The participating provider should submit any services completed by nurse practitioners or physician assistants who are part of a collaborative agreement. Services for durable medical equipment (DME), home health, and physical, occupational or speech therapies, all require that an M.D. or D.O. be the ordering care provider. Per the state of Missouri Department of Health and Human Services, physician assistants and nurse practitioners cannot be the ordering care provider for these types of services.

Enrollees may change their assigned PCP by contacting Member Services at any time during the month. Customer Service is available 8 a.m. to 5 p.m. Monday through Friday Central Time.

Enrollees who do not select a PCP at enrollment are offered the opportunity to select one. However, there are occasions when the UnitedHealthcare Community Plan must auto-assign a PCP to complete the enrollment process.

You may print a monthly Primary Care Provider Panel Roster by visiting UnitedHealthcareonline.com.

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all participants understand, support, and benefit from the primary care case management system. The coverage shall 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, care provider on-call, hospital switchboard, PCP’s nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.
PCPs and Specialists Serving in the PCP Role (i.e. Internal Medicine, Pediatrics, or OB/GYN) - Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of the PCPs include:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this Guide.
- Conduct a baseline examination during the member’s first appointment.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines.
- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with special health care needs.
- Help ensure the integration of clinical and non-clinical disciplines and services in the overall plan of care for special needs members.
- Use any member lists supplied by the health plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each member’s overall course of care.
- Be available personally to accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one medical doctor (MD) practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone anytime.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the advance directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Document procedures for monitoring patients’ missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Copies of medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Disabilities (ADA) standards.
- Complying with the Department of Social Services Access and Availability standards for scheduling Emergency, Urgent Care and Routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Rural Health Clinic, Federally Qualified Health Center or Primary Care Clinic as PCP

Members may choose a Rural Health Clinic as the PCP. The Rural Health Clinic (RHC) program is intended to increase access to primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities, however, they must be located in rural, underserved areas.

Members may also choose a Federally Qualified Health Center (FQHC) as the PCP. An FQHC is a center or clinic that provides primary care and other services, such as:

- Preventative (wellness) health services from a care provider, physician assistant, nurse practitioner and/or social worker.
• Mental health services
• Immunizations (shots)
• Home nurse visits

Lastly, members may choose a Primary Care Clinic (PCC) as the PCP. A primary care clinic is a medical facility that focuses on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious, or not considered life threatening. If there is a condition discovered at a primary care clinic that may be considered extremely dangerous to the patient, a referral to a specialist may be made. Doctors at these clinics usually include internists, family physicians and pediatricians.

Primary Care Provider Checklist
PCPs should take the following steps when providing services to UnitedHealthcare Community Plan members:

• Verify eligibility at www.emomed.com, through LINK at UnitedHealthcareonline.com, or by calling Provider Services.
• Verify member identity with photo identification, if this is your office practice.
• Obtain prior authorization from UnitedHealthcare Community Plan, if required.
• To locate the prior authorization information, go to UHCCommunityPlan.com, select For Health Care Professionals, Missouri, and then Prior Authorization.
• Refer to UnitedHealthcare Community Plan contracted specialists unless otherwise authorized by UnitedHealthcare Community Plan.
• Identify and appropriately bill other insurance carriers.
• Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 paper claim form. See Chapter 11 for more information on submitting forms.

Specialist Care Providers Responsibilities
In addition to your requirements applicable to all care providers, the responsibilities of specialist care providers include:

• Contact the PCP to coordinate the care/services.
• Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member’s PCP or who self-refer.
• Provide the PCP copies of all medical information, reports, and discharge summaries resulting from the specialist’s care.
• Communicate all findings and recommendations, in writing, to the PCP and note them in the patient’s medical record.
• Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital, at a minimum.
• Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
• Provide covered specialty care services to members in accordance with accepted community standards of care and practices.
• Verify the eligibility of the member prior to the provision of covered specialty care services.
• Provide only those covered specialty care services, unless otherwise authorized.
• Comply with the Department of Social Services Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
• Provide anytime coverage. PCPs and Specialists serving in the PCP role must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for all after-hours access. PCPs and obstetricians serving in the PCP role are required to participate in all activities related to these surveys.
Specialists Checklist

Specialists should take the following steps when providing services to UnitedHealthcare Community Plan members.

- Verify eligibility at www.emomed.com, through Link at UnitedHealthcareonline.com, or by calling Provider Services.
- Check the member’s ID card each time the member present for service and verify against photo identification if this is your office practice.
- Obtain prior authorization from UnitedHealthcare Community Plan, if required.
- To locate the prior authorization information, go to UHCCommunityPlan.com, select For Health Care Professionals, Missouri, and then Prior Authorization.
- Identify and bill other insurance carriers when appropriate.

Prenatal Care Responsibilities

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

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

You must provide the following information to UnitedHealthcare Community Plan when the pregnancy is confirmed:

- Patient’s name and member ID number
- Obstetrician’s name, phone number, and member ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery
- Any concomitant diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy
- Complying with the Department of Social Services Access and Availability standards for scheduling prenatal visits.

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

Childhood Lead Poisoning Prevention Services

Childhood lead poisoning prevention services may include screening, diagnosis, treatment, and follow-up. All children enrolled in MO HealthNet Medicaid, regardless of whether coverage is funded through title XIX or XXI, are required to receive blood lead screening tests at ages 12 months and 24 months. For more information, see the CMS documents Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels among Young Children.

Ancillary Care Provider Responsibilities

Ancillary care providers include pharmacy, home health, durable medical equipment, infusion care, therapy, and other non-care providers. PCPs and specialist care providers are required to use the UnitedHealthcare Community Plan Ancillary network.

UnitedHealthcare Community Plan contracted ancillary providers are responsible for maintaining sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary Care Provider Checklist

Ancillary care providers should take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify eligibility at www.emomed.com, through LINK at UnitedHealthcareonline.com, or by calling Provider Services
• Failure to verify member enrollment and assignment may result in claim denial.

• Check the member’s ID card each time the member presents for service and verify against photo ID if this is your office practice.

• Obtain prior authorization using the Link app. To access the app, sign in to UnitedHealthcareOnline.com to access Link, then select the UnitedHealthcare Online app, if required.

• Please visit UHCCommunityPlan.com to view the current requirements. To locate the prior authorization information, select For Health Care Professionals, Missouri, then Prior Authorization.

• Identify and bill other insurance carriers, when appropriate.

Appointment Standards (Department of Social Services Access & Availability Standards)

Comply with the following appointment availability standards:

Primary Care Providers
PCPs should arrange appointments for:

• Emergency appointment type – available 24 hours a day, seven days a week

• Urgent appointment type – within 24 hours of request

• Routine appointment with symptoms type – within one week or five business days of request, whichever is earlier

• Routine appointment without symptoms type – within 30 calendar days from request

• In Office Waiting for Appointments – Shall not to exceed one hour of the scheduled appointment time

Specialty Care Providers
Specialists should arrange appointments for:

• Routine appointment type – within 30 working days of request/referral

Prenatal Care Providers
Prenatal care providers should arrange OB GYN appointments for:

• First and second trimester – within seven calendar days of request

• Third trimester – within three days of request

• High risk – within three calendar days of identification of high risk

UnitedHealthcare Community Plan also conducts periodic access and availability surveys to monitor appointment availability and access standards. PCPs, Specialists, and Obstetricians are required to participate in all activities related to these surveys.
Chapter 3: Care Provider Office Procedures

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled with Missouri’s Department of Social Services, MO HealthNet, which is Missouri’s Medicaid program. Eligibility for the program is determined by Missouri’s Department of Social Services. An individual who becomes eligible for the program either chooses, or is assigned to one of the contracted health plans.

Verifying Member Enrollment

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

• Provider Portal – access Link through our website at UnitedHealthcareonline.com. UnitedHealthcare Provider Service is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday.

• Emomed.com

Member Assignment

Assignment to UnitedHealthcare Community Plan

UnitedHealthcare Community Plan is assigned Missouri Department of Social Services eligible members on a daily basis. UnitedHealthcare Community Plan is responsible for managing the member’s care on the date that the member is enrolled with the plan and until the member is disenrolled from UnitedHealthcare. Disenrollment decisions are made by Missouri Department of Social Services and are not the responsibility of UnitedHealthcare Community Plan. Disenrollment usually takes effect at month’s end, but at times may occur in the middle of the month. At the time of assignment to UnitedHealthcare Community Plan, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The Member Handbook explains the member’s rights and responsibilities in obtaining health care through UnitedHealthcare Community Plan.

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

Newborn eligibility information is available by calling MO HealthNet at 573-751-3425 or go to one of the following links: http://dss.mo.gov/fsd/Emomed.com

Unborn Enrollment Changes:

Please encourage your patients to notify Missouri Department of Social Services when they know they are expecting. Effective Feb. 1, 2014, Missouri Department of Social Services will begin notifying Managed Care Organizations (MCOs) daily of an unborn when Missouri HealthNet learns that an individual associated with the MCO is expecting. The MCO or you may use the online change report via the Missouri website to report the baby’s birth. With that information, Missouri verifies the birth, through interfaces and from the mother. The MCO and/or your information is taken as a lead. To assist with timely verification, once baby is born, the mother should notify Missouri Department of Social Services.

Patients who are our members may call MO HealthNet at 573-751-3425 or go to the following link: dss.mo.gov/fsd.

Newborns can get UnitedHealthcare Community Plan covered health services beginning on their date of birth, so it is important to check eligibility daily until the mother has enrolled her baby in a managed care plan.

PCP Selection:

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

Obtain copies of the Member Handbook online at UHCCommunityPlan.com or contact Provider Services.

UnitedHealthcare Community Plan Members can go to CommunityPlan to look up a provider.
Choosing a Primary Care Provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is automatically assigned to a primary care provider (PCP). The assignment takes into consideration the distance to the PCP, the PCP’s capacity, and if the PCP is accepting new patients. UnitedHealthcare Community Plan’s Member Services department will assign members to the closest and appropriate PCP.

Depending upon the age, medical condition and location of the member, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change his/her PCP at any other time the change will be effective on the date of the request.

Assignment to PCP Panel Roster

Once a member is assigned a PCP, view panel rosters electronically on the UnitedHealthcareOnline application on Link.

PCP-Initiated Transfers

A PCP may wish to transfer a member due to an inability to establish or maintain a professional relationship, experiences incompatibility with a member or member is non-compliant. The PCP maintains responsibility for providing care for the patient until a transfer is complete.

1. To initiate a transfer of the member, the PCP must contact the health plan in writing via fax at 844-881-4772 or mail with the specific documentation of the event(s) that occurred. Document the date(s) of failed appointments or a detailed accounting of reasons for termination request, patient name, date of birth, MO HealthNet number, current address, current telephone number and the care provider’s name.

2. A summary is prepared by UnitedHealthcare Community Plan within 10 business days of the request. The health plan will attempt to contact the member, educate and try to resolve the issue to develop a satisfactory PCP member relationship.

3. If the member and health plan are unable to resolve the current PCP member issue, the health plan works with the member in finding another PCP for continuity of care and refers the member to care management, if necessary.

4. If the health plan is unable to reach the member, the health plan sends the member a letter (with a copy to the PCP) advising they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP’s panel approaches the max limit, they are removed from the auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. If, at any time, a PCP would like to update or change the PCP panel limits, this can be done by sending a written request.
Chapter 3: Care Provider Office Procedures

Interpreter Services

Free in office phone interpreter service is available for all UnitedHealthcare Community Plan members.

Contact Member Services for assistance.

Member ID Card

Be sure to check the member’s ID card at each visit and to copy both sides of the card for your files. You may also take the precaution of verifying the identity of the person presenting the ID card against some form of photo ID, such as a driver’s license, if this is your office practice.

If any potential fraud, waste and abuse situation, events or circumstances (provider or member) come to your attention, please notify UnitedHealthcare Community Plan in writing per instructions regarding fraud, waste and abuse addressed in Chapter 13 of this manual, or you may call the Fraud, Waste, and Abuse Hotline.

The members' ID cards also reflect the members' PCP assignment on the front of the card.

Member Identification Numbers

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Members use this number to communicate with UnitedHealthcare Community Plan regarding a specific subscriber/member. The Missouri Department of Social Services Medicaid Number is also provided on the member ID card.
Sample Health Member ID Card

UnitedHealthcare Community Plan of Missouri 06/2017
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Chapter 3: Care Provider Office Procedures

In case of emergency call 911 or go to nearest emergency room.

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.MyUHC.com/CommunityPlan or call.

For Members:
- Behavioral Health: 866-292-0359 TTY 711
- Dental/Vision: 866-292-0359 TTY 711
- NurseLine: 866-351-6827 TTY 711

For Providers:
- www.UHConline.com 866-815-5334
- Dental Providers: 855-934-9818

Medical and BH Claims: PO Box 5240, Kingston, NY, 12402-5240
Transportation: 866-292-0359 Pharmacy: 800-392-2161 or 573-751-6527
UHC17XXX approved xx/xx/xxxx

Printed: 02/03/17

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Printed: 02/03/17
Chapter 4: Covered Services

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically Necessary Definition

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

- Necessary to meet the basic health needs of the client
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service

General Care Provider Responsibilities

The following benefits should not be considered exhaustive. The specific services delivered to Community Plan members are described in detail on the Community and State United Healthcare website.

For specific covered services, please reference UHCCommunityPlan.com.

Contact Provider Services with questions.

For a list of covered services, go to the Missouri Department of Social Services website: dss.mo.gov > mhd > mc > pdf > services.pdf.

Ambulance Services

Emergency Ambulance Transportation

Emergency ambulance services (in-network or out-of-network) are a covered benefit and do not require an authorization.

Emergency transports are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member’s health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Bill any ambulance transport that does not meet the definition of an emergency transport as a non-emergency transport. This includes all scheduled runs (regardless of origin and destination) and transports to nursing facilities or the member’s residence.

Non-Emergent Ambulance Transportation

Non-emergency ambulance transports to your office, clinic or therapy center are covered when:

1. The member is bed confined before, during, and after transport; and
2. The services cannot reasonably be provided at the member’s residence (including a nursing facility or ICF/MR).

Ambulance services provided to a member receiving inpatient hospital services, where the member is transported to another facility for services (e.g., diagnostic testing) and the member is returned to the originating hospital for continuation of inpatient care, is not included in the payment to the hospital and must be billed by the ambulance care provider.

Non-emergent ambulance transportation needs to be scheduled in your office, clinic or therapy center.

Prior authorization is not required.

Air Ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is contraindicated and:

1. Great distances or other obstacles are involved in getting the member to the destination;
2. Immediate and rapid admission is essential; or
3. The point of pickup is inaccessible by land vehicle.

Prior Authorization is required.

Emergency/Urgent Care Services

Emergency services are covered for all UnitedHealthcare Community Plan members; however, you should educate the members regarding appropriate and inappropriate use of the emergency room. The PCP should treat non-emergency services, such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats.
A prior notification is not required for emergency services. Covered services include, but are not limited to, the following:

- Emergency services based on prudent layperson definition of emergency health condition
- Hospital emergency department room and ancillary services and care provider services 24 hours a day, seven days a week, both by in and out-of-network care providers
- Medical screening examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services
- Emergency ground, air and water transportation
- Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts

We will pay out-of-network care providers for emergency services at the current MO HealthNet program rates in effect at the time of service. We will attempt to negotiate mutually acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we have financial responsibility.

