2024
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

District of Columbia Dual Choice

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United Healthcare Community Plan

Welcome

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

Click the following links to access different care provider manuals:

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**

Easily find information in this manual using the following steps:

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

If you have questions about the information or material in this manual, or about our policies, please call Provider Services at **1-888-350-5608**.

Important information about the use of this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and District statutes and regulations and/or District contracts, applicable federal and District statutes and regulations and/or District 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 District statutes and regulations.

This manual will be amended as policies change.

Participation Agreement

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

Terms and definitions as used in this manual:

- "Enrollee" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- "Community Plan" refers to UnitedHealthcare's Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to "ID card" includes a physical or digital card

Thank you for your participation in our program and the care you offer our enrollees.

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-888-350-5608**
Training	**UHCprovider.com/training**	**1-888-350-5608**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-866-842-3278** option 1
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
One Healthcare ID support	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
Resource library	**UHCprovider.com** > Resources > Resource Library	

UnitedHealthcare Community Plan supports the District of Columbia (D.C.) goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following enrollees:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the District Medicaid Office in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid

The District will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call Provider Services at **1-888-350-5608.**

How to join our network

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

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile at **UHCprovider.com/attestation.**

Approach to health care

UnitedHealthcare at Home

The UnitedHealthcare at Home (UAH) clinical care program is a holistic, integrated care delivery program that provides, arranges and coordinates medical care, behavioral health and social services for all plan D-SNP enrollees. The program accomplishes this through tailored and coordinated interventions by the UAH Interdisciplinary Care Team (ICT) in collaboration with the enrollee's care providers. As a result, the UAH program helps ensure that enrollees with complex medical, behavioral and social needs receive the right care at the right time and in the right place. By improving access to care, enrollee education and coordinating care across care providers, we can help improve enrollee health and well-being and care outcomes while reducing unnecessary ED visits and hospitalizations.

The UAH ICT helps enrollees by:

- Arranging and providing care for enrollees in their homes through clinical exams, complete and emergent care management, and transitional care coordination following an acute inpatient stay
- Providing an integrated approach to managing all benefits for D-SNP enrollees and those enrollees eligible for long-term services and supports (LTSS)
- Developing and authorizing enrollee service plans and coordinating home- and community-based services (HCBS)

UAH's integrated care model includes multiple touch points with the enrollee's primary care physician (PCP) for ongoing collaboration and optimal clinical management. UAH clinicians develop and update Individualized Care Plans (ICP) for enrollees based on evidence-based guidelines and partner with the PCP to develop and adjust the care plan.

The ICT also manages enrollee care and coordinates with care providers by:

- Sharing clinical information, including updated ICPs through the Provider Portal after every visit
- Scheduling physician office visits
- Tracking clinical outcomes
- Meeting with care providers to review patient gaps in care
- Communicating evidence-based guidelines and UAH protocols

The relationship begins with an initial call to the PCP to introduce UAH. It includes ongoing collaboration to align in the following areas:

- Changes in enrollee condition or significant changes to ICP
- Transitions of care including emergency room (ER), hospitalization, and skilled nursing facility (SNF) admissions
- Advance care planning discussions and goals of care identification
- Specialty referrals
- Initiation of Home Health Services
- Authorization of HCBS for eligible enrollees

The UAH program requirements are also included in the UnitedHealthcare Administrative Guide. For member referrals or to speak with a member of the ICT, call the clinical care program at **1-855-409-7073**.

Compliance

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of

the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

For more information, go to **UHCprovider.com** > Resources > Resource Library > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**
  - Free continuing medical education (CME) and non-CME courses are available on our Cultural Competency page as well as other important resources.
  - Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.
- **Translation/interpretation/auxiliary aide services**
  - You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to enrollees as required, to provide enrollees with an equal opportunity to access and participate in all health care services.
  - If the enrollee requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the enrollee.
  - Enrollees have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of enrollees with limited English proficiency, or enrollees who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the enrollee refuses. Document the refusal of professional interpretation services in the enrollee's medical record.
  - Any materials you have a enrollee sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.
  - If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for enrollees who are deaf or hard of hearing so they receive them prior to the Virtual Visit.

This means using electronic means, where allowed

- **Care for enrollees who are deaf or hard of hearing**
  - You must provide a sign language interpreter if a enrollee requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to enrollees who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET.
  - To arrange for interpreter services, please call 1-877-842-3210 (TTY 711).
- **I Speak language assistance card**
  - This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare enrollees.
- **Materials for limited English-speaking enrollees**
  - We provide simplified materials for enrollees with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired enrollees.

For more information, go to **uhc.com > Language Assistance.**

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® (we previously used MCG Guidelines) for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the **UnitedHealthcare Provider Portal Digital Guide Overview course**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment,

and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

API is becoming the newest digital method in health care to distribute information to care providers and business partners in a timely and effective manner.

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

Electronic data interchange (EDI) is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple enrollees and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/resource-library**.