If you are Emergency Room staff requesting a non-emergency service, please call Provider Services 866-815-5334 to complete your request.

**Urgent Care (Non-Emergent)**

Services for urgent care are covered.

For a list of Urgent Care Centers, contact Provider Services.

**Family Planning**

Family Planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. UnitedHealthcare Community Plan members can access family planning services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

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

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

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies specifically for sterilization infertility treatment
- In-vitro fertilization is not covered including, but not limited to:
  - GIFT
  - ZIFT
  - Embryo Transport
- Infertility Services – not covered if the sole purpose of the service is to achieve pregnancy.

**Note:** Diagnosis of infertility is covered, but treatment is not covered.

- Morning after pill – not covered. Contact the Missouri Department of Social Services to verify if the state covers.

**Parenting/Child Birth Education Programs**

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

**Voluntary Sterilization**

In-network is covered with a consent requirement. The member needs to give consent 30 days before surgery, be mentally competent, and 21 years of age or older at the time of consent.

- Tubal Ligation
- Vasectomy

Out of Network: Authorization required.

Refer to the Department of Health & Human Services Regulations for additional information on sterilization.
Hospice

UnitedHealthcare Community Plan is responsible for In-Home Hospice and Short-Stay Inpatient Hospice. These services require a prior authorization.

Home Hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice, and not receiving continuous home care. We cover continuous home care to the hospice care provider to maintain a member at their place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a member requires continuous care, which is primarily nursing care to achieve palliation or management of acute medical symptoms.

Respite Hospice

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

Inpatient Hospice

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

Inpatient hospice services provided for members receiving residential services provided by the facility are not covered under Managed MO HealthNet/Medicaid. Residential inpatient hospice services are covered by Department of Social Services. Department of Social Services will cover benefits to the hospice care provider for both the hospice services provided and for the residential services provided by the facility.

Inpatient Concurrent Review

Inpatient Concurrent Review: Clinical Information

Inpatient Concurrent Review notification is required within 24 hours or one business day of admission. It is the process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone, fax or EMR.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, 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 Community Plan requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. Central Time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. Central Time (but no later than 12 p.m. Central Time the next business day). UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Laboratory Procedures

Lab Services

LabCorp is the preferred Lab provider. Contact LabCorp directly.
UnitedHealthcare Community Plan requires you to use our contracted laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other practitioner or dentist in one of our in-network, contracted laboratories do not require prior authorization except as noted on our prior authorization list.

When submitting claims, you need to have a Clinical Laboratory Improvement Amendments (CLIA #) on file, or claims will deny. CLIA standards are national and are not Medicaid-exclusive. CLIA applies to all care providers rendering clinical laboratory and certain other diagnostic services. See the Billing and Encounters Chapter for more details on the CLIA number.

Maternity

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

If the member is in-patient longer than the federal requirements a prior notification is needed. Please call the prior authorization department.

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more pre-natal visits. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit.

Non-routine newborn care, i.e. care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is also covered but require a prior authorization. Midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A CNM must identify the licensed care provider or group of care providers with whom there is an arrangement for referral and consultation if complications arise.

Obstetrical maternity care medical services must be furnished on an outpatient basis by the care provider, nurse practitioner, care provider’s assistant, or licensed professional nurse under a care provider’s supervision, and must be within the staff’s scope of practice or licensure as defined by state law. Although you do not necessarily have to be present when services are provided, as the care provider, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

Department of Health & Human Services Regulations

Sterilization and Hysterectomy Procedures

Reimbursement for sterilization procedures are based on the person’s documented voluntary request for such service. The intent of this policy is to assure individuals considering sterilization are fully aware of the consequences, the available alternatives to sterilization and have had ample time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the requirements for making payment for sterilization have been met. The regulations require a written consent form must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is performed. The individual must be at least 21 years of age at the time the consent form is signed by the patient.

The individual must not be mentally incompetent or a resident of an institution such as a mental hospital or other facility for the treatment of mental disorders. An individual may consent to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since the individual has signed the Medical Assistance Consent Form. However, in the case of premature delivery, the Medical Assistance Consent Form must have been signed at least 30 days before the normally expected date of delivery. In the absence of compliance with the requirement outlined in this policy, both for sterilization procedures and hysterectomies, no payment can be made to any of the parties concerned, i.e., care provider, anesthetist or hospital.

Hysterectomies

Hysterectomy services cannot be reimbursed if performed for sterilization purposes. Patients undergoing hysterectomies for medical reasons other than sterilization purposes must be advised, orally and in writing, sterility will result.

Per Missouri Administrative Code 18-004.0, “All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101,” Informed Consent Form,” (see 471-000-110) signed and dated by the client in which she states she was informed before the surgery was performed this surgical procedure will result in permanent sterility.
Exception: Missouri Department of Social Services does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify, in writing, the individual was already sterile before the hysterectomy and states the cause of the sterility.

2. The individual requires a hysterectomy because of a life-threatening emergency situation and as the care provider performing the hysterectomy, you certify, in writing, the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgment was not possible. You must also include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim for services, a copy of the signed medical assistance hysterectomy statement. Mail the claim, with documentation attached, to claims administration identified on the back of the enrollee ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The enrollee may not be billed if consent forms are not submitted.

Sterilization Informed Consent

An individual is considered as having provided Informed consent only if the Medical Assistance Consent Form for sterilization procedures developed by the Department of Social Services is properly executed. Any other already existing consent forms you use do not preclude the use of the Medical Assistance Consent Form developed by Department of Social Services. It is your responsibility to be sure the individual fully understands, to the best of their ability, the planned sterilization procedure, has been advised of available alternative, non-permanent methods of family planning and has had an opportunity to have any questions answered. Informed consent may not be obtained while the individual is in labor for childbirth, is seeking to obtain or is obtaining an abortion, or is under the influence of alcohol or other substances that affect the individual’s state of awareness. The consent form must be signed and dated by the individual sterilized, and by the care provider performing the sterilization procedure.

A copy of the signed Consent Form must be given to the patient, a copy must be submitted together with the Request for Payment form and you should retain a copy.

Sterilization Consent Form

Follow the Federal CMS regulations when completing the sterilization consent form.

You may also find the form on the Missouri Department of Social Services website dss.mo.gov/fsd/health-care/.

1. Complete all applicable sections of the form. CMS ruled for valid sterilization form has all applicable items completed before payment is made. You must complete applicable sections of the consent form before submitting it together with the billing form for payment. The Missouri Medical Assistance Program cannot make payment for sterilization procedures until all applicable items on the consent form have is completed, accurate and in conformance with sterilization regulation requirements.

2. Your statement section of the form should be completed after the sterilization is performed. CMS policy is you should sign and date the form after the sterilization is performed. This may be the same date of the sterilization procedure or some date after the date of the procedure. If you sign and dates the consent form prior to performing the sterilization, the form is invalid.

3. The state’s definition of “shortly before” is not more than 30 days prior to the procedure. That means you should explain the procedure to the patient within that time frame. However, while the explanation can be given up to 30 days prior to the procedure, you should not sign and date the form until after the procedure is performed.

Services Not Covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by MO HealthNet, but not through Managed Care, such as:
  - Prescription Drugs
  - Long-term care services in a nursing home
  - Nursing facility services
  - Intermediate care facilities for persons with mental handicap
Chapter 4: Covered Services

E. Home and community based waiver services

F. Dental services

   Exception: Dental services performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary - prior authorization required.

G. Residential inpatient hospice services

   • Mental health and substance abuse care. Services covered by Optum.
   • Phones and TVs used when in the hospital
   • Personal comfort items used in the hospital such as a barber
   • Contact lenses, unless used to treat eye disease
   • Sunglasses and photo-gray lenses
   • Ambulances, unless medically necessary
   • Infertility services

**Pregnancy Termination Services**
Pregnancy termination services are not a UnitedHealthcare Community Plan covered benefit, except in cases to preserve the life of the woman. In this case, you are required to follow the Missouri Department of Social Services and consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the patient’s primary care provider. Patients must use the care provider network.
Chapter 5: Medical Management

Referral Guidelines

You are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice.

You are expected to monitor the progress of referred members’ care and help ensure that members are returned to your care as soon as medically appropriate. We require prior authorization of all out of-network referrals. The request is generally processed like any other authorization request. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the Medical Director for review and determination. Out-of-network referrals are generally approved for, but not limited, to the following circumstances:

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

Out-of-network referrals are monitored on an individual basis and trends related to individual care providers or geographical locations are reported to Network Management to assess root causes for action planning.

Vision

Vision is covered by MARCH Vision Care and requires prior confirmation for the following:

- Eye glasses (lenses and frames)
- One pair every 24 months
- Medically necessary contact lenses (ages 20 and younger when criteria is met)
- Replacement pair of glasses (ages 20 and younger when glasses are misplaced or broken)

Obtain confirmation by speaking with MARCH Vision Call Center at 844-616-2724 or by using the Interactive Voice Recognition System or eyeSynergy® web portal, which verifies member eligibility for requested benefits and services through MARCH.

Please contact MARCH Vision Care for education on benefits, lab order submission and for any demographic changes, including, but not limited to, address and phone number changes, change in office hours or available providers and Federal Tax Identification number changes. In addition, we welcome you to attend one of our training sessions on eyeSynergy®, our online web portal that gives you anytime access to eligibility, benefit, claim and lab order information.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. Prior Authorization is required for admission.

Render emergency care at once, with notification of any admission to the Prior Authorization Department or fax your Prior Authorization Form (locate form at UHCCommunityPlan.com, Click on Health Care Professionals, Select State and select Provider Forms) by 5 p.m. Central Time the next business day.

Fax: 844-881-4772

Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses evidence based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage under-utilization.

The criteria are available in writing upon request or by calling the Prior Authorization Department.

Inpatient admission starts when you write the order a member’s condition meets an acute inpatient level of stay.

Care in the Emergency Room

Screen UnitedHealthcare Community Plan members who visit an emergency room to determine whether a medical emergency exists. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan provides coverage for these services without regard to the emergency care provider’s contractual relationship with UnitedHealthcare Community Plan. Emergency services, i.e. care provider and outpatient services furnished by a qualified care provider necessary to treat an emergency condition, are covered both within and outside UnitedHealthcare Community Plan’s service area.
An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

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

Admission Authorization and Prior Authorization Guidelines

All UnitedHealthcare Community Plan prior authorizations must contain the following information:

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

The Prior Authorization Fax Request Form can be located at UHCCommunityPlan.com. Click on Health Care Professionals, select State and select Provider Forms. Fax 844-881-4772

If you have questions, please contact Prior Authorizations.

Services Requiring Prior Authorization

For a list of services that require prior authorization, please go to UHCCommunityPlan.com. Click on Health Care Professionals, select State, Provider Information Tab, Prior Authorization.

Seek Prior Authorization/Notify UnitedHealthcare Community Plan Within the Following Time Frames:

Emergency Facility Admission
Notify UnitedHealthcare Community Plan one business day of an emergency or urgent admission.

Inpatient Admissions
After Ambulatory Surgery Notify UnitedHealthcare Community Plan one business day of an inpatient admission.

Non-Emergency Admissions and/or Outpatient Services (Except Maternity)
Seek prior authorization at least 14 business days prior to non-emergency, non-urgent facility admissions and/or outpatient services; in cases in which the admission is scheduled less than five business days in advance, notify at the time the admission is scheduled.

Cardiology Prior Authorization Program

To improve compliance with evidence-based and professional society guidance, UnitedHealthcare Community Plan uses a Cardiology Prior Authorization Program.

Before ordering cardiac catheterizations, electrophysiology (EP) implants, echocardiograms and stress echocardiograms, in an office or outpatient setting, you are required to obtain a prior authorization. We also require prior authorization for inpatient EP implants.
Cardiac procedures ordered through an emergency room treatment visit, while in an observation unit, or when performed at an urgent care facility, do not require a prior authorization. Failure to complete the Cardiology Prior Authorization protocol results in an administrative denial. Claims denied for failure to request prior authorization may not be balance-billed to the patient.

To obtain or verify a prior authorization number:

**Online:** UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Cardiology Notification & Authorization - Submission & Status.

**Phone:** 866-889-8054 from 8 a.m. to 5 p.m., Central Time Monday – Friday

If initiating the prior authorization by phone, you'll need the medical record available.

An authorization number is required for each individual CPT code and each authorization number is CPT-code specific.

Please refer to UHCCommunityPlan.com under the Cardiology section for a current listing of Cardiology procedures that require prior authorization, a prior authorization crosswalk table as well as the evidence-based clinical guidelines.

**Radiology Prior Authorization Program**

To improve compliance with evidence-based and professional society guidance for Radiology procedures, UnitedHealthcare Community Plan uses a Radiology Prior Authorization Program.

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

Imaging studies ordered through an emergency room treatment visit, while in an observation unit, when performed at an urgent care facility, or during an inpatient stay, do not require a prior authorization.

Failure to complete the Radiology Prior Authorization results in an administrative denial. Claims denied for failure to request prior authorization may not be balance-billed to the patient.

You may obtain or verify a prior authorization number:

**Online:** UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Radiology Notification & Authorization - Submission & Status.

**Phone:** 866-889-8054 from 8 a.m. to 5 p.m., Central Time Monday – Friday

If initiating the prior authorization by phone, you will need the medical record available.

An authorization number is required for each individual CPT code and each authorization number is CPT-code specific.

Please refer to UHCCommunityPlan.com under the Radiology section for a current listing of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk table as well as the evidence-based clinical guidelines.

**Reimbursement**

Authorization by UnitedHealthcare Community Plan helps ensure reimbursement for all services provided. You should:

- Determine if the member is eligible on the date of service by using the Eligibility and Benefits application on Link, contacting UnitedHealthcare Community Plan’s Provider Services Department, or the MO HealthNet Medicaid Eligibility System
- Submit appropriate and requested documentation to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what was authorized by UnitedHealthcare Community Plan.
- Determine if the member has other insurance that should be billed first.

Even with a valid prior authorization number you will be reimbursed only for covered services as designated by your contract with UnitedHealthcare Community Plan.
In the event of a conflict between this manual and your contract, the contract shall govern unless the agreement dictates otherwise.

UnitedHealthcare Community Plan will not reimburse:

• Services not determined by UnitedHealthcare Community Plan to be medically necessary
• Non-covered services
• Services provided to members who are not enrolled on the date(s) of service

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

• Prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition
• Maintain health
• Prevent the onset of an illness, condition or disability
• Prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity
• Prevent the deterioration of a condition
• Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capabilities that are appropriate for individuals of the same age
• Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member

Evidence-Based Clinical Guidelines

UnitedHealthcare Community Plan has adopted evidence-based clinical guidelines to guide our quality and health management programs.

Utilization Management Guidelines

UnitedHealthcare Community Plan uses MCG Care Guidelines as our Utilization Management Guidelines.

Utilization Management (UM) is based on a member’s medical condition and is no way influenced by financial incentive of any kind. UnitedHealthcare Community Plan pays its contracted PCPs and specialists on a fee-for-service basis. We also pay contracted hospitals and all other types of providers in the UnitedHealthcare Community Plan network on a fee-for-service basis. The plan’s UM staff works with you to help ensure members receive the most appropriate care in the place best suited for the needed services. The staff is expected to encourage appropriate use and to discourage under use. The UM staff does not receive incentives for any UM decisions they make.

You may refer candidates for case management by contacting Care Management at 800-599-5985. Additionally, UnitedHealthcare Community Plan provides the Healthy First Steps program which proactively manages women with high-risk pregnancies.

Find medical policies and coverage determination guidelines at UHCCommunityPlan.com > For Health Care Professionals > Missouri > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

Utilization Management (UM) Appeals

These appeals contest UnitedHealthcare Community Plan’s utilization management decisions. They are appeals of UnitedHealthcare Community Plan’s determination that an admission, extension of stay, level of care, or other health
care services, based on review of the information available to UnitedHealthcare Community Plan, is not medically necessary or is considered experimental or investigational. They also can be appeals of denials of any admission, extension of stay or other healthcare service due to reasons such as late notification or lack of complete or accurate information. Any member, member’s designee, or care provider who is dissatisfied with any aspect of UnitedHealthcare Community Plan’s UM decisions has a right to file a UM appeal.

You can request an appeal within 90 days following the date on the original denial notification letter. Mail the request and a copy of the medical record to:

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

Resolution of a standard appeal is 45 calendar days. You may request an expedited appeal if a delay would seriously jeopardize the life, health, or ability to attain, maintain or regain maximum function. Resolution of an expedited appeal is two calendar days.

You may request an expedited appeal by calling 866-815-5334.

Request an expedited appeal when the appeal involves, but is not limited to:

- Continued or extended health care services, procedures, or treatments
- Additional services for a member undergoing a course of continued treatment
- A denial in which you believe an immediate appeal is warranted
- When the standard time frame could seriously jeopardize the life, health, or ability to attain, maintain or regain maximum function

You may make a request for a Missouri State Fair Hearing within 90 days of the initial denial by writing to the health plan at:

UnitedHealthcare Community Plan
13655 Riverport Drive,
Maryland Heights, MO 63043

A copy of the medical record should accompany the hearing request.

UnitedHealthcare Community Plan appeals do not have to be exhausted prior to requesting a State Fair Hearing. You may find a copy of the Clinical Criteria used in making utilization management decisions by contacting the UnitedHealthcare Community Plan Utilization Management.

**Concurrent Review Guidelines**

Review is conducted by phone, via email or fax for each day of the stay using MCG Care Guidelines criteria. You must cooperate with all requests for information, documents or discussions from the health plan for purposes of concurrent review including, but not limited to, clinical information on patients status and discharge planning. When criteria are not met, the case is referred to a medical director for determination. The health plan denies payment for hospital days without a documented need for acute care services. The health plan requires you to chart progress notes each day of the stay. Failure to document results in payment denial to the hospital and you.

**Emergency/Urgent Care**

For an emergency, the member should seek immediate care at the closest Emergency Room (ER). If the member needs assistance to the ER, they may call 911. No referral is needed to use the ER. Members have been instructed to contact their PCP as soon as they can after receiving emergency care. There is no cost for ER services or emergency ambulance services.

After the member has received emergency care, the hospital must request approval within one hour for pre-approval for additional care to make sure the member remains in stable condition. If the health plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the enrollee’s care, the health plan must give you, the treating care provider, the opportunity to talk with the health plan’s Medical Director. You may continue with care until the health plan’s medical care provider is reached or one of the approved guidelines are met:

1. A plan care provider with privileges at the treating hospital assumes responsibility for the enrollee’s care.

2. A plan care provider assumes responsibility for the enrollee’s care through transfer to another place of service.
3. An MCO representative and the treating care provider reach an agreement concerning the enrollee’s care.

4. The enrollee is discharged.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services. Members are not financially responsible for these services.

Should a member require emergency services outside the service area, the same above rules apply.

**Lock-In Program**

The lock-in program is a method used to limit or restrict the use of the MO HealthNet Managed Care Program to designated provider(s) when it has been determined a member has misused medical services. Utilization patterns are analyzed to identify patterns of fraud, misuse, abuse and wasteful, inappropriate or unnecessary care. A member may also be referred to the lock-in program by their provider, a facility or other source. The lock-in program implemented by the health plan does not include a lock-in for pharmacy services, as this is the responsibility of the state agency. The health plan coordinates with the state to verify appropriate identification for the pharmacy lock-in program.

Members in the lock-in program continue to have free choice of care providers who participate in the MO HealthNet program. Members may request a change of designated care provider during the lock-in period. You have the right to accept or refuse recipients for treatment as a lock-in participant and both you and the member must be agreeable to the lock-in relationship. The primary-care provider is responsible for providing and/or directing, the member’s medical care and for making any necessary referrals to other care providers as medically indicated during the lock-in period.

Lock-in periods are for a minimum of 12 months and a maximum of 24 months. Case reviews are conducted by the health plan no sooner than 12 months and no longer than 24 months after start of the lock-in period. Case reviews assess member utilization patterns for continued misuse of medical services. If a pattern of member misuse continues, the lock-in period is renewed for an additional 12 to 24 months.

Members selected for lock-in or whose lock-in program was extended have all appeal and fair hearing rights accorded by state and federal regulations.

**Maternal/Child Homecare**

United Healthcare Community Plan of Missouri provides coverage for post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits, at least one in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours. Please obtain an authorization prior to discharge. The attending physician determines the location and schedule of the post-discharge visits.

**Neonatal Resource Services (NICU Case Management)**

Our Neonatal Resource Services program manages NICU cases inpatient and post-discharge to reduce costs and improve outcomes.

Our dedicated team of NICU nurse case managers, social workers and medical directors collaborate to provide both clinical care and psychological services.

**Neonatal Resource Services (NRS)**

Neonatal Resource Services (NRS) Program helps ensure quality of care and efficiency in treatment of NICU babies. The NRS Program Eligible Member is defined as a newborn who has been admitted to the NICU upon birth (including babies that get transferred from PICU to NICU) and/or any infants readmitted within the first 30 days of life. All babies admitted to the NICU will be followed by NRS. (Detained babies will also be eligible for the program for the initial inpatient hospitalization only).

NRS Neonatologists and NICU nurses proactively manage NICU patients through evidence-based medicine and the use of care plans.

The NRS nurse case manager will:

- Collaborate with the family, care provider, and Discharge Planner on a coordinated discharge to help ensure timely provision of care and delivery of services
- Develop alternate strategies for care management Interventions (as needed)
- Facilitate the discharge
• Coordinate services post-discharge as required if member is under NRS case management (the NRS Program also provides onsite nurses in many markets).

The NRS program includes a multidisciplinary approach to case management in the 30-day post discharge period. The NRS nurse case manager’s role is comprehensive and includes:

• Discharge planning and facilitation of timely release
• Coordination of alternative care options, including home care, equipment and skilled nursing
• Post-discharge Support for 30 days, except detained babies
• Educating parents and families on local community resources and support services available
• Case managers provide benefit solutions to families in order to help ensure appropriate services for the neonate

The member is allowed to participate with the PCP in selecting the care provider.

If a network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider.

Once the second opinion has been given, the member and his/her PCP discuss information gathered from both evaluations. If follow up care is recommended, the member consults with the PCP prior to receiving treatment for appropriate referrals and/or approvals.

A third surgical opinion, provided by a third care provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

Delegated Medical Management

Delegation Oversight
We may assign medical management to a medical group/Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a “delegate”. Care providers associated with these delegates may use the delegate’s office and protocols for authorizations. The delegate’s medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established timeframes may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals
When we review a member or care provider’s adverse determination appeal from a delegate, we use MCG (formerly Milliman Care Guidelines) as the externally licensed medical
management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

**Semi-Annual Reporting**
The delegate provides UnitedHealthcare Community Plan with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

**Purpose of Medical Management Program**
The Medical Management Program helps determine if medical services are:

- Medically necessary.
- Covered under the UnitedHealthcare Community Plan benefit.
- Performed at both the appropriate place and level of care.

**Determining Medical Necessity**
Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, delegates use UnitedHealthcare Community Plan’s medical policies. If other nationally recognized criteria disagree with Medicaid coverage guidelines, delegates follow Medicaid coverage guidelines.

Members may call the delegate’s general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make utilization management (UM) decisions. The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage.
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

**Medical Management Denials/Adverse Determinations**
UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

**Denials, Delays or Modifications**
UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials. We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member’s medical condition, in accordance with the applicable state and federal law.

We base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified...
addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board-certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate. Determination rules include:

- You may not review your own referrals.
- Care providers qualified to make an appropriate determination will review referral requests considered for denial.
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individual(s) who can hold financial ownership interest in the organization may not influence the clinical or payment decisions.

Possible request for authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Referral approved, but changed the requested care provider or treatment plan. (e.g., requested chiropractic, approved physical therapy).
- Extension – Delay of decision (e.g., need additional information, require consultation). CMS allows an extension when a Medicaid member requests one.
- Delay in Delivery – Postpone access to an approved service until a certain date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization request for health care services.

Reasons for denials of requests for services include:

- Not a covered benefit – The requested service(s) is excluded under the member’s benefit plan.
- Not medically necessary or benefit coverage limitation – Specify criteria or guidelines used to make the determination.
- Member not eligible at the time of service.
- Benefit exhausted - Include what benefit was exhausted and when.
- Not a participating care provider – A participating care provider/service is available within the medical group/IPA in-network.
- Experimental or investigational procedure/treatment.
- Self-referred/no prior authorization (for non-emergent post-service).
- PCP can provide requested services.

Written Denial Notice

The written denial is an important part of the member’s chart and the delegate’s records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services.
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion.
- Member-specific information about how the member did not meet criteria.
- Appeal rights.
- An alternative treatment plan, if applicable.
- Benefit exhaustion or planned discharge date.

CMS requires the use of the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/NDMC) for Medicaid plan members. Do not alter this template except to add text to the requested areas.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan will provide appropriate and approved templates to the delegates.

Minimum Content of Written or Electronic Notification

Written or electronic notices to deny, delay or modify a health care services authorization request must include the following:

- The requested service(s)
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification, or partial approval, including:
  - Clear, understandable explanation of the decision
  - Name and description of the criteria used
  - How those criteria were applied to the member’s condition
- Notification the member can get a free copy of the benefit provision, guideline, protocol or other criterion
used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary
- Appeal and grievance processes, including:
  - When, when, how and where to submit a standard or expedited appeal
  - The member’s right to appoint a representative to file the appeal
  - The right to submit written comments, documents or other additional relevant information
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
- The name and phone number of the health care professional responsible for the decision.

**Medical Group/IPA’s Responsibilities Related to Member Grievance and Appeals**

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:
- Within one hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing.
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated timeframe. (Standard appeals with 24 hours, expedited appeals within two hours. Timeframes apply to every calendar day.)
- Comply with all final UnitedHealthcare Community Plan determinations.
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or State Fair Hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.
- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested timeframes on adverse determinations reversals.
- Respond to requests for proof of overturned appeals.

**Referrals**

**Referral authorization procedure**

The delegate may initiate a member referral. (Refer to the delegated group’s pre-authorization list, as applicable). The following capitated medical services are examples of when a referral authorization may be needed:
- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA’s facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:
- Review the service request for medical necessity.
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member.
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination.

If the request is not approved, the delegate must issue the member a denial letter.

**Referral Authorization Form**

The delegate may design its own authorization form, without approval from UnitedHealthcare Community Plan. The form should include all the following:
- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/IPA address)
- Verification of member eligibility

The delegate provides this form to the following:
- Referral care provider
- Member
- Member’s medical record
- Managed care administrative office
Chapter 5: Medical Management

The delegate does so within 36 hours of receipt of information necessary to make a decision. This includes one working day and does not exceed 14 calendar days.

If UnitedHealthcare Community Plan is financially responsible for the services, the delegate submits the authorization information to the plan.

**Continuity of Care**

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It is intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out-of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of (1) 60 calendar days or (2) until the member has transferred without disruption of care to an in-network care provider.
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member’s enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation.

Members in their third trimester of pregnancy may receive services from their prenatal care provider (whether in-network or out-of-network) without any form of prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a non-participating care provider without formal approval by UnitedHealthcare Community Plan or the delegate. Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member’s responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member’s condition and the potential effect on the member’s treatment. We also consider how changing the care provider can affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services who are not capitated and are practicing in the same geographic area.

**Notification Requirements for Facility Admissions when UnitedHealthcare pays claims**

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient and observation status cases. This information is needed to verify eligibility, authorize care, and initiate concurrent review and discharge planning.

In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

**Authorization Log and Denial Log Submission**

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted at least twice a week to the Authorization Log Unit at [clinicaloperations@uhc.com](mailto:clinicaloperations@uhc.com). When no inpatient acute, observation statuses or skilled nursing facility cases are active, the delegate must submit its weekly authorization log indicating either “no activity” or “no admissions” for each designated admission service type specified in this section and for the applicable reporting time.
Authorization logs covering facility and skilled nursing facility daily information includes the following:

- Member ID
- Member name
- Member date of birth
- Attending care provider: (Name and address, with TIN if available)
- Facility care provider: (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your Provider Advocate.
Chapter 6: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth younger than the age of 21 in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT).

You are expected to adhere to the EPSDT periodicity schedule adopted by MO HealthNet for all enrollees (including women who are pregnant) younger than age 21. EPSDT screening includes immunizations; hearing, vision, and speech screening, nutritional assessment; dental screening; growth and development tracking.

For complete details about diagnoses codes, full and partial screening, examinations, and immunization requirements, go to [dss.mo.gov > mhd > providers > education].

To find the Healthy Child Forms, go to [dss.mo.gov > mhd > providers].

Find detailed instructions on how to fill out the Healthy Child form at [manuals.momed.com > forms > HCY Screening Guide > Instructions]

Full Screening

You must perform a full screen as an enrolled MO HealthNet care provider, nurse practitioner or nurse midwife (only infants age 0-2 months and females age 15-20 years) and must include all of the following components.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment (Provider must use the HCY Lead Risk Assessment form)
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

If all of the components are not included, you cannot bill for a full screen and should bill only for a partial screen.

Interperiodic Screens

Interperiodic Screens are medically necessary screens outside the periodicity schedule that do not require the full screen components. This screen may be used to initiate expanded HCY services. Office visits and full or partial screenings that occur on the same day by the same care provider are not covered unless the medical necessity is clearly documented in the participant’s record.

Interperiodic Screens commonly are used for school and athletic physicals. A physical examination may be necessary in order to obtain a physician’s certificate stating a child is physically able to participate in athletic contests at school. When this is necessary, use diagnosis code V20.2 as the primary diagnosis. This also applies for other school physicals when required as conditions for continuation of educational purposes.

Safe/Care Examinations

MO HealthNet covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE trained care providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through MO HealthNet on a fee-for-service basis.

Information on SAFE-CARE examinations are located in Section 13.15 of the MO HealthNet care provider manual at [dss.mo.gov > mhd > providers].

Call MO HealthNet for more information.

Lead Screening/Treatment

Refer children with an excess of 10ug/dL lead blood level to UnitedHealthcare Community Plan by calling Provider Services. All children with elevated blood lead levels of 10ug/dL or greater will be offered enrollment in a care coordination program.
Chapter 6: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

Vaccines for Children program (VFC)

Vaccines for Children program provides childhood immunizations. Bill claims for administered vaccines with the correct vaccine-specific CPT codes.