Getting started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system
- Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist® integrates enrollees UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca.**

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable

resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

Chat support now available
Have a question? Skip the phone and chat with a live service advocate when you **sign in** to the UnitedHealthcare Provider Portal. Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.

The secure **UnitedHealthcare Provider Portal** allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks, such as submitting prior authorization requests, checking claim status, submitting appeal requests, and finding copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register.

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits -** View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **CareConductor -** View UnitedHealthcare Community Plan and UnitedHealthcare Dual Complete enrollee plans of care and notes. Learn more at **UHCprovider.com** under Case Management and PCP Reports.
- **Claims -** Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **CommunityCare enrollee roster -** See a list of admission and discharge information. Learn more at **UHCprovider.com** under Case Management and PCP Enrollee Reports.
- **Prior authorizations and notifications -** Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty pharmacy transactions -** Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the **UnitedHealthcare Provider Portal**. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile -** View and update your care provider demographic data that UnitedHealthcare enrollees sees for your practice. For more information, go to **UHCprovider.com/mpp**.
- **Document Library -** Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to **UHCprovider.com/documentlibrary**.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

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

- Manage overpayments in a controlled process
- Create a transparent view between you and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Run real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the UnitedHealthcare Provider Portal. On-site and online training are available.

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

Privileges

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

Provider Services

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

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

How to contact us

**We no longer use fax numbers for most departments, including benefits, prior authorization and claims.*

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-800-888-2998**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care Model (care management/disease management)	**dc_uah@uhc.com** **1-855-409-7073**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Claims	**UHCprovider.com/claims** **1-888-350-5608** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-888-350-5608** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.

Topic	Contact	Information
Dental services	**uhcdentalproviders.com** **1-866-321-2789**	Review covered and noncovered benefits, confirm enrollee eligibility.
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** **1-888-350-5608**	Confirm member eligibility.
Enterprise Voice Portal	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent.
Fraud, waste and abuse (payment integrity)	**UHCprovider.com/DCcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-800-455-4521** (NAVEX) or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984	Labcorp is network laboratory.
Medicaid D.C. Department of Health Care Finance	dc-medicaid.com/dcwebportal/home Provider Enrollment: dcpdms.com/Account/Login 1-202-906-8319 (inside DC metro area) 1-866-752-9233 (outside DC metro area)	Contact Medicaid directly
Medical claim, reconsideration and Appea	**UHCprovider.com/claims** **1-888-350-5608** Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with..

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-866-242-7726** TDD **711**	Available 8 a.m.– 5 p.m. ET, Monday-Friday, except District-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	**1-888-350-5608**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.
NurseLine	**1-877-303-2422**	Available 24 hours a day, 7 days a week.
One Healthcare ID support center	**1-855-819-5909**	Available 7 a.m.– 9 p.m. CT, Monday - Friday; 6 a.m.– 6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday.
Pharmacy services	**professionals.optumrx.com** **1-877-899-6510** Optum Rx ®	Optum Rx ® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript® tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

Topic	Contact	Information
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/paan** • Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-888-350-5608** TDD **711**	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments Check request status • Information and advance notification prior authorization lists **UHCprovider.com/DCcommunityplan/priorauth**
Provider Services	**UHCprovider.com/DCcommunityplan** **1-888-350-5608**	Available 8 a.m.– 6 p.m. ET, Monday-Friday.
Radiology prior authorization	**UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Reimbursement policy	**UHCprovider.com/DCcommunityplan/policies**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	**UHCprovider.com/contactus** Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Available 24 hours a day, 7 days a week.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare: 1-866-475-5886 Initial 24 visits: 1-866-418-9812, TTY 1-866-288-3133 Additional Medicaid transportation: 1-866-475-5886	To arrange nonemergent transportation, please call ModivCare at least 3 business days in advance. Available 8 a.m.– 5 p.m. local time, Monday – Friday.

Topic	Contact	Information
Utilization management	Provider Services: **1-888-350-5608**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols**. Request a copy of our UM guideline
Vision services	UnitedHealthcare Community Vision Network/March Vision Network: **1-844-366-2724** March Vision Network Provider Reference Guide marchvisioncare.com/providerreferenceguides	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from UnitedHealthcare Community Vision Network/March Vision Network: Attend a training session at eyesynergy.com. Our portal gives you 24/7 access to eligibility, benefit, claim, and lab order information.
Website for District of Columbia Community Plan	**UHCprovider.com/DCcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	UHCprovider.com	1-888-350-5608
General provider assistance		1-877-842-3210
Eligibility	UHCprovider.com/eligibility	1-888-350-5608
Referrals	UHCprovider.com/referrals	1-888-350-5608
Provider Directory	UHCprovider.com/findprovider	1-888-350-5608

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll an enrollee or discriminate against them based on age, sex, race, physical or behavioral handicap, national origin, religion, type of illness or condition. You may only direct the enrollee to another care provider type if that illness or condition may be better treated by someone else.