Vaccine administration fees are reimbursable when submitted with an appropriate modifier. UnitedHealthcare Community Plan is unable to reimburse for private stock vaccines when they are available through VFC.

Contact VFC with questions.
Phone 800-219-3224
Fax: 573-526-5220

Care Provider Coding

UnitedHealthcare Community Plan is required to report compliance with EPSDT standards to the state and will do so based upon claims data and chart review. Appropriate ICD CM Code and CPT coding are crucial to this effort. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare Community Plan claim platforms.

Procedure and ICD CM Codes

- **Newborn:** 99431-99433 ICD9 = V20.2 OR ICD10 = Z00.129 or Z00.121: Routine infant or child health check, development testing of infant or child. ICD9 = V30 through V39 OR ICD10 = Z38.00 through Z38.2.

- **Child:** 99381-99384, ICD9 = V20.2 OR ICD10 = Z00.129 or Z00.121: Routine infant or 99391-99394 child health check, development testing of infant or child.

- **Adult:** 99385 and ICD9 = V70.0 OR ICD10 = Z00.00 or Z00.01: Routine general 99395 medical exam at health care facility; health checkup OR

Whenever you use one of the above-listed codes, UnitedHealthcare Community Plan will assume you performed an EPSDT exam for a given age category.

- **ICD9 = V70.9 OR ICD10 = Z00.8:** Unspecified general medical exam

If the enrollee also has a medical diagnosis addressed at the visit, use the appropriate ICD CM code, in addition to one of the above-noted “V” or “Z” codes.
Chapter 7: Value Added Services

Value added services are pending approval from the state. Services may or may not be covered.

The following are services offered to our Missouri UnitedHealthcare Community Plan members.

If you have questions about any of these services, please call Provider Services at 866-815-5334.

Airwaze

Airwaze is an app for smartphones that provides tailored asthma education, customizable medication reminders and other self-management tools. This tool is offered under care management for members aged 5-18 who are diagnosed with and need help maintaining control of their asthma.

Adult Pain Management/Chiropractic Services

Evidence-based medicine supports the use of chiropractic care to improve lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. Offering this benefit is one of many approaches to help combat opioid addiction and overuse. We will provide members older than 21 with up to six visits per calendar year to an in-network chiropractor. This additional health benefit does not require a prior authorization.

To access the fee schedules online, use the following steps:
1. Go to www.myoptumhealthphysicalhealth.com
2. Enter your Provider ID & Password
3. Click “Tools & Resources”
4. Click “Plan Summaries” or “Fee Schedules”

The two covered CPT codes are 98940 and 98941.

Chiropractic care providers are contracted through Optum Physical Health - myoptumhealthphysicalhealth.com or 800-873-4575.

Call Provider Services for claim related questions.

Call Provider Services for information.

Baby Blocks™ Program

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

Baby Blocks™ Benefit

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

How it Works
1. UnitedHealthcare Community Plan members are invited by care provider, mail, and phone call to enroll in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointment at UHCBabyBlocks.com.
3. Members are reminded of upcoming appointments and are prompted to record completed visits at UHCBabyBlocks.com.
4. At milestones throughout the program, members choose a reward for themselves or their baby.

How You Can Help
1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and discuss the benefits of the program.
3. Encourage the member to enroll at UHCBabyBlocks.com.

Members must self-enroll on a smartphone or computer by going to UHCBabyBlocks.com and clicking on “Sign Up Here”. 
Chapter 7: Value Added Services

Dental Services

Covered
A Dental Provider Manual is available for detailed coverage information.

In general the following types of services are covered:

- Diagnostic Periodontics
- Preventive Prosthodontics (limited)
- Restorative Oral and Maxillofacial Surgery
- Endodontics

This includes the following:

- Treatment of trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury.
- Services when the absence of dental treatment would adversely affect a pre-existing medical condition.
- Diagnostic, preventive and restorative procedures, prosthodontic services, and medically necessary oral and maxillofacial surgeries
- Dentures
  - Coverable for children younger than 21 or for persons under a category of assistance for pregnant women
- Topical fluoride treatment
  - Fluoride treatment for participants age 21 and older is limited to participants and conditions

Non-Covered
Please refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines are applied to all claims.

For detailed dental information, go to: uhcproviders.com

Early Intervention Program

Early Intervention promotes the development of infants and toddlers with developmental challenges, delays and certain disabling conditions. The program provides service to eligible children from birth to three years of age, and their families.

Foster Care

On My Way
On My Way teaches youth aging out of foster care how to navigate the complex social support systems, including health care. Members will have access to On My Way and through use of our care management system.

On My Way is a new initiative designed by the UnitedHealthcare Innovation Center of Excellence to help young adults transition to adulthood and independence. Youth in foster care often do not have access to the same kind of support and guidance of other teens. Youth are struggling for independence while trying to make smart life decisions. This requires support and guidance, even for young adults who have grown up in a stable and supportive environment. Our new, interactive mobile and web-enabled game, which we will make available to our Missouri foster care transition age youth members, takes the overwhelming transition process and breaks it down into bite-size, manageable steps and connects foster youth with the support/guidance they need and want (e.g., they can easily connect with peer support staff).

Peer Support Specialist
We will have a foster-care peer support specialist working with youth in the foster care system and their families. Working with the member and the family to define the member’s recovery goals and to develop the skills and knowledge needed, the foster-care peer support specialist provides phone and/or face-to-face communication statewide to UnitedHealthcare Community Plan members. The participating member and his/her foster family receive assistance in navigating the complexities of multiple support systems and work together to achieve improvement in the member’s overall physical and behavioral health. This additional health benefit also can help to reduce hospitalizations and emergency room visits related to behavioral health conditions in children and youth in foster care services.

For detailed dental information, go to: uhcproviders.com

Call Provider Services for more information.

Healthy First Steps

Healthy First Steps™ (HFS) is a program aimed at improving birth outcomes focused on managing pre-natal and post-partum care of pregnant members.
HFS-Maternal Care Model
The objective of the HFS-Maternal care model is to create a structure that consistently:

- Increases early identification and enrollment of expectant mothers
- Assesses the risk level of each member and directs them to proper care
- Increases the member’s understanding of pregnancy and newborn care
- Encourages pregnancy and lifestyle self-management
- Encourages appropriate pregnancy, postpartum and infant care provider visits
- Fosters a care provider-member partnership for care in non-emergent settings
- Encourages tobacco session in partnership with our Quit for Life Tobacco cession Program
- Increase the mother’s self-efficacy by identifying and building the mother’s support system;
- Helps ensure appropriate postpartum and newborn care;
- Develop the care provider/member partnership and relationship before and after delivery.

Healthy First Steps (Maternity Case Management)
Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, the Healthy First Steps program uses early identification to

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Notify UnitedHealthcare Community Plan promptly of a member’s confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps coordinator at 800-599-5985.
- Submit an American College of Gynecology or any initial prenatal visit form to Healthy First Steps at fax 877-353-6913.

Access to Care Providers in Key Specialties
Medical support for the Healthy First Steps Model will be provided by Board Certified in Maternal and Neonatal Medicine care providers. These care providers will be providing clinical supervision and education to our staff, as well as conducting peer-to-peer discussions with other care providers. The HFS program will be responsible for helping ensure members receive the services and education they need at the right time, in the right place and according to specific member needs.

Call the Provider OB Referral line.

Healthify
This is a web-based tool to deliver social service referrals (food, housing, employment, energy, support groups, child care, and clothing) to members at risk for poor outcomes or inappropriate healthcare use. For more information, go to: healthify.us.

Hypoallergenic Bedding
Improve asthma control and fewer asthmatic exacerbations related to allergies, or irritation from dust or synthetic bedding. This enhanced benefit can help to reduce hospitalizations and emergency room visits related to allergic reactions to standard bedding.

Hypoallergenic Bedding Limited to individuals with asthma, in case management, limited to $150 annually per member. Service is a one-time, annual benefit that requires prior authorization and documentation or a referral from you indicating diagnosis of severe asthma.

Service is limited to members in asthma case management. The member’s service coordinator will determine and authorize eligibility.

Join For Me
JOIN for ME is a childhood obesity program developed to address childhood obesity. The JOIN for ME program focuses on the importance of cultivating a healthier environment and healthier behaviors at home with the entire family, and it has proven to be an effective and accessible treatment of childhood obesity. We will offer this enhanced benefit in the St. Louis area through a group intervention model, where a child and caregiver participate together.

Through participation in the program, the member and his/her family will learn healthy eating and exercise habits, and how to reduce obesity. Program for ages 6–17 years old. Call Provider Services for more information.
KidsHealth

The online KidsHealth website improves education and increases health literacy, which leads to health promotion.

This website includes health and wellness resources to encourage healthy behaviors among children, young adults and their parents. A vast amount of content is provided, including assistance for high-risk members with managing conditions, such as diabetes, asthma and stress. Videos, written and spoken articles are provided through a link on the member website, kidshealth.org or, or may be accessed through a computer, tablet or smartphone.

For members 20 years and younger.

Mindfulness: Be Here Now

We will deliver this programming to social worker and community partners in Southeast/Boothill area of Missouri, totaling 160 community partners. The focus is caregiver well-being, and provide community partners with mindfulness techniques that have been shown to result in reduced burnout, greater performance and improved quality of care. At the end of the programming year, we will review program measurements. There will be four sessions in 2017 for up to 40 participants (total 160 community partners and social workers) to deploy mindfulness practices and reduce direct care worker/caregiver burnout.

My Healthline (Cell Phone Program)

MyHealthLine, our free cellphone program, enables us to more closely connect with our members, particularly those who are high-risk, to support their overall health, wellness and access to care. Members can quickly and easily reach us to discuss health-related questions or concerns or to locate a PCP. Our care managers can make outbound calls to coordinate care and follow up on important activities to improve a member’s health. MyHealthLine uses free cellphones provided by SafeLink, part of the Federal Lifeline program. Our members who meet federal eligibility requirements receive 350 voice minutes per month and unlimited texting, plus a pre-programmed member services number that does not count against the minutes. They are also automatically enrolled in the Connect4health texting program.

My Money

My Money Connect is a member incentive program designed to promote health, well-being and financial independence for MO HealthNet members. The program provides a reloadable prepaid debit MasterCard® to members with an integrated wellness rewards program, enabling them to earn incentives for taking steps to improve their health. By helping to motivate positive health behaviors and closing gaps in care, this program improves health outcomes. All members are eligible.

Non-Emergency Transportation (NEMT)

We recognize some members require NEMT to and from services beyond what the state agency covers and understand it provides a crucial support for members who are taking personal responsibility for improving their overall health. Our NEMT enhanced service helps improve our members’ access to care, and all members who are eligible for state-approved transportation services are qualified for this additional health benefit.

NEMT includes unlimited trips for eligible members to and from WIC, methadone clinics, inpatient behavioral health, and to the pharmacy immediately following a covered service appointment.

To request and schedule rides, members call UnitedHealthcare member services. If members need assistance in scheduling rides, the service coordinators, member services advocates (MSAs) and the mobility manager are all available to assist. Services may be scheduled up to 14 days in advance, and hotel stays will be paid for trips that require an overnight stay with prior approval for eligible members.

Non-emergency trips which are urgent, such as when a member is discharged from the hospital, may be made through the call center after 5 p.m. Central Time. Urgent calls are the ONLY calls taken in person by a Reservation Specialist after 5 p.m. Central Time. Schedule rides up to 30 days in advance.

For non-urgent appointments, members must call transportation at least three days in advance before their appointment.
Bus transportation will also be available as another transportation option if the member:

1. Lives less than half a mile from a bus stop.
2. Their appointment is less than half a mile from the bus stop.

**NurseLine**

NurseLine is available at no cost to our members, 24 hours a day, seven days per week. Members may call NurseLine to determine if they need to go to the urgent care center, the emergency room, or to schedule an appointment with their primary care provider. Our nurses also help members with education and information about staying healthy.

866-351-6827

**Quit for Life®**

The Quit For Life® Program is the nation’s leading phone-based tobacco cessation program. It employs an evidence-based combination of physical, psychological and behavioral strategies to enable participants to take responsibility for, and to overcome their addiction to, tobacco use. Using an integrated mix of medication support, phone-based cognitive behavioral coaching and web-based learning and support tools, the Quit For Life Program produces an average quit rate of 25.6 percent for a Medicaid population and an 88 percent member satisfaction.

For members 18 and older.

Call **Provider Services** for more information.

**SUD Recovery Coaching**

Our SUD (Substance Use Disorder) recovery coach support system will work with members to develop present-focused coping skills for encouragement and safety, and a sense of responsibility for their own recovery. This benefit also emphasizes support to those individuals who have a behavioral health diagnosis and need the additional support while working through SUD treatment and recovery. There is no limitation on age.

Members who may qualify for this benefit are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral.

Call **Provider Services** for more information.
Chapter 8: Mental Health and Substance Use

United Behavioral Health operating under the brand Optum is the administrator of mental health and substance use disorder benefits for UnitedHealthcare Community Plan members. The national Optum Network Manual generally applies to all types of business. There are some sections where differences may apply based on state law. This chapter does not replace the national Optum Network Manual; rather, it supplements the national manual by focusing on the core services and procedures specific to the Missouri HealthNet membership. As a care provider, you must have a National Provider Identification (NPI) number and a Missouri Medicaid provider identification number to render services for a Missouri HealthNet member and receive payment from the health plan. To request an ID number, go to the Missouri Department of Social Services website, mmac.mo.gov, to the section titled, Apply to be a Missouri Medicaid Provider.

Covered Services

Behavioral Health covered services are for the treatment of mental, emotional and substance use disorders. UnitedHealthcare Community Plan service coordinators have an integrated Care Management program with medical and behavioral health providers of the health plan that include Behavioral Health to assist members and Primary Care Providers (PCPs) in using and receiving services. Our Behavioral Health program utilizes Optum clinician centers with patient resources accessible from the provider website, providerexpress.com, see Live and Work Well (LAWW) clinician center. Health Condition Centers can be located at the Clinical Resources tab at providerexpress.com. These centers provide information and instruments for several mental health and substance abuse diagnoses, symptoms, treatment options, prevention and other resources in one, easy-to-access area to both behavioral clinicians and PCPs to share with patients. They are available to both behavioral clinicians and medical care providers to share with patients. The Provider Express Recovery and Resiliency page also includes tools to use when working with individuals who are addressing mental health and substance use issues.

The benefits available for MO HealthNet members who seek services for mental health or substance use disorders are the following:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility
- Outpatient assessment and treatment:
  - Partial hospitalization.
  - Social detoxification.
  - Day Treatment
  - Intensive Outpatient
  - Medication management.
  - Outpatient therapy (individual, family, or group)—Injectable psychotrophic medications.
- Substance use disorder treatment.
- Psychological evaluation and testing.
- Initial diagnostic interviews.
- Hospital observation room services (up to 23 hours and 59 minutes in duration).
- Child-parent psychotherapy.
- Multi-systemic therapy.
- Functional family therapy.
- Electroconvulsive therapy.
- Telemental Health
- Rehabilitation services
  - Day treatment/intensive outpatient.
  - Dual-disorder residential.
  - Intermediate residential (SUD).
  - Short-term residential.
  - Community support.
  - Psychiatric residential rehabilitation.
  - Secure residential rehabilitation.
  - Community support.
  - Day rehabilitation.
Chapter 8: Mental Health and Substance Use

Eligibility

It is your responsibility to verify the member’s Medicaid eligibility on day of service prior to rendering service to a Missouri HealthNet member.

View eligibility online on the Eligibility and Benefits application on Link.

Authorizations

Members shall be able to access all behavioral health outpatient services (mental health and substance use) without a referral.

Prior authorization may be required for services more intensive than standard outpatient, such as Intensive Outpatient Program, Day Treatment, Partial, Inpatient or Residential. You must ensure the prior authorizations are in place before rendering non-emergent services.

Prior authorization requests can be obtained by calling: 866-815-5334. Fax: 844-881-4772

Portal Access

Website: UnitedHealthcareOnline.com
This site will give you access to Link, the new gateway to UnitedHealthcare’s online tools. Use the tools to do eligibility and benefit verification, electronic claim submission, view claim status, and submit notifications/prior authorizations.

Website: UHCCommunityPlan.com

Use this site to view the Prior Authorization list, access forms, and access to the Provider Manual.

Customer Service Center phone number: 866-815-5334 to verify eligibility and benefit information (available 8 a.m. to 5 p.m. Central time, Monday through Friday).

Website: providerexpress.com

Use this site to update provider practice information, review guidelines and policies, and to view the national Optum Network Manual.

Provider Service phone number: 866-815-5334

Appeals and Grievances

Call 866-815-5334 and a Customer Service representative will assist with the Appeals and Grievances process. The care provider may file an appeal or grievance within 90 calendar days of the notice of action.

Written requests can be sent to:

United Behavioral Health
Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 855-312-1470

Claims

You should submit claims using the current 1500 Claim Form (v 02/12) or UB-04 form, (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to, ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Effective October 1, 2015, in compliance with federal regulations.

Include all data elements necessary to process a complete claim including: the member number, Customary Charges for the MHSA Services rendered to a member during a single instance of service, Provider’s Federal Tax I.D. number, National Provider Identifier (NPI), code modifiers and/or other identifiers requested.

In addition, you are responsible for billing of all services in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the CMS website for additional information on CCI billing standards.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with usual and customary charges indicated on the claim.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor. You may choose any clearinghouse vendor to submit claims through this route. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For all UnitedHealthcare Community Plan claims, use Payer ID 86050.
Clinician Claim Forms: submit paper claims using the CMS 1500 Claim Form (v 02/12) or the UB-04 claim form or their successor forms in accordance with your Agreement. The claims should include all itemized information such as diagnosis (ICD-10-CM code as listed in DSM-5), length of session, member and subscriber names, member and subscriber dates of birth, member identification number, dates of service, type and duration of service, name of the rendering clinician (i.e., individual who actually provided the service), credentials, Tax ID and NPI numbers.

Facility Claim Forms: submit paper claims using the UB-04 billing format, or its successor, which includes all itemized information such as diagnosis (ICD-10-CM code as listed in DSM-5), member name, member date of birth, member identification number, dates of service, procedure or revenue codes, name of facility and Federal Tax ID number of the facility, NPI of the facility and admitting care provider, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility’s agreement. Facilities may file claims through an EDI vendor.

Paper claims can be submitted to the following address:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

For Claims/Customer Service, toll-free line: 866-815-5334

Monitoring Audits

We will conduct routine on-site monitoring audits of MO HealthNet providers. These audits will focus on the physical environment, policies and procedures, and quality of documentation in the treatment records.

The national Optum Network Manual outlines the scoring parameters as well as additional reasons other on-site audits may occur.
Chapter 9: Member Rights and Responsibilities

UnitedHealthcare Community Plan’s Member Handbook contains a section regarding the member rights and responsibilities when accessing services. UnitedHealthcare Community Plan members are asked to treat you with respect and courtesy.

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.

Access to Protected Health Information

Community Plan members have the right to access health information maintained in a designated record set held at your office or through UnitedHealthcare Community Plan. Members may make a request to see and obtain a copy of certain health information UnitedHealthcare Community Plan maintains electronically, such as medical records and billing records. They may request from you to obtain copies of their health information maintained electronically. If members’ health information is maintained electronically, members can request UnitedHealthcare or you send a copy of their electronic health information in an electronic format. They may also request a copy of their health information be provided to a third party.

Amendment of PHI

UnitedHealthcare Community Plan members have the right to request information held by you or UnitedHealthcare Community Plan be amended if they believe the information inaccurate or incomplete. Any request for amendment of PHI must be in writing and provide reasons for the requested amendment. The request must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member. If the request is denied, members may have a statement of disagreement added to members’ health information.

Accounting of Disclosures

UnitedHealthcare Community Plan members have the right to request an Accounting of certain Disclosures of their PHI made by you or UnitedHealthcare Community Plan during six years prior to the request. This accounting must include disclosures by business associates. The accounting will not include disclosures of information made: (i) for treatment, payment and health care operations purposes; (ii) to members or pursuant to member’s authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require UnitedHealthcare Community Plan to provide an accounting.

Right to Request Restrictions

Members have the right to request restrictions to UnitedHealthcare Community Plan’s or your use and disclosures of the individual’s PHI for treatment payment and healthcare operations. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented. You and UnitedHealthcare Community Plan must agree to individual’s request to restrict disclosure. Members have the right to request restriction on uses or disclosures of their information for treatment, payment, or health care operations. In addition, members may request to restrict disclosures to family members or to others who are involved in their healthcare or payment for their healthcare.

Right to Request Confidential Communications

Members have the right to request communications from you or UnitedHealthcare Community Plan received at an alternative location or by alternative means. You will accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A health plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

Member Rights and Responsibilities

You may find the following information regarding Native American Access and Member Rights and Responsibilities in the Member Handbook at the web link under the Member Information tab at uhcommunityplan.com.
Chapter 9: Member Rights and Responsibilities

Native American Access to Care
Native American members can access care to tribal clinics and Indian Hospitals without approval.

Member Rights
The following information is intended for UnitedHealthcare Community and State members. Members should:

• Request information on Advance Directives
• Have respect, dignity and privacy
• Have courtesy and prompt treatment
• Receive culturally competent assistance including having an interpreter during appointments and procedures
• Receive information about UnitedHealthcare Community Plan, rights and responsibilities, their benefit plan and which services are not covered
• Know the qualifications of their health care provider
• Give their consent for treatment unless unable to do so because life or health is in immediate danger
• Discuss any and all treatment options with you without interference from us
• Refuse treatment through an Advance Directive or withhold their consent for treatment
• Be free from any form of restraint or seclusion used as discipline, retaliation, convenience or force them to do something they don’t want to do
• Receive preventive care covered by their benefit plan
• Receive information about network care providers and practitioners, and choose a care provider from our network
• Change care provider at any time for any reason
• Tell us if they are not satisfied with their treatment or with UnitedHealthcare Community Plan; when they tell us, they can expect a timely response from us
• Appeal any payment or benefit decision we make
• Review medical records maintained by their care provider and request changes and/or additions to any area they feel is needed
• Be given information about their illness or condition, understand treatment options, regardless of cost or whether such services are covered by UnitedHealthcare Community Plan and participate with you in making decisions about your health care
• Get a second opinion with a network care provider
• Expect health care professionals are not prohibited or otherwise restricted from advising them about health status, medical care or treatment regardless of benefit coverage
• Make suggestions about UnitedHealthcare Community Plan’s member rights and responsibilities policies
• Have the right to additional information upon request, such as, information on how the health plan works and a care provider’s incentive plan, if they apply

Member Responsibilities
The following information is intended for UnitedHealthcare Community and State members. Members should:

• Understand the benefit plan and follow it to obtain the most benefits
• Show ID card to you, prevent others from using their ID card
• Give you true and complete information; ask questions about treatment so they understand
• Work with you to set treatment goals and follow the treatment plan they and their doctor agree upon
• Get to know you before they are sick
• Keep appointments or tell you when you cannot keep the appointment
• Treat UnitedHealthcare Community Plan staff, you and your staff with respect and courtesy
• Tell us their opinions, concerns and complaints
• Get any approvals needed before receiving treatment
• Use the emergency room only when there is a serious threat to life or health
• Notify us of any change in address or family status
• Make sure you are in network
• Follow your advice and understand possible results if they do not follow your advice
• Give you and us information that could help improve your health
We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

- A responsibility to supply information (to the extent possible) the organization and you need in order to provide care.
- A responsibility to follow plans and instructions for care they have agreed to with you.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
# Chapter 10: Medical Records

## Medical Record Charting Standards

All participating primary care UnitedHealthcare Community and State care providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. You are subject to UnitedHealthcare Community and State’s periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

<table>
<thead>
<tr>
<th>Confidentiality of Record</th>
<th>Office policies and procedures exist for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Confidentiality of the patient medical record</td>
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<tr>
<td></td>
<td>• Initial and periodic training of office staff concerning medical record confidentiality</td>
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<tr>
<td></td>
<td>• Release of information</td>
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<tr>
<td></td>
<td>• Record retention</td>
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<tr>
<td></td>
<td>• Availability of medical record when housed in a different office location (as applicable)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Record Organization</th>
<th>• An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:</td>
</tr>
<tr>
<td></td>
<td>– Identifiable order to the chart assembly</td>
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<tr>
<td></td>
<td>– Papers are fastened in the chart</td>
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<tr>
<td></td>
<td>– Each patient has a separate medical record</td>
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<tr>
<td></td>
<td>• Medical records are:</td>
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<tr>
<td></td>
<td>– Filed in a manner for easy retrieval</td>
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<td></td>
<td>– Readily available to the treating practitioner where the member generally receives care</td>
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<tr>
<td></td>
<td>– Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations.</td>
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<td></td>
<td>• Medical records are:</td>
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<tr>
<td></td>
<td>• Stored in a manner that helps ensure protection of confidentiality</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedural Elements</th>
<th>Medical records are legible*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• All entries are signed and dated</td>
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<tr>
<td></td>
<td>• Patient name/identification number is located on each page of the record</td>
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<tr>
<td></td>
<td>• Linguistic or cultural needs are documented as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient’s first language is something other than English</td>
</tr>
<tr>
<td></td>
<td>• Mechanism for monitoring and handling missed appointments is evident</td>
</tr>
<tr>
<td></td>
<td>• An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives.</td>
</tr>
<tr>
<td></td>
<td>• A problem list includes a list of all significant illnesses and active medical conditions</td>
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<tr>
<td></td>
<td>• A medication list includes prescribed and over the counter medications and is reviewed annually*</td>
</tr>
</tbody>
</table>
### History

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

- **Medical and surgical history**
  - A family history that minimally includes pertinent medical history of parents and/or siblings
  - A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history beginning at age 11
  - Current and history of immunizations of children, adolescents and adults
  - Screenings of/for:
    - Recommended preventive health screenings/tests
    - Depression
  - High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit
  - Medicare patients for functional status assessment and pain
  - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

### Problem Evaluation and Management

Documentation for each visit includes:

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

Tracking and referral of age and gender appropriate preventive health services consistent with:

- Preventive Health Guidelines
- Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
- Clinical decisions and safety support tools are in place to help ensure evidence based care, such as flow sheet
- Treatment plans are consistent with evidence-based care and with findings/diagnosis
- Timeframe for follow-up visit as appropriate
- Appropriate use of referrals/consults, studies, tests
- X-rays, labs consultation reports are included in the medical record with evidence of practitioner review
- There is evidence of practitioner follow-up of abnormal results
- Unresolved issues from a previous visit are followed up on the subsequent visit
- There is evidence of coordination with behavioral health provider
- Education, including lifestyle counseling is documented
- Patient input and/or understanding of treatment plan and options is documented
- Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented

*Critical element
Screening and Documentation Tools
Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Provider Advisory Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

Medical Record Review
On an adhoc basis, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. You are expected to achieve a passing score of 85% or better. Medical Records should include:

- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two visits and documented, and ongoing physical assessments documented on each subsequent visit
- Problem list, includes the following documented data:
  - Biographical data, including family history
  - Past and present medical and surgical intervention
  - Significant illnesses and medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions are prominently noted. Also note if there are no known allergies or adverse reactions.
- Past medical history is easily identified and include serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record
- Document tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of Advance Directive, or other document as allowed by state law, or notate patient does not want one.

- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Patient education, counseling and/or coordination of care with other care providers or health care professionals
- Notation regarding the date of return visit or other needed follow-up care for each encounter
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review
- Consultation and abnormal studies including follow-up plans

Patient hospitalization records should include, as appropriate:

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

## Part 1 - PRACTITIONER OFFICE SITE CHECKLIST

### Confidentiality & Record Organization & Office Procedures

<table>
<thead>
<tr>
<th>Yes or No</th>
<th>Confidentiality &amp; Record Organization &amp; Office Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The office has a policy regarding member record confidentiality that addresses office staff training on confidentiality, release of information, record retention and availability of member records housed in a different office location (as applicable)</td>
</tr>
<tr>
<td>2.</td>
<td>Staff are trained in medical record confidentiality</td>
</tr>
<tr>
<td>3.</td>
<td>Confidentiality policy is available upon request</td>
</tr>
<tr>
<td>4.</td>
<td>The office uses a Release of Information (ROI) form that requires patient signature</td>
</tr>
<tr>
<td>5.</td>
<td>Member records are stored in an organized fashion for easy retrieval</td>
</tr>
<tr>
<td>6.</td>
<td>Records are stored in a secure location only accessible by authorized personnel</td>
</tr>
<tr>
<td>7.</td>
<td>Each patient has a separate medical record</td>
</tr>
<tr>
<td>8.</td>
<td>There is an identified order to the record assembly (EMR = Yes)</td>
</tr>
<tr>
<td>9.</td>
<td>Pages are fastened in the record (EMR = Yes)</td>
</tr>
<tr>
<td>10.</td>
<td>There is a policy for timely transfer of medical records to other locations or providers</td>
</tr>
<tr>
<td>11.</td>
<td>Member records are available to the treating practitioner where the member generally receives care</td>
</tr>
<tr>
<td>12.</td>
<td>Medical records are released to entities as designated consistent with federal regulations</td>
</tr>
<tr>
<td>13.</td>
<td>There is a mechanism to monitor and handle missed appointments</td>
</tr>
</tbody>
</table>
# Chapter 10: Medical Records

## Part 2 - MEMBER RECORD REVIEW

### Section 1 – Procedural Elements

<table>
<thead>
<tr>
<th>Yes or No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The medical record is legible</td>
<td></td>
</tr>
<tr>
<td>2. All entries are signed and dated</td>
<td></td>
</tr>
<tr>
<td>3. Patient name/identification number is located on each page of the record</td>
<td></td>
</tr>
<tr>
<td>4. Medical records contain patient demographic information</td>
<td></td>
</tr>
<tr>
<td>5. Medical records identifies primary language spoken and any cultural or religious preferences if applicable</td>
<td></td>
</tr>
<tr>
<td>6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the record</td>
<td></td>
</tr>
<tr>
<td>7. If answered no to #6 above; then adults 18 and older, emancipated minors, and minors with children were given information about advance directives</td>
<td></td>
</tr>
<tr>
<td>8. A problem list includes significant illnesses and active medical conditions</td>
<td></td>
</tr>
<tr>
<td>9. A medication list includes prescribed and over-the-counter medications and is reviewed annually</td>
<td></td>
</tr>
<tr>
<td>10. The presence or absence of allergies or adverse reactions is clearly displayed</td>
<td></td>
</tr>
</tbody>
</table>