The company complies with applicable Federal and State civil rights laws and does not discriminate, exclude people, or treat them different on the basis of any of the following: Race or Ancestry, Color, Creed, Religion, Age, National origin, Language, Marital status, sex (including orienttion and gender identity), Medical Condition or Disability (including physical or behavioral impairment), Pregnancy, Family Responsibilities, Source of Income, Place of Residence, Political Affiliation, Personal Appearance.

Communication between care providers and enrollees

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

UnitedHealthcare Community Plan enrollees and/or their representative(s) may take part in the planning and implementation of their care. To help ensure enrollees and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate enrollees, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize enrollees (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for enrollees enrolled in high-risk care management.

Provide official notice

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

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

Visit the **UHCprovider.co/attestation** to view ways to update and verify your provider demographic data or to update NPI information for care providers in your office.

Transition enrollee care following termination of your participation

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

Arrange substitute coverage

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

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a care provider

See **UHCprovider.co/attestation** to view ways to update and verify your provider demographic data. Attach demographic data and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > Form W-9
- To update your care provider information online, go to the Provider Portal at **UHCprovider.com** > Sign In My Practice Profile

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

Updating your practice or facility information

You can update your practice information through the Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data
- Calling our Enterprise Voice Portal at **1-888-350-5608**

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is

appropriate for infections, fever, and symptoms of cold or flu.

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

Participate in quality initiatives

Thank you for your help in our quality assessment and improvement activities. The quality metrics we cover annually help increase member satisfaction, improve the health outcomes of our populations, and reduce cost burden for our members (supports the triple aim approach). You must follow our clinical guidelines, enrollee safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by government agencies and professional specialty societies and can change from year to year. Your participation is vital to develop systems interventions to address underlying factors of disparate utilization, health-related behaviors, and health outcomes.

Provide access to your records

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

Performance data

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

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

You may view protocols at **UHCprovider.com**.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan enrollees as those offered to commercial enrollees.

Protect confidentiality of enrollee data

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

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

Follow medical record standards

Please reference Chapter 9 for Medical Record Standards.

Inform enrollees of advance directives

The federal Patient Self-Determination Act (PSDA)

gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to enrollees on District laws about advance treatment directives, enrollees' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform enrollees of District laws on advance directives through enrollee documents and other communications.

Your Agreement

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

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

If an enrollee asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the enrollee's benefit contract. For enrollee information, go to **UHCCommunityPlan.com/dc**.

Also reference Chapter 12 of this manual for information on health care ptofessional claim reconsiderations, and appeals.

Critical incidents: adverse events, serious reportable incidents and reportable incidents

All care providers must report all incidents and clinical quality of care issues to the enrollee's case manager or UnitedHealthcare's Quality Intervention Services department. To do so, complete the DC LTSS Critical Incident Report Form and email it to **critical_incidents@uhc.com**. All incidents must be reported within 24 hours or next business day of occurrence (or discovery). In addition, report all serious reportable incidents (SRIs) to The District through the D.C. Care Connect (DCCC) portal (if you have access). See the DC-LTSS Critical Incident Report Form at **UHCprovider.com/DCcommunityplan > Other Resources**.

All enrollees can experience critical incidents. Critical Incidents fall into any of these 3 categories:

- **SRI** -- A severe event or situation that requires immediate response, notification to, and internal review and investigation by the care provider. SRIs include, but are not limited to:
  - Death
  - Abuse, neglect, or exploitation
  - Theft of consumer personal property
  - Serious physical injury
  - Inappropriate or unauthorized use of restraints
  - Suicide attempt
  - Serious medication error
  - Serious fire incidents that could have resulted in serious bodily harm or death
- **Adverse event (AE) --** An event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient. AEs can occur in health care facilitates in our provider network or through health care delivered through your program. To further align with the District of Columbia's Patient Safety Reporting Program, we report any AEs within certain categories. These categories are defined by the National Quality Forum and are found at qualityforum.org/Topics/SREs/List_of_SREs.aspx.

Adverse events include the following:

- Surgical or invasive procedure events:
  - Surgery or other invasive procedure performed on the wrong side
  - Surgery or other invasive procedure performed on the wrong patient
  - Wrong surgical or other invasive procedure performed on a patient
  - Unintended retention of a foreign object in a patient after surgery or other invasive