### Section 2 – History

<table>
<thead>
<tr>
<th>Yes or No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical and surgical history is present</td>
<td></td>
</tr>
<tr>
<td>2. The family history includes pertinent history of parents and/or siblings</td>
<td></td>
</tr>
<tr>
<td>3. The social history minimally includes pertinent information such as occupation, living situation, etc.</td>
<td></td>
</tr>
</tbody>
</table>

### Section 3 – Preventive Services

<table>
<thead>
<tr>
<th>Yes or No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evidence of social screening; high risk behaviors such as drug, alcohol &amp; tobacco use, sexual activity, exercise and nutrition counseling (may answer N/A if &lt; 12 yrs old)</td>
<td></td>
</tr>
<tr>
<td>2. Evidence of current age appropriate immunizations</td>
<td></td>
</tr>
<tr>
<td>3. Annual comprehensive physical (or more often for newborns)</td>
<td></td>
</tr>
<tr>
<td>4. Documentation of mental &amp; physical development for children and/or cognitive functioning for adults</td>
<td></td>
</tr>
<tr>
<td>5. Evidence of depression/mental health screening (may answer N/A if &lt; 12 yrs old)</td>
<td></td>
</tr>
<tr>
<td>6. Evidence of tracking and referral of age and gender appropriate preventive health services</td>
<td></td>
</tr>
<tr>
<td>7. Use of flow sheets or tools to promote adherence to Clinical Practice Guidelines/Preventive Screenings</td>
<td></td>
</tr>
<tr>
<td>8. Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), if applicable</td>
<td></td>
</tr>
</tbody>
</table>
Section 4 – Problem Evaluation and Management
Documentation for each visit includes:

<table>
<thead>
<tr>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appropriate Vital Signs (TPR, BP)</td>
</tr>
<tr>
<td>2. Documented annually – Height, Weight and BMI Measurement</td>
</tr>
<tr>
<td>3. Chief Complaint</td>
</tr>
<tr>
<td>4. Physical Assessment</td>
</tr>
<tr>
<td>5. Diagnosis</td>
</tr>
<tr>
<td>6. Treatment Plan</td>
</tr>
</tbody>
</table>

Treatment Plans are Consistent with Evidence-Based Care and with Findings/Diagnosis

<table>
<thead>
<tr>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Appropriate use of referrals/consults, studies, tests (N/A if services not warranted)</td>
</tr>
<tr>
<td>8. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review (N/A if no testing conducted in past 12 mos)</td>
</tr>
<tr>
<td>9. Follow-up of all abnormal diagnostic tests, procedures, x-rays, consult or referrals</td>
</tr>
<tr>
<td>10. Timeframe for follow-up visit as appropriate</td>
</tr>
<tr>
<td>11. Unresolved issues from the first visit are followed-up on the subsequent visit</td>
</tr>
<tr>
<td>12. There is evidence of coordination of care with behavioral health (N/A if not under the care of a BH provider)</td>
</tr>
<tr>
<td>13. Education, including counseling is documented</td>
</tr>
<tr>
<td>14. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented</td>
</tr>
</tbody>
</table>

Scoring

Audit Score

UHC Clinical Practice Consultant:

Provider or Representative:

Review Date:

\[
\begin{array}{cccc}
\text{(Questions)} & \text{(# N/A)} & \text{= (Adjusted # of Questions)} & \text{(# Yes)} & \text{= (Score)} \\
\end{array}
\]

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

*Items are MUST PASS
Chapter 11: Quality Management (QM) Program

Provider Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets four times a year at a minimum and has oversight responsibility for issues affecting health services delivery. It is the decision-making body ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QMC is composed of UnitedHealthcare Community Plan management staff and reports its recommendations and actions to the UnitedHealthcare Community Plan Board of Directors. The QMC has three standing sub-committees:

- **Provider Advisory Committee (PAC)** reviews and recommends action on topics concerning credentialing and recredentialing of you and facilities, peer review activities, and performance. You give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management, and quality improvement. A Medical Director chairs the Provider Affairs Subcommittee.

- **Healthcare Quality and Utilization Management Committee (HQUMC)** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical care.

- **Service Quality Improvement Subcommittee (SQIS)** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and care provider intervention for quality improvement activities as needed.

Cooperation with Quality Improvement Activities

You must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax.

Quality Improvement Program

The Quality Improvement program at UnitedHealthcare is a comprehensive program under the leadership of the Chief Executive Officer and the Chief Medical Officer. A copy of our Quality Improvement program is available upon request. The Quality Improvement program consists of the following components:

- Quality improvement measures and studies
- Clinical practice guidelines
- Health promotion activities
- Service measures and monitoring
- Ongoing monitoring of key indicators (e.g., over and under use, continuity of care)
- Health plan performance information analysis and auditing (e.g., HEDIS®)
- Care CoordinationSM
- Educating members and care providers
- Risk management
- Compliance with all external regulatory agencies

Your participation is an integral component of UnitedHealthcare Community Plan’s Quality Improvement program. The quality management program is allowed to use your performance data to conduct quality activities.

As a participating care provider, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback via your Network Account Manager. We require your cooperation and compliance to:
• Participate in quality assessment and improvement activities.
• Provide feedback on our Care CoordinationSM guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
• Advise us of any concerns or issues related to patient safety.
• Protect the confidentiality of patient information.
• Share information and follow-up on other UnitedHealthcare Community Plan care providers and provide seamless, cohesive care to patients.
• Maintain medical records according to UnitedHealthcare Medical Records documentation Standards contained in this manual.
• Use Data Sharing information we provide to help improve service delivery to your patients.
• Allow the plan to use performance data.
• Offer MO HealthNet members the same number of office hours as you do to commercial members or do not restrict the number of office hours you offer MO HealthNet patients.

If you are interested in learning more about any of the Quality Management processes or initiatives, contact your Provider Advocate or Provider Services at 866-815-5334.

Care Provider Satisfaction

On an annual basis, UnitedHealthcare Community Plan conducts ongoing assessments of care provider satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of care provider satisfaction include:
• Annual Provider Satisfaction Surveys;
• Regular visits to care providers;
• Care provider town hall meetings.

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare Community Plan engages independent market research firms Center for the Study of Services (CSS) to field the survey and Market Strategies International to analyze and report findings. UnitedHealthcare Community Plan provides CSS eligible care provider lists for each Community Plan from which CSS draws random samples for fielding.

Survey results are reported to our Quality Management Committee. The results are compared by the health plan year over year and also in comparison to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and key improvement targets. Additionally, improvement plans are implemented as a result of the targets identified.

Credentialing Standards

UnitedHealthcare Community Plan will credential and re-credential you according to applicable Missouri statutes and regulations and the National Committee of Quality Assurance (NCQA). The following key elements are required to begin the credentialing process:
• A completed credentialing application including Attestation Statement;
• Current medical license;
• Current Drug Enforcement Administration (DEA) certificate;
• Current professional liability insurance

We will verify information from primary sources regarding licensure, education and training, board certification, Medicaid eligibility and malpractice claims.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan’s credentialing and recredentialing process is to determine your competence and suitability for initial and continued inclusion in UnitedHealthcare Community Plan’s care provider network. All individual contracted care providers are subject to the credentialing and recredentialing process before they can evaluate and treat UnitedHealthcare Community Plan members.

Types of Care Providers Subject to Credentialing and Recredentialing

UnitedHealthcare Community Plan credentials and recredits the following types of practitioners:
• MDs (Doctors of Medicine)
• DOs (Doctors of Osteopathy)
• DDSs (Doctors of Dental Surgery)
• DMDs (Doctors of Dental Medicine)
Facility Care Providers
Facility care providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:
Meet state and federal licensing and regulatory requirements and NPI number. Current unrestricted license to operate Confirm the care provider has been reviewed and approved by an accrediting body. Space between minimums and Site Malpractice coverage/liability insurance that meets contract minimums. Site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency. No Medicare/Medicaid sanctions.

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

Credentialing and Recredentialing activities are completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website.

First time applicants will need to call the UnitedHealthcare Community Plan for Health Care Professionals (United Voice Portal) at 877-842-3210 from 8 a.m. to 6 p.m. Eastern Time to initiate the credentialing process. To reach a representative, after entering your Tax Identification Number, select the following prompts: Credentialing > Medical > Join the Network.

You will be given a CAQH number or opportunity to update your CAQH number and instructions on how to complete the application online.

Peer Review

Credentialing Process
All applicants are reviewed by the Provider Advisory Committee (PAC) Decisions are final and binding and not subject to appeal if they relate to mandatory participation criteria at the time of initial credentialing. You are notified in writing of the credentialing determination and the credentialing process shall not take longer than 60 business days.

Recredentialing Process
UnitedHealthcare Community Plan recredits practitioners every three years to help assure time-limited documentation is updated, changes in health and legal status are identified, and you comply with UnitedHealthcare Community Plan’s guidelines, processes, and care provider performance standards. You are notified prior to your next credentialing cycle to complete your application on the CAQH website. Failure to respond to UnitedHealthcare Community Plan’s request for recredentialing information will result in administrative termination of privileges as a UnitedHealthcare Community Plan participating care provider. You will be afforded three opportunities to respond to UnitedHealthcare Community Plan’s request for recredentialing information before action is taken to terminate care participation privileges.

Advanced Directives
As part of re-credentialing, we may audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether you are following the policies and procedures related to advance directives, which include:

- Respect the advance directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Adhere to medical record charting standards that should reflect the patient’s advance directives.

You must submit the following supporting documents to CAQH upon completion of the application:

- Curriculum Vitae
- Medical license
- DEA certificate
- Malpractice Insurance Coverage
- IRS Form W-9
Care Provider Performance Review

As part of the recredentialing process, UnitedHealthcare Community Plan queries its Quality Management database for information regarding care provider performance. This includes, but is not limited to:

- Member complaints
- Quality of care issues

Applicant Rights and Notification

You have the right to review the information in support of credentialing/ recredentialing applications and to request the status of your application. This review is at your request and is facilitated by the credentialing staff. The credentialing staff notifies you of any information obtained during the credentialing or recredentialing process that varies significantly from the information you gave UnitedHealthcare Community Plan. You have the right to correct errors when asked for clarification from the credentialing staff.

Confidentiality

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

Failure to Meet Recredentialing Requirements

If you fail to meet our recredentialing requirements, your participation with our network will terminate. We will give you a written termination notice. The termination notice will include the reason for the termination, the effective date of that termination, and an explanation of their appeal rights, if applicable.

Resolving Disputes

Contract Concern or Complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to:

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

A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your applicable Provider Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, please follow the dispute resolution provisions of your applicable Provider Agreement.

If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can’t resolve the complaint through informal discussions with you, please follow the dispute resolution provisions of your applicable Provider Agreement.

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the Member Handbook, and this care provider manual.

HIPAA Compliance – Care Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare Community Plan is a “covered entity” under the regulations as are all health care providers who conduct business electronically.

Transactions and Code Sets

These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final
Transactions and Code sets Rule. If you conduct business electronically, you are required to do so using the standard formats adopted under HIPAA, or use a Clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare Community Plan.

**Unique Identifier**

HIPAA also requires the development of unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions. (National Provider Identifier – NPI)

**National Provider Identifier (NPI)**

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

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and you should share with all impacted trading partners, such as care providers to whom you refer patients, billing companies, and health plans.

**Privacy of Individually Identifiable Health Information**

The privacy regulations help ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients’ personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information and to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

**Security**

The Security Regulations require covered entities to meet basic security objectives.

1. Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Help ensure compliance with the Security Regulations by the covered entity’s workforce.

UnitedHealthcare expects all participating care providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines.

Additional information on HIPAA regulations can be obtained at [cms.hhs.gov](http://cms.hhs.gov).

**Ethics & Integrity**

**Introduction**

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

**Compliance Program**

As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity.

The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program;
- Development and implementation of ethical standards and business conduct policies;
• Creating awareness of the standards and policies by education of employees;
• Assessing compliance by monitoring and auditing;
• Responding to allegations or information regarding violations;
• Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty.
• Reporting mechanisms for employees, managers and others to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has Compliance Officers for each health plan. In addition, each health plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the health plan.

**Reporting and Auditing**

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to your attention should be reported to a UnitedHealthcare Community Plan senior manager in the health plan or directly to the Compliance Office.

UnitedHealthcare Community Plan’s Special Investigations Unit (SIU) is an important component of the Compliance program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by you and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities.

To facilitate the reporting process of any questionable incidents involving plan members or care providers, call our Fraud and Abuse line.

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

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews and audits to help ensure compliance with law, regulations, and policies/contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an appropriate investigation. You are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by your applicable Provider Agreement and this Manual) and access to your office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

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

**Extrapolation Audits of Corporate-wide Care Provider Billing**

UnitedHealthcare Community Plan will work with the state of Missouri to perform “individual and corporate extrapolation audits” and this may affect all programs supported by dual funds (state and federal funding), as well as state-funded programs, as requested by the Missouri Department of Health and Human Services.

**Record Retention, Reviews and Audits**

You must agree to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Records must be maintained for a period of not less than 10 years from the close of the Missouri program agreement between the state and UnitedHealthcare Community Plan, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. United Healthcare and its affiliated entities (including OptumHealth) will request and obtain prior approval from each care provider for the disposition of records under review or inspection.

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

You must cooperate with the state or any of its duly authorized representatives, the Missouri Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other audit agency prior-approved by the state, at any time during the term of your applicable Provider Agreement.
These entities shall, at all reasonable times, have the right to enter onto your premises. You agree to allow access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, and records and/or to otherwise evaluate (including periodic information systems testing) your performance and charges.

All reviews and audits shall be performed in such a manner that will not unduly delay your work. If you refuse to allow access to all documents, papers, letters, or other materials, this will constitute a breach of your applicable Provider Agreement.

You must keep records for a period of ten years following the close of the agreement between the state and UnitedHealthcare Community Plan, unless the state authorizes in writing their earlier disposition. You agree to refund to the state any overpayment disclosed by any such audit.

However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 10 year period, you agree to retain the records until completion of the action and resolution of all issues which arise from it and for one year thereafter. The state shall also retain the right to perform financial, performance, and other special audits on such records maintained by you during regular business hours throughout the term of your applicable Provider Agreement.

Delegating and Subcontracting
If you delegate or subcontract any function, the subcontract or delegation must include all requirements of your applicable Provider Agreement and this Guide.

**Practitioner Office Site Quality**

United Healthcare Community Plan and affiliates monitor complaints or quality of services (QOS) concerning participating care providers and facilities. Complaints about you and/or facilities are recorded, investigated, and appropriate follow-up is conducted to assure members receive care in a safe, clean, accessible and appropriate environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all Primary Care provider office sites to help ensure the quality of the facility in which the care is provided.

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

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

**Criteria for Site Visits**

The following table outlines the criteria used to require a site visit. When the threshold is met, a site visit is conducted according to United Healthcare Community and State policy and procedure.