procedure
  - Intraoperative or immediately postoperative/postprocedural death in an American Society of Anesthesiologists (ASA) class 1 patient
- Product or device events:
  - Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting
  - Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended
  - Patient death or serious injury associated with intravascular air embolism what occurs while being cared for in a health care setting
- Patient protection events:
  - Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
  - Patient death or serious injury associated with patient elopement (disappearance)
  - Patient suicide, attempted suicide, or self-harm that results in serious injury, while being care for in health care setting
- Care management events:
  - Patient death or serious injury associated with a medication error (i.e. errors involved the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, wrong route of administration)
  - Patient death or serious injury associated with unsafe administration of blood products
  - Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
  - Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
  - Patient death or serious injury associated with a fall while being care for in a health care setting
  - Any stage 3, stage 4 and unstageable pressure ulcers acquired after admission/presentation to health care setting
  - Artificial insemination with the wrong donor sperm or wrong egg
  - Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
  - Patient death or serious injury resulting from failure to follow up or communicate lab pathology or radiology test results
  - Any other reportable or serious reportable incidents as described in the District's approved EPD waiver and required for reporting under the EPD waiver program
- Environmental events:
  - Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a health care setting
  - Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
  - Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting
  - Patient death or serious injury associated with the use of physical restrains or bedrails while being care for in health care setting
- Potential criminal events:
  - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider
  - Abduction of a patient/resident of any age
  - Sexual abuse/assault on a patient or staff enrollee within or on the grounds of a health care setting
  - Death or serious injury of a patient or staff enrollee resulting from a physical assault that occurs within or on the grounds of a healthcare setting

- **Reportable incident (RI) --** A significant event or situation involving a participant. It must be reported to UnitedHealthcare and investigated by the provider. RIs include:
  - Medication error
  - Missing person
  - Hospitalization
  - Suicide threat
  - Vehicle accident
  - Fire or police involvement

  - ER visit
  - Emergency relocation
  - Property destruction
  - Other events or situations that involve harm or risk of harm to a participant/enrollee

You must cooperate fully in the investigation of reported AEs, SRIs and RIs including submitting all requested documentation. Events are reviewed by the chief medical officer and our Provider Advisory Committee. Based on how severe the incident is, any identified trend or failure on the part of the care provider to cooperate with the investigation requires them to submit a written plan of correction to address/correct any problem or deficiency. Not submitting a written plan of corrections within the time frame requested as well as having subsequent problems with critical incident reporting, investigations or cooperation will result in further actions. Call our Quality Intervention Services (QIS) Department with any questions at **1-800-391-3991**.

UnitedHealthcare Community Plan has policies and procedures for documenting, reporting, investigating and addressing adverse events and serious reportable events and reportable events for EPD waiver enrollees. Find policies at **UHCprovider.com.**

Healthcare-acquired conditions and never events

Consistent with the Affordable Care Act administered through CMS, we will implement the requirements related to the provider preventable conditions initiative. This includes:

- Adjustment of reimbursement for health care-acquired conditions (HCAC)
- Present on admission (POA) indicator requirement
- No reimbursement for never events
- Other provider preventable conditions (OPPC) as defined by any additional District regulations that expand or further define the CMS regulations. Find the policies at **UHCprovider.com**.
- HCACs identified in the Section 2702 of the Patient Protection and Affordable Care Act of 2010, when any of the following conditions are not present upon admission in any inpatient setting but acquired in that setting:
  - Foreign object retained after surgery
  - Air embolism
  - Blood incompatibility
  - Catheter associated urinary tract infection
  - Pressure ulcers (decubitus ulcers)
  - Vascular catheter associated infection
  - Mediastinitis after coronary artery bypass graft (CABG)
  - Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
  - Manifestations of poor glycemic control
  - Surgical site infection following certain orthopedic procedures
  - Surgical site infection following bariatric surgery for obesity
  - Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures
- **Never events in any inpatient or outpatient setting, including:**
  - Surgery performed on the wrong body part
  - Surgery performed on the wrong patient
  - Wrong surgical procedure performed on a patient
- **Provider preventable conditions:**
  - Conditions identified in the state plan
  - Conditions found by the state, based on a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines
  - Conditions that have a negative consequence for the beneficiary
  - Condition includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient

We have built both inpatient and outpatient edits on claims that captures HCACs and never events. Our operations and clinical teams then perform retrospective claims audits and report our findings

at our quarterly operational committee known as Service and Quality Improvement Subcommittee (SQIS).

Appointment standards (The District's access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- New enrollee appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed 1 hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for routine appointments within 30 working days of request/referral.

Behavioral health care

- Urgent care: 24 hours a day, 7 days a week
- Routine appointments for diagnoses and treatment of nonurgent health conditions and routine/well-health assessments: within 30 days of request
- Psychiatric crises:
  - Phone-based assessments: within 15 minutes of request
  - Medically necessary face-to-face visits: within 90 minutes

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within 7 calendar days of request
- Third trimester: within 3 days of request
- High-risk: within 3 calendar days of identification of high risk

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

Other standards of care

- Enrollees can directly contact a qualified clinical staff person via our Nurseline: **1-877-303-2422**, available 24 hours a day, 7 days a week
- Home health agency services: return enrollee calls within 72 hours

Provider Directory

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

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

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

Provider Directory after 10 business days.

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

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

To help ensure we have your most current Provider Directory information, submit applicable changes to:

Delegated care providers, submit changes to your designated submission pathway.