<table>
<thead>
<tr>
<th>QOS Issue</th>
<th>Criteria</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue may pose a substantive threat to patient’s safety</td>
<td>Access to facility in poor repair to pose a potential risk to patients</td>
<td>One complaint</td>
</tr>
<tr>
<td></td>
<td>Needles and other sharps exposed and accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug stocks accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other issues determines to pose a risk to patient safety</td>
<td></td>
</tr>
<tr>
<td>Issues with physical appearance, physical accessibility and adequacy of</td>
<td>Office facilities are dirty; smelly or otherwise in need of cleaning</td>
<td>Two complaints in six months</td>
</tr>
<tr>
<td>waiting and examination room space</td>
<td>Office exams rooms do not provide adequate privacy</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>All other complaints concerning the office facilities</td>
<td>Three complaints in six months</td>
</tr>
</tbody>
</table>
Chapter 12: Billing and Encounter Submission

National Provider Identifier (NPI)

A requirement of HIPAA legislation is you be assigned a unique (NPI). The health care industry is to use the NPI to identify itself in all standard transactions.

If you have not applied for assignment of an NPI, please contact National Plan and Provider Enumeration System (NPPES).

Once you are assigned an NPI, report the new identifier to UnitedHealthcare Community Plan.

Please call the UHG VETSS line or Provider Services.

All laboratory claims must include the Unique Care provider Identification Number (UPIN) or NPI number of the referring care provider, in addition to the elements of a Clean Claim. This requirement is consistent with current CMS policy. Like CMS, the health plan will also require all laboratory claims include the NPI of the referring care provider.

A current Federal Tax Identification Number and NPI are required on all claims.

A Medicaid ID number is not required for providers to participate with UnitedHealthcare Community Plan of Missouri.

General Billing Guidelines

Claims will be considered for reimbursement only if billing requirements are met and are a covered benefit for the enrolled member. If prior authorization was required, the prior authorization number must be entered in box 23 of the 1500 claim form. Submitting a referral with the claim does not guarantee reimbursement. Reimbursement for services depends on the member’s enrollment on the date(s) of service, medical necessity, and limitations and exclusions as stated in rules governing the plan, and UnitedHealthcare Community Plan policies and procedures. Exclusions include excessive, inappropriate or non-covered charges. We may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to help ensure compliance with applicable policies, standards, procedures, state and federal law. We may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

Fee Schedule

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

Modifier Codes

Use the appropriate modifier codes on your claim form. The modifier must be used based on the date of service.

Member ID Card for Billing

The member ID card contains both the health plan member assigned ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill using the member assigned ID number, but will accept a bill with the DCN.

Acceptable Claim Forms

UnitedHealthcare Community Plan requires you to use one of two forms when billing for services.

- All paper claims should be submitted on the 02/12 1500 Claim Form. The 02/12 1500 Claim Form is used for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a hospital and other care providers.
- Use UB-04 form to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

UnitedHealthcare Community Plan will not process claims received on any other type of claim form.
Clean Claims and Timely Claim Submission Requirements

Whether you use an electronic or a paper form, complete a CMS 1500 or UB-04 form. A complete claim includes the following information (additional information may be required by us for particular types of services or based on particular circumstances or state requirements).

For services rendered by a nurse practitioner or care provider assistant, submit the claim under the nurse practitioner or care provider assistant and not the supervising care provider.

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

Electronic Claims Submission and Billing

UnitedHealthcare Community Plan offers you the option of submitting claims to UnitedHealthcare Community Plan by electronic data interchange (EDI). EDI offers you several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turn-around. UnitedHealthcare Community Plan can accept claims electronically when UnitedHealthcare Community Plan is secondary and there is no need to send a paper claim as backup.

Please note the following:
- Clearinghouse connectivity is OptumInsight at www.enshealth.com/ for our Payer ID: 86050. Your software vendor is responsible for establishing your connectivity via a clearinghouse or entity that uses OptumInsight if you are not a direct OptumInsight client.
- All claims are set up as “commercial” through the clearinghouse.
- Our Payer ID is: 86050.
- Clearinghouse Acknowledgment Reports and Payer specific Acknowledgment Reports identify claims failing to successfully transmit electronically.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for placement of data for both HCFA 1500 & UB04.

Questions can be addressed to EDI Claims.

EDI Companion Documents

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

The companion documents are located on our website at UHCCommunityPlan.com under Tools & Resources > EDI Education for Electronic Transactions

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

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.
As we make information available on various transactions, we will identify our requirements for those transactions in the companion guide. Changes will be included in the Change Summary located in each document.

**Importance & Usage of EDI**

**Acknowledgment/Status Reports**

Software vendor reports only show the claim left your office and either was accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by the health plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached us for payment or if claim(s) have been rejected for an error or additional information.

You **MUST** review your reports, clearinghouse acknowledgment reports and the plan’s status reports to eliminate processing delays and timely filing penalties for claims that have not reached us.

**How do I get these reports?**

Your software vendor is responsible for establishing your connectivity to our clearinghouse OptumInsight at [enshealth.co](http://enshealth.co/).

If you are not already a direct OptumInsight client, we will instruct you in how your office will receive Clearinghouse Acknowledgment Reports.

**How do I correct errors?**

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing late.

**IMPORTANT:** If a claim is rejected and corrections are not received within 90 days from date of service or EOB from primary carrier, the claim is considered late billed and denied as not allowed for timely filing.

**e-Business Support**

UnitedHealthcare Community Plan offices will be staffed and open during normal business hours 8 a.m. to 5 p.m., Central Time Monday through Friday.

- ERA – To enroll for 835 Electronic Remittance Advice (ERA), you **MUST** enroll via a clearinghouse or entity that uses OptumInsight if you are not a direct OptumInsight client.
- EFT – Electronic Funds Transfer

Business support is available for the following EDI issues: 

**EDI Claims**

**EDI Log-on Issues**

You may find forms and additional information regarding electronic services at uhccommunityplan.com. Go to Healthcare Professionals, select your state, then the Electronic Data Interchange menu. Contact your software vendor and/or clearinghouse prior to contacting UnitedHealthcare Community Plan.

**Important EDI Payer Information**

- Claim Payer ID: 86050
- ERA Payer ID: UFNEP

**Completing the CMS 1500 Claim Form**

This section applies to paper CMS 1500 claims submitted to UnitedHealthcare Community Plan.

For instructions on completing the CMS 1500 form, go to the National Uniform Claim Committee website nucc.org

You may use the **UnitedHealthcare ICD-10-CM Code Lookup Tool** to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare Community Plan claim platforms.
Chapter 12: Billing and Encounter Submission

UB-04

Use the UB-04 claim form to bill all hospital inpatient, outpatient, and emergency room services.

- Use revenue codes to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
- ICD CM Code diagnosis codes are required.
- Use the ICD CM Code procedure codes to identify surgical procedures billed on the UB-04.
- CPT/HCPCS and modifiers must be used to identify other services rendered.

You may use the UnitedHealthcare ICD-10-CM Code Lookup Tool to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare claim platforms.

Subrogation and Coordination of Benefit

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

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

2. **COB** – Coordination of benefits is administered according to the member’s benefit contract and in accordance with applicable statutes and regulations.

UnitedHealthcare Community Plan is considered the payer of last resort. You should identify and verify any other insurance coverage for the member. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as the final payee, submit the primary payer’s Explanation of Benefits or remittance advice with the claim.

Capitated Services

Include on the UB-04 all services related to an inpatient stay. These services include being admitted to the hospital as well as receiving emergency room treatment, observation and/or other outpatient hospital services.

We deny claims submitted with service dates that do not match the itemization and medical records. This is a billing error denial.

Reminders

- Indicate the Attending Provider Name and Identifiers for the patient’s medical care and treatment on institutional claims for any services other than non-scheduled transportation claims.
- Also send the Referring Provider NPI and name on outpatient claims when the Referring Provider for the services is different than the Attending Provider.
- As of Jan. 1, 2013, claims must include the NPI of the attending care provider in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims. That NPI must not be your billing NPI or an organizational NPI; it must an individual provider NPI.

- For Behavioral Health care providers, currently, our systems have been updated to receive more than one NPI per agency. Providers can now bill using multiple site-specific NPIs.

Hospital and Clinic Method of Billing Professional Services

UnitedHealthcare Community Plan billing policy requires hospital and clinics billing for professional services bill on a CMS 1500 with the servicing care provider’s name in box 31 and the servicing care provider’s group NPI number in box 33a.

Correct Coding Initiative (CCI)

UnitedHealthcare Community Plan performs coding edit procedures, based primarily on the Correct Coding Initiative (CCI) and other nationally recognized and validated sources.
Comprehensive and Component Codes

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. You should only report the most extensive service performed.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.
- Standards of medical practice. Services and/or procedures integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or Multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, you should report only the expected result.

Billing Multiple Units

Reminder when billing multiple units:

- If the same procedure is provided multiple times on the same date of service, you must enter the procedure code once on the claim form with the appropriate number of units.
- The unit field is used to specify the number of times the procedure was performed on the date of service.
- The total bill charge is the unit charge multiplied by the number of units.

Billing Guidelines for Obstetrical Services

Follow the reporting procedure below when submitting OB delivery claims to UnitedHealthcare Community Plan. You must follow these procedures or the claim will be denied by UnitedHealthcare Community Plan.

- Follow CPT coding guidelines and bill the most comprehensive code for the services provided.
- If billing for delivery and prenatal care together, the date should be the date of delivery. Use one unit with the appropriate charge in the charge column.
- Only use CPT Evaluation and Management (E/M) codes 99201-99215, when 3 or less prenatal visits are performed.
- Use global delivery code (59400, 59519, 59610 and 59618).

Billing Guidelines for Transplants

The Missouri Department of Social Services covers transplants that are medically necessary and defined as non-experimental by Medicare. UnitedHealthcare Community Plan only covers the transplant evaluation and work-ups. Obtain prior authorization for the transplant evaluation. Ensure and facilitate all required referrals and evaluations to complete the pre-transplant evaluation process in a timely manner once the member is referred to the center as a possible candidate.

Clinical Laboratory Improvements Amendments (CLIA)

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

Report any additional conditions on a separate CMS 1500 Form.

If you bill electronically, the CLIA number is reported in Loop 2300 or 2400, REF/X4,02.

For more information about the CLIA number, you may contact the CMS CLIA Central Office at 410-786-3531 or access the CMS website.
Ambulance Claims (Emergency)

Ambulance claims must include both the ambulance point of origin and destination address, city, state, and zip in box 32 of the HCFA form. The accident state must be listed in box 10 and ambulance claims must not bill diagnosis code 799.99.

National Drug Code (NDC)

Claims must include NDC and unit of measurement for the drug billed, HCPCS/CPT code and units of service for the drug billed and actual metric decimal quantity administered.

You must submit the National Drug Code (NDC) on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. You are required to submit claims with the exact NDC that appears on the product administered. Do not bill for one manufacturer’s product and dispense another. It is considered a fraudulent billing practice to bill using an NDC other than the one administered. You must enter the identifier N4, the eleven-digit NDC code, unit/basis of measurement qualified, and actual metric decimal quantity administered. Include HCPCS/CPT code.

Medical Necessity Definition

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

- Necessary to meet the basic health needs of the client
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the client or his or her care provider
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value
- No more intense level of service than can be safely provided.

UnitedHealthcare Community Plan only pays for medically necessary services.

Place of Service Codes

Click here for Place of Service codes or go to cms.gov > Medicare > coding > place of service codes.

UnitedHealthcare Community Plan Remittance Advice

All online transactions for members enrolled in Medicaid are accessible on Link.

If you are not already registered on Link, you may do so directly on the Link home page.

We have Claims and Payments tutorials online at Unitedhealthcare.com> Help > Claims and Payments. You will find a Quick Reference Guide regarding payments, eligibility and referrals as well as other helpful tools relating to transactions.

Inquiring About a Claim

UnitedHealthcare Community Plan has developed multiple options to help you when inquiring about claims; UnitedHealthcare Community Plan Provider Service, and the UnitedHealthcare Community Plan Provider Portal.

Provider Service

Provider Service is the primary point of contact if you require assistance with claims.

They work closely with all departments in UnitedHealthcare Community Plan to resolve issues. By following a few guidelines, you can help UnitedHealthcare Community Plan provide you with prompt, efficient service. Please have all applicable information ready before you call:

- Provide the Member’s ID number, date of service, procedure code, amount billed, provider’s ID Number and claim number (if known).
- Allow 45 days from date of submission prior to inquiring about a claim.
- Limit telephone inquiries to a maximum of five claims per call.
UnitedHealthcare Community Plan
Provider Portal

Your online transactions are accessible through LINK on UnitedHealthcareonline.com. If you are not already registered, you may do so directly on the website. The web-based care provider portal offers the convenience of online support anytime. This site was developed specifically with you in mind allowing for personal support. On the provider portal, you may verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, or review a member roster.

Link: Your New Gateway to UnitedHealthcare Community Plan’s Online Provider Tools and Resources

Link includes many of the same applications as Optum Cloud Dashboard, but with a new interface that can help make your work measurably faster and easier. Link users can quickly move between applications and even customize the screen to put common tasks just one click away.

Use Link applications to help simplify daily administrative tasks for your practice:

- Check member eligibility across multiple lines of business
- Submit claims reconsideration requests
- Review coordination of benefits information
- Use the integrated applications to complete multiple transactions at once
- Reduce phone calls, paperwork and faxes
- Registration is required to access Link.

To access LINK, please visit or go to UnitedHealthcareonline.com. Use your Optum ID to sign in.

If you need an Optum ID: go to UnitedHealthcareonline.com. Follow the instructions for obtaining a user ID. You will receive your user ID and password within 48 hours.

Link Applications

- Eligibility and Benefits Center
- Claims Management
- Claims Reconsideration

Learn More: Find Link training on UnitedHealthcareonline.com
Click “Link-Learn More”

Chapter 12: Billing and Encounter Submission
Chapter 13: Resolving Claim Issues

Claim Correction

What is it?
A corrected claim is a replacement of a previously submitted claim.

When to use:
You should only submit a corrected claim for a claim already processed. The purpose of claim correction is to correct information on the original submission.

How to use:
Use the claims reconsideration application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID.

You may also submit the claim by mail with a claim reconsideration request form.

Allow up to 30 days to receive payment for initial claims and 30 days to receive a response to adjustment requests.

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

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

Resubmitting a Claim

What is it?
When you resubmit a claim, you are creating a new claim.

When to use it:
If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission. A denied claim has been through claim processing and determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

A rejected claim is one that has not been processed due to problems detected before claim processing. Claims are typically rejected for incorrect patient names, date of birth, insurance ID’s, address, etc. Since rejected claims have not been processed yet, there is no appeal — the claim just needs to be corrected through resubmission.

Common Reasons for Rejected Claims
Some of the common causes of claim rejections are:
- Errors to patient demographic data - age, date of birth, sex, etc. or address
- Errors to provider data
- Incorrect patient insurance ID
- No referring provider ID or NPI number

How to use:
To resubmit the claim, follow the same submission instructions as a new claim.

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Reconsideration (Step One of Dispute)

What is it?
Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.

A claim reconsideration request is typically the quickest way to address any concern you have about whether a claim was paid correctly. You may submit a claim reconsideration request electronically, by phone, mail or fax.