Nondelegated care providers, visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

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

Provider data attestation

Confirm your provider data every quarter through the Provider Portal at **UHCprovider.com/attestation**, then Sign In or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access the Provider Portal for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses an enrolle can make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

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

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

Identify and bill other insurance carriers when appropriate.

If you have questions, please call the UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m.-9 p.m. CT, Monday-Friday.

Timeliness standards for notifying enrollees of test results

After receiving results, notify enrollees within:

- **Urgent:** 24 hours
- **Nonurgent:** 10 business days

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

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and enrollees may seek services from

any participating care provider. We encourage enrollees 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 enrollee a "medical home."

The PCP plays a vital role as a care manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to enrollees, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our enrollees. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

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

NPs may enroll with the District as solo providers, but PAs cannot. PAs must be part of a group practice.

Enrollees may change their assigned PCP by contacting Enrollee Services at any time during the month.

We ask enrollees who don't select a PCP during enrollment to select one. UnitedHealthcare

for UnitedHealthcare Community Plan enrollees with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying enrollees who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Coordinate each UnitedHealthcare Community Plan enrollee's overall course of care
- Accept UnitedHealthcare Community Plan enrollees at your primary office location at least 20 hours a week for a 1 MD practice and at least

Primary care provider checklist

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

Community Plan may auto-assign a PCP to complete the enrollment process.

Women have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any nonwomen'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 enrollees and care providers to help ensure all enrollees understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week.
During nonoffice hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services. **Recorded messages are not acceptable.**

Consult with other appropriate care providers to develop individualized treatment plans for

30 hours per week for a 2 or more MD practice
- Be available to enrollees by telephone any time
- Tell enrollees about appropriate use of emergency services
- Discuss available treatment options with enrollees

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

Specialists include internal medicine, pediatrics, and/or obstetrician/ gynecology

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan enrollee's first appointment
- Treat UnitedHealthcare Community Plan enrollees' general health care needs. Use nationally recognized clinical practice guidelines
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan enrollees to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect enrollees' advance directives. Document in a prominent place in the medical record whether an enrollee has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and based on UnitedHealthcare Community Plan standards. Document procedures for monitoring enrollees' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to enrollees upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan enrollee medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the District's Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Federally Qualified Health Center or Primary Care Clinic

Enrollees may choose a health care provider who meets the PCP requirements and performs PCP-type services within a federally qualified health center (FQHC) or primary care clinic (PCC) as their PCP.

- **FQHC --** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker
  - Behavioral health services
  - Immunizations (shots)
  - Home nurse visits
  - Dental services
- **PCC --** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the enrollee to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan enrollees recommended by their PCP or who self-refer
- Verify the eligibility of the enrollee before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the enrollee's medical record. Share this information in writing with the PCP
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by the District and local laws
- Comply with the District's 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 enrollees by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care provider responsibilities

Ancillary providers include:

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

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

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

Ancillary care provider checklist

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

Chapter 3: Care provider office procedures and enrollee benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityplan.com/DC**	**1-866-242-7726**
Member handbook	**UHCprovider.com**	**1-888-350-5608**
Prior authorization	**UHCprovider.com/paan**	**1-888-350-5608**
D-SNP	**UHCprovider.com/DC** > Medicare > **District of Columbia Dual Complete® Special Needs Plans**	**1-888-350-5608**

Benefits

Medicaid

Go to **UHCCommunityplan.com/DC** or **UHCprovider.com/eligibility** for more information.

Dual-eligible benefits

UnitedHealthcare Dual Complete (D-SNP) is a Medicare Advantage plan for enrollees who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For District of Columbia-specific D-SNP information, go to **UHCprovider.com/health-plans-by-state/DC/medicare-plans/dual-complete-snp-plans.html**

Choosing a PCP

Each enrolled UnitedHealthcare Community Plan enrollee either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new enrollees. UnitedHealthcare Community Plan will assign enrollees to the closest and appropriate PCP.

Depending on the enrollee's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the enrollee changes the initial PCP assignment, the change will be effective on the 1st of the next month the enrollee requested the change. If an enrollee asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the 1st of the next month after the change is requested.

Deductibles/copayments

Beneficiaries in the program qualify for Medicaid to pay the cost-sharing for Medicare Part A and Part B deductibles and coinsurance for Medicaid covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate 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, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the enrollee's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction

These service are considered as clinically appropriate used evidence based guidelines or clinical review criteria for the covered medical issue and there is no other equally effective, more conservative or substantially less costly treatment available to the enrollee. We don't consider experimental treatments medically necessary

Enrollee assignment

Assignment to UnitedHealthcare Community Plan

Enrollees are assigned to Medicaid based on the D-SNP election into UnitedHealthcare. We manage the enrollee's care on the date the enrollee is enrolled until the enrollee is disenrolled from Medicaid UnitedHealthcare Community Plan. The District makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end.

At enrollment time, each enrollee receives a welcome letter that includes information on finding a copy of the UnitedHealthcare Community Plan Evidence of Coverage, Summary of Benefits and Enrollee Handbook. The documents explain the enrollee's health care rights and responsibilities through UnitedHealthcare Community Plan.

For enrollee information, go to **UHCCommunityPlan.com/DC**.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for enrollees may change from Fee for Service (FFS) to Medicaid Managed Care during hospitalization.

Get eligibility information by calling Provider Services.

Primary care provider selection

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

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

Enrollee eligibility

UnitedHealthcare Community Plan serves enrollees enrolled with the District's the Medicaid program. The District determines program eligibility. An individual who becomes eligible for the District's program chooses one of the District's contracted health plans.

Enrollee ID card

Check the enrollee's ID card at each visit and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

If a fraud, waste and abuse event arises from a care provider or an enrollee, go to **uhc.com/fraud** to report it. Or you may call the Fraud, Waste and Abuse hotline.

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

Enrollee identification numbers

Each enrollee receives a 9-digit UnitedHealthcare Community Plan enrollee identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/enrollee. The District's Medicaid Number is also on the enrollee ID card.

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Primary care provider initiated transfers

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

1. To transfer the enrollee, call the Enrollee Services number on the back of the enrollee's card, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, enrollee name, date of birth, Medicaid number, current address, current phone number and the care provider's name.
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the enrollee and resolve the issue to develop a satisfactory PCP-enrollee relationship.
3. If the enrollee and UnitedHealthcare Community Plan cannot resolve the PCP enrollee issue, we work with the enrollee to find another PCP. We refer the enrollee to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the enrollee by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the enrollee with the new PCP information.

Verifying enrollee enrollment

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

- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- Provider Services is available from 8 a.m.-6 p.m. ET, Monday through Friday

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCCommunityplan.com/DC**	**1-866-242-7726**
Prior authorization	**UHCprovider.com/paan**	**1-888-350-5608**
Pharmacy	**UHCprovider.com/pharmacy**	**1-888-350-5608**
Dental	**dbp.com**	**Medicaid:** **1-866-321-2789** **D-SNP:** **1-844-275-8750**

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

Ambulance services

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health.
- Impairment to bodily functions.
- Dysfunction of a bodily organ or part.

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

Bill ambulance transport as a nonemergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled runs and transports to nursing facilities or the enrollee's residence.

Nonemergent ambulance transportation

UnitedHealthcare Community Plan enrollees may get nonemergent stretcher/ambulance transportation services through ModivCare for covered services. Enrollees may get transportation when they are bed-confined before, during and after transport.

Nonemergent stretcher/ambulance transportation must be requested at least 3 business days in advance. Go to modivcare.com or call 1-866-475-5886.

Schedule nonemergent ambulance or stretcher rides up to 30 days in advance. Nonemergent stretcher/ambulance requests are accepted from 8 a.m.- 8 p.m.

Nonemergency medical transportation

Nonemergency medical transportation (NEMT) services are arranged by the vendors ModivCare or Saferide depending on the enrollees plan benefits. Transportation is provided by taxi, van, bus or public transit, depending on an enrollee's medical needs. Wheelchair service is provided if required by medical necessity.

Enrollees that are enrolled in UHC Dual Choice DC-Q0001 receive their NEMT transportation through SafeRide. Enrollee's are eligible for 36 one way trips and can schedule their trips by calling Enrollee Services at **1-866-242-7726**. NEMT requests are accepted Monday - Sunday from 8:00 a.m.- 8:00 p.m. ET.

Enrollees that are enrolled in UHC Dual Choice DC-S001 or UHC Dual Choice DC-Y001 receive their NEMT transportation through ModivCare. Enrollees are eligible for unlimited trips and can schedule their trips by calling Enrollees Services at **1-866-242-7726**, Monday - Sunday from 8:00 a.m.- 8:00 p.m. ET.

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Stress echocardiograms

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the enrollee for claims we deny for this reason.

Request prior authorization online or by phone.

- Online: **UHCprovider.com/cardiology**
- Phone: **1-866-889-8054** Monday through Friday from 7 a.m. – 7 p.m., local time

Make sure the medical record is available.

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

Dental services

In-network credentialed dental care providers may provide routine dental services.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services.

Facility services require a prior authorization.

The following services are covered for enrollees 21 and over. However, some limitations may apply:

- Diagnostic
- X-rays
- Preventive
- Restorative
- Endodontics
- Periodontics
- Dentures/denture repair
- Oral surgery
- Prosthesis
- Implants

Standard ADA coding guidelines apply to all claims.

To find a dental care provider, go to **UHCprovider.com/findprovider**.

Durable medical equipment and supplies

Durable medical equipment (DME) is equipment and supplies that provides therapeutic benefits to an enrollee because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

719A Form

The 719A form is a prescription order form required document for the providers to obtain to support the DME Medicaid services provided to District Dual Choice enrollees. The care provider is required to ensure the form is maintained in the care provider

records to support the services provided to the enrollees and provided to support any prior authorization request for DME/POS services.