When to use:
You think a claim has not been properly processed.
If you disagree with the outcome of a claim determination, the first step is to submit a claim reconsideration request in one of the following ways:
Chapter 13: Claim Corrections, Resubmits, Reconsiderations, Appeals and Grievances

How to use:
Electronically – Claim Reconsideration application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID.

Phone – Call Provider Services at 866-815-5334 or use the number on the back of the member’s ID card.
- If the reconsideration is called in, the Tracking number will begin with SF and be followed by 18 numeric digits

Mail – Submit paper claim reconsideration request, using the Claim Reconsideration Request Form
- The Claim Reconsideration Request Form is available at UnitedHealthcareOnline.com > Tools & Resources > Forms

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Fax – 801-994-1224

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?
When the patient provides incorrect insurance information at the time of service, proof of timely filing includes:
- A denial or rejection letter from another insurance carrier
- Another insurance carrier’s explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the patient on the date of service of the claim

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

How to use:
Use the Reconsideration process for timely filing issues. You may submit electronically, phone, mail or fax.

Electronic claims – include confirmation using your EDI acceptance report stating we received your claim. For mailed or faxed reconsiderations, submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
- Correct patient name
- Correct date of service
- Submission date of claim

Additional Information:
Timely filing limits can vary greatly based on state requirements and contract types. If you are not aware of your timely filing limit, please refer to your provider agreement.

Appeal (Step Two of Dispute)

What is it?
An appeal is a second review in which you did not agree with the outcome of the reconsideration.

When to use:
If you do not agree with the outcome of the Claim Reconsideration decision in step one, you may use the Claim Appeal process.

How to use:
Submit all relevant documentation with your appeal. This may include a cover letter, the medical records, and any additional information. You may choose to send your information electronically, by mail or fax.

Electronic claims – Use the Claims Management or ClaimsLink application on Link. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID. The system allows you to upload attachments for additional information.

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

Fax – 801-994-1082

Our provider advocates are available to assist you in navigating our processes to better serve our members.

There is a one year timely filing limitation, from the date of the first EOB, to complete all steps in the reconsideration and appeal process.
**Tips for successful claims resolution**

Use the following tips to help process claim reconsiderations:

- Do not allow claim issues to accumulate or go unresolved.
- Provider contracts only allow a limited time to request an adjustment.
- If you cannot verify a claim is on file, then call Provider Services.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File claims disputes within contractual time requirements.
- For claim/service denied for exceeding the maximum daily frequency allowed for the procedure:
  - If exceeding the maximum daily frequency is required, please submit the medical records justifying medical necessity. If you have questions about the maximum daily frequency of a CPT/HCPCS, please contact Provider Services.
- United Healthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an Explanation of Benefits (EOB) from other insurance or source of healthcare coverage prior to billing UnitedHealthcare Community Plan, as required by contract.
  - When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid, and why.
  - You should refer to your contract for submission deadlines concerning third party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason.

**How to use:**

If you have identified an overpayment and prefer we recoup the funds in your next payment, please call Provider Services.

You must notify UnitedHealthcare Community Plan of an overpayment on a claim. Send refunds to UnitedHealthcare Community Plan with an Overpayment Return Check or the Return Overpayment through Adjustment Request form.

If you are mailing a refund check, please send a letter with the check and include the following:

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

**Where to send:**

Send refunds requested by UnitedHealthcare Community Plan with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

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

Instructions and the forms are located on [UnitedHealthcareOnline.com > Tools & Resources > Forms](UnitedHealthcareOnline.com)

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

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

**Overpayment**

**What is it?**
If you or UnitedHealthcare Community Plan identifies an overpaid claim you do not dispute, you must send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our agreement and applicable law.
If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination. See Dispute section in this chapter.

### Sample Overpayment Report

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

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Date of Service</th>
<th>Original Claim #</th>
<th>Date of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>01/01/14</td>
<td>14A000000001</td>
<td>01/31/14</td>
</tr>
<tr>
<td>222222222</td>
<td>02/02/14</td>
<td>14A000000002</td>
<td>03/15/14</td>
</tr>
<tr>
<td>333333333</td>
<td>03/03/14</td>
<td>14A000000003</td>
<td>04/01/14</td>
</tr>
<tr>
<td>444444444</td>
<td>04/04/14</td>
<td>14A000000004</td>
<td>05/02/14</td>
</tr>
<tr>
<td>555555555</td>
<td>05/05/14</td>
<td>14A000000005</td>
<td>06/15/14</td>
</tr>
</tbody>
</table>

### Provider Grievance

**What is it?**
Grievances are re complaints related to your health plan policy, procedures, or payments.

**When to file:**
You may file a grievance related to:
- Benefits and limitations
- Eligibility and enrollment of a member or provider
- Member issues or health plan issues
- Availability of health services from the health plan to a member
- Issues related to the delivery of health services
- Issues related to the quality of service

**How to file:**
You may file verbally or in writing. To file a grievance, call Provider Services toll free at 866-815-5334 or TTY: 711, Monday through Friday 8 a.m. to 5 p.m. Central Time. Send written grievances to:

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

*No special form needed for submission.* Send care provider name, contact information and your grievance.

### Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions related to Appeals and Grievances.

**Appeals**

**What is it?**
Appeal is a formal expression of dissatisfaction with an action.

**Action is when the plan:**
- Makes an adverse determination or limits authorization of requested service(s) including the type or level of service;
- Reduces, suspends or terminates a previously authorized service;
- Refuses or denies, in whole or part, payment for services;
- Fails to provide services in a timely manner, as defined by the state or CMS; or
- Fails to act within the time frames required by state or CMS.

**When to use:**
You play an integral role in the appeal process for UnitedHealthcare Community Plan members. This includes you acting on the member’s behalf with written consent, and providing medical records and certification of the emergent nature of appeals as appropriate.
Where to send:

- Appeal the decision by calling or writing to Member Services within 45 calendar days from the date the service was denied at:
  
  UnitedHealthcare Community Plan Attn:
  Appeals and Grievances
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

- Member has the right to present the appeal in person Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time at:
  
  UnitedHealthcare Community Plan
  13655 Riverport Drive
  Maryland Heights, MO 63043

How to use:

CMS allows UnitedHealthcare Community Plan members the right to appeal any decision regarding provision of services or claim payment whether the decision is made by UnitedHealthcare Community Plan or by you. Whenever you deny a service, you are obligated, under CMS’s requirements, to provide that patient who is our member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help with the appeal. The member has the right to present evidence, and allegations of fact or law, in person as well as in writing.
- The enrollee or representative may review the case file, including medical records and any other documents or records, before and during the appeal process.
- Send written comments or documents to be considered in deciding the appeal.
- Ask for an expedited appeal if waiting for this health service would increase the risk to the patient’s health. You have limited time (two business days) to represent evidence and allegations of fact or law, in person and in writing.
- Ask for continuation of services during the appeal. However, the patient may be required to pay for the health service if the service is continued and it is decided the patient should not have received the service.
- Time frame we have to resolve standard appeal is 45 calendar days from the day we receive the appeal.
- Time frame we have to resolve an expedited appeal is three working days from the day we receive the appeal. We may extend the expedited appeal response up to 14 calendar days if any other following conditions apply:
  1. Enrollee request
  2. We show the satisfaction of Department of Social Services upon request there is need for additional information and how the delay is in the enrollee’s interest.

Member Grievance

What is it?

Grievance are re complaints related to your health plan policy, procedures, or payments.

When to use:

You may file a grievance when acting as the member’s authorized representative.

Where to send:

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

Mailing address:

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

You should receive an answer no longer than 30 working days from the date you filed the complaint/grievance.

The member may also file a grievance in writing to the state of Missouri within 30 calendar days of receipt of the first determination letter.

UnitedHealthcare Community Plan
13655 Riverport Drive
Maryland Heights, MO 63043

State Fair Hearings

What is it?

A Fair Hearing is a chance for a member to share why they think a decision about their claim is wrong when MO HealthNet services are denied, reduced or terminated.
When to use:
Members have 90 days from the date of the letter to ask for a hearing. After the member asks for a hearing, they will be mailed a hearing form. After they fill out the hearing form and send it back, a date will be set for the hearing.

How to use:
Your patient who is a UnitedHealthcare Community Plan member may ask for a state fair hearing in writing within 90 calendar days of the date the service was denied at the following mailing address:

**MO HealthNet**
P.O. Box 6500
Jefferson City, MO 65102-6500

• The member may call UnitedHealthcare Community Plan Customer Service for assistance in writing the letter.
• If the member has not been given this right in a letter, contact the Participant Services Unit at 800-392-2161.
• The member may have someone else, such as a family member, friend, healthcare provider, or lawyer attend with them.
• Hearings are held on the phone. They may go to the local Family Support Division office for the hearing or can have the hearing from home.
A toll-free Fraud, Waste and Abuse Hotline is available to facilitate reporting of any questionable incidents involving plan members or care providers.

UnitedHealthcare Community Plan’s Anti-Fraud, Waste and Abuse Program focuses on proactive prevention, detection, and investigation of fraudulent and abusive acts committed by care providers and health plan members.

The mission of the Anti-Fraud, Waste, and Abuse Program is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money UnitedHealthcare Community Plan has paid for such claims. We will also appropriately refer and report suspected fraud, waste and abuse cases to law enforcement, regulatory, and administrative agencies pursuant to state and federal expectations. UnitedHealthcare Community Plan seeks to protect the ethical and fiscal integrity of its members, you, government programs, public, and employees, as well as safeguard the health and well-being of its members.

UnitedHealthcare Community Plan incorporates applicable federal and state regulatory and contractual requirements in to its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are particularly vulnerable to fraud, waste and abuse and strives to tailor its efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

Suspected instances of fraud, waste and abuse are thoroughly investigated. In appropriate cases, the matter is reported to regulatory authorities and/or law enforcement, in accordance with federal and state requirements. We cooperate with law enforcement and regulatory agencies in the prevention, detection, and investigation of fraud, waste and abuse. You are contractually obligated to cooperate with the company and government authorities on matters related to FWA, including as it relates to responding to requests for information.

Find the Fraud, Waste and Abuse Policy at UnitedHealthcareonline.com. Click Policies, Protocols and Guides. Then, click Administrative Guides on the left side menu.

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are aimed at reducing fraud within the health care programs funded by the federal government. Under Section 6032 of the DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

Exclusion Checks

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

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov or General Services Administration (GSA) System for Award Management at SAM.gov

What You Need to Do for Exclusion Checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may request documentation of the exclusion checks to verify they were completed. If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond.

UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.
Chapter 15: Care Provider Communications & Outreach

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

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

Care Provider Websites

UnitedHealthcare Community Plan promotes the use of Web-based functionality among its care provider population. UnitedHealthcare Community Plan’s Web-based provider portal (UHCCommunityPlan.com) facilitates care provider communications pertaining to administrative functions. Our interactive website enables you to electronically determine member eligibility, submit claims, and ascertain the status of claims. We have implemented an internet based prior authorization system on UnitedHealthcareonline.com, which allows you internet access the ability to request medical and advanced outpatient imaging procedures online rather than by phone. The website also contains an online version of the this manual, clinical practice guidelines, (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines) electronic data interchange, quality and utilization requirements and educational materials such as newsletters, bulletins and other care provider information.

A website is also available to members including access to the Member Handbook, newsletters, provider search tool and other important plan information (UHCCommunityPlan.com, Select Member).

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces and distributes a Provider Newsletter to the entire Missouri network at least three times a year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance. The newsletters also include notifications regarding changes in laws and regulations. UnitedHealthcare Community Plan uses electronic bulletins, posted on the UHCCommunityPlan.com website, to rapidly disseminate urgent information that impacts the entire network.

Care Provider Manual

UnitedHealthcare Community Plan publishes this manual online, which includes an overview of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources. If you do not have Internet access, you may request a hard copy of this manual by contacting Provider Services.

Care Provider Office Visits

Care provider advocates visit primary care providers and specialist offices on a regular basis. Each Care Provider Advocate is assigned to a specific care provider group to deliver face-to-face support. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and problem resolution.
Chapter 16: Care Provider Forms Appendix

You may locate these forms on the state’s website at dss.mo.gov and click Healthcare or go to http://dss.mo.gov/mhd/providers/ for more information about care provider participation.

For all the Missouri Department of Health contact numbers, go to dss.mo.gov and click Find Offices.
Chapter 17: Glossary

AABD
Assistance to the Aged, Blind, and Disabled

Action
The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care
Care provided to persons sufficiently ill or disabled requiring
1. Constant availability of medical supervision by attending care provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Ambulatory Care
Ambulatory care services are provided on an outpatient basis. While many inpatients may be ambulatory, the term “ambulatory care” usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Care Provider Services
Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal
An oral or written request by a member or member’s personal representative received by UnitedHealthcare Community Plan for review of an action.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

CHIP
Children’s Health Insurance Program

Clean Claim
A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Contracted Health Professionals
Refers to those primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan who provide specific covered services to members, and represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Covered Services
Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing
The verification of applicable licenses, certifications, an experience to assure care provider status is extended only to professional, competent care providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.
American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Delivery System
The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, care provider offices, and home health care.

Disallow Amt
Medical charges for which the network care provider is not permitted to receive payment from the health plan and cannot bill the member. Examples are:

1. The difference between billed charges and contracted rates; and
2. Charges for services that are bundled or unbundled as detected by Correct Coding Initiative edits.

Discharge Planning
Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Disenrollment
The discontinuance of a member’s eligibility to receive covered services from a Contractor.

Durable Medical Equipment (DME)
Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a care provider.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Emergency Care
The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

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

Expedited Grievance
A grievance where delay in resolution would jeopardize the member’s life or materially jeopardize the member’s health.

Grievance
An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health plan Employer Data and Information Set (HEDIS)
Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers’ needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, care provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPPA
Health Insurance Portability and Accountability Act

Home Health Care (Home Health Services)
Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

KB
Katie Beckett – a program that provides home health nursing and other medical services to children under 18 years old who otherwise would be hospitalized because of their high level of health care needs.
Medicaid
The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

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

• Necessary to meet the basic health needs of the client;
• Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
• Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
• Consistent with the diagnosis of the condition;
• Required for means other than convenience of the client or his or her care provider;
• No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value; and
• No more intense level of service than safely provided.

Member
Refers to an individual determined UnitedHealthcare Community Plan eligible and enrolled with UnitedHealthcare Community Plan to receive services pursuant to the Agreement.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan enrollee when they are outside of their geographic territory.

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

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

Primary Care Provider (PCP)
A care provider, such as a family practitioner, pediatrician, internist, general practitioner, care provider assistant, advanced registered nurse practitioner or obstetrician who serves as a gatekeeper for their assigned members’ care.

Prior Authorization (Notification)
A unit under the direction of the UnitedHealthcare Health Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of providers.

Quality Management (QM)
A methodology used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

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

Service Area
A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by Missouri Department of Social Services.
Specialist
A care provider duly licensed in the state of Missouri and has completed a residency or fellowship in his or her specialty and has been approved to sit for the board examination for the specialty.

State Fair Hearing
An administrative hearing that can be requested if the member or care provider does not agree with a Notice of Decision or Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families.

Third Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title XIX
Section of Social Security Act which describes the Medicaid program coverage for eligible persons.

Utilization Management (UM)
The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.