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

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

Emergency room care

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

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact Provider Services.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool in the Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call Provider Services.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.)

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

For policies and protocols, go to UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans**.

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

Family planning

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

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

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

Noncovered items include:

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

Parenting/child birth education programs

- Child birth education is not covered.
- High-risk prenatal education is covered.
- Lactation class is covered.

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the District's regulations for more information on sterilization.

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination services are provided to enrollees. This program is a proactive approach to help enrollees manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide enrollees with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of enrollees
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with care providers to improve enrollee outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes

- Support enrollee empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to enrollees that address topics that help enrollees manage their condition. Our program provides personalized support to enrollees in case management. The care manager collaborates with the enrollee to identify educational opportunities, provides the appropriate health education and monitors the enrollee's progress toward management of the condition targeted by the care coordination program.

Facility admission notification requirements

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

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

Hearing services

For enrollees in the UHC Dual Choice DC-Q001 plan their Monaural and binaural hearing aids are covered under the D-SNP Supplemental Benefit, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered.

For enrollees in UHC Dual Choice DC-S001 or UHC Dual Choice DC-Y001 plans, their Monaural and binaural hearing aids are covered under their Medicaid benefits, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered.

Hospice

Routine home care

UnitedHealthcare Community Plan covers benefits for routine home care every day the enrollee is at home, under hospice and not receiving continuous home care.

Continuous home care

We cover care provider hospice at the enrollee's home during a medical crisis. A medical crisis is when a enrollee requires continuous nursing care to manage symptoms.

General inpatient care

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

Respite hospice care

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the enrollee is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the enrollee when necessary to relieve the caregiver. It is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Laboratory

Labcorp is the preferred lab provider. Contact Labcorp directly.

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

For more information on our in-network labs, go to UHCprovider.com > Our Network > **Preferred Lab Network**.

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

See the Billing and submission chapter for more information.

Maternity/pregnancy

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of an enrollee's confirmed pregnancy to help ensure appropriate follow-up.

Access the digital Notification of Pregnancy form on the Provider Portal at **UHCprovider.com**.

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan enrollee for 3 or more consecutive months or had 7 or more prenatal visits.

Medicaid and Medicare do not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk enrollees. High-risk enrollee claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-888-350-5608** or go to or go to **UHCprovider.com/paan**. For more information about prior authorization requirements, go to UHCprovider.com/DCcommunityplan > **Prior Authorization and Notification**.

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

1. The woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan enrollee, and
2. If she has an established relationship with a nonparticipating obstetrician.

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

A UnitedHealthcare Community Plan enrollee does not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan enrollees when medically necessary.

Maternity admissions

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

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

Provide the following information within 1 business day of the admission:

- Date of admission
- Enrollee's name and Medicaid ID number
- Obstetrician's name, phone number, care provider ID
- Facility name (provider ID)
- Vaginal or Caesarean delivery

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

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

Any care delivered by a midwife must be from a midwife (CNM) who is a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

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

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

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

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the enrollee's discharge date. Prior authorization is required for home health care visits for postpartum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Home care and all prior authorization services

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

Hysterectomies

Hysterectomies cannot be reimbursed if performed for sterilization. Enrollees who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The enrollee should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.

Find the form on the District's website at dhcf.dc.gov/page/medicaid-mco-programs

See "Sterilization consent form" section for more information.

Exception: The District does not require informed consent if:

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

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the enrollee's 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.

Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the woman's life. In this case, follow the District's consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the enrollee's PCP. Enrollees must use the UnitedHealthcare Community Plan provider network.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the enrollee's documented request. This policy helps ensure UnitedHealthcare Community Plan enrollees thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the District Medicaid Program must have documented evidence that all the sterilization requirements have been met before making a payment. The enrollee must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. Find the form at dc-medicaid.com/dcwebportal/providerSpecificInformation/providerInformation.

The enrollee must not be mentally incompetent or live in a facility treating behavioral disorders. The enrollee may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

An enrollee has only given informed consent if the District Medicaid Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the enrollee fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the enrollee is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The D.C. Medicaid Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed prior to the procedure, along with your signature and the date. This may be the same date of the sterilization or a date prior. If you sign and date the consent form before performing the sterilization, the form expires 180 days from the date of signatures.
- The District's definition of "shortly before" is not more than 30 days before the procedure but more than 72 hours after date of signature. Explain the procedure to the enrollee within that time frame.

You may also find the form on the District's website dc-medicaid.com/dcwebportal/providerSpecificInformation/providerInformation

Have 3 copies of the consent form:

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

Pharmacy

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its list of covered medications. This list applies to all UnitedHealthcare Community Plan of District of Columbia enrollees.

We cover drugs listed on our Formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or network mail order pharmacy service, and other coverage rules are followed. We have additional coverage requirements or limits for certain prescription drugs.

If an enrollee requires a nonFormulary medication, call Pharmacy Prior Authorization at **1-800-711-4555** or use the online Prior Authorization and Notification tool in the **Provider Portal**.

Pharmacy prior authorization

The rules apply to drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-711-4555**. We review expedited requests within 24 hours and standard requests within 72 hours

Specialty pharmacy medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

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

- Positron emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the enrollee for claims we deny for this reason.

Request prior authorization online or by phone at:

- Online: **UHCprovider.com/Radiology**
- Phone: **1-866-889-8054** from 7 a.m. – 7 p.m., local time, Monday through Friday. Make sure the medical record is available.

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

Screening, brief interventions, and referral to treatment services

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

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

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

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

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

Referral to treatment: Refer enrollees whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the alcohol and drug program at the Department of Behavioral Health (DBH).**

SBIRT services will be covered when all are met:

- The billing and servicing providers are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per care provider, per year

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

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

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

Medication-assisted treatment

Medication-assisted treatment (MOUD/MAUD) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (FDA)-approved medications for OUD include Buprenorphine, Methadone, and Naltrexone.

If you need help finding a behavioral care provider, call the number on the back of the enrollee's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MOUD/MAUD care provider in the District of Columbia:

1. Go to **UHCprovider.com.**
2. Select "Our Network," then "Find a Provider".
3. Search and select the care provider information.
4. Click on "Medical Directory".
5. Click on "Medicaid Plans.
6. Click on applicable state.
7. Select applicable plan.
8. Refine the search by selecting "Medication Assisted Treatment".

If you have questions about MAT, please call Provider Services at **1-888-350-5608 a**nd enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Tuberculosis screening and treatment; direct observation therapy

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

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all enrollees at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of enrollees. PCPs must comply with all applicable District laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

Vision services are covered by UnitedHealthcare Community Vision Network / March Vision Network. Please see the Reference Guide at marchvisioncare.com for information such as compliance, electronic payment information, safety resources and training or call **1-844-366-2724**.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorization requests must have the following:

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

For behavioral health and substance use disorder authorizations, please call Enrollee Services at **1-866-242-7726**.

If you have questions, go to UHCprovider.com/DCcommunityplan > **Prior Authorization and Notification**.

Type of request	Decision TAT	Extension	Care provider authorization decision notification
Nonurgent pre-service	14 calendar days of receipt	14 calendar days	Communicated orally or in writing to the care provider who requested the authorization within 24 hours of the decision
Urgent/expedited pre-service	72 hours of receipt	14 calendar days	Communicated orally or in writing to the care provider who requested the authorization within 24 hours of the decision
Concurrent review	72 hours of receipt	N/A	Communicated orally or in writing to the care provider who requested the authorization within 24 hours of the decision
Retrospective review	14 calendar days	14 calendar days	Communicated orally or in writing to the care provider who requested the authorization within 24 hours of the decision

An extension may apply if either:

- You or the enrollee requests an extension
- We need more information and can show the District the extension is in the enrollee's interest

Concurrent review guidelines

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

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

Concurrent review details

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

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

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to

engage our enrollees directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses InterQual, (We previously used 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, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate 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, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the enrollee's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the enrollee

These service are considered as clinically appropriate used evidence based guidelines or clinical review criteria for the covered medical issue and there is no other equally effective, more conservative or substantially less costly treatment available to the enrollee. We don't consider experimental treatments medically necessary

Determination process

Benefit coverage for health services is determined by the enrollee specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely communicate with enrollees about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at **UHCprovider.com/policies** > **For Community Plans**.

Referral guidelines

You must coordinate enrollee referrals for medically necessary services beyond the scope of your practice. Monitor the referred enrollee's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

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

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered

services. You should:

- Determine if the enrollee is eligible on the date of service by using the Provider Portal on **UHCprovider.com** then Sign In, contacting UnitedHealthcare Community Plan's Provider Services Department, or the D.C. Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the enrollee has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Noncovered services
- Services provided to enrollees not enrolled on the date(s) of service

Second opinion benefit

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

Criteria:

- The enrollee's PCP refers the enrollee to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion one before the appointment. The care provider giving the second opinion will then forward their report to the enrollee's PCP and treating care provider, if different. The enrollee may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should call Enrollee Services at District of Columbia at **1-866-242-7726**.
- Once the second opinion has been given, the enrollee and the PCP discuss information from both evaluations
- If follow-up care is recommended, the enrollee meets with the PCP before receiving treatment

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 or care provider from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care
  - Intermediate care facility (ICF) services or Medicaid Waiver services for individuals with intellectual or developmental disabilities (IDD) who meet the ICF level of care
- Behavioral health and substance use care. This service is covered by the District Department of Behavioral Health
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Ambulances, unless medically necessary
- Infertility services

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/DCcommunityplan > **Prior Authorization and Notification**.

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** 1 business day.
- **Inpatient Admissions; After Ambulatory Surgery:** 1 business day.
- **Nonemergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time.

Utilization management guidelines

Call **1-888-350-5608** to discuss the guidelines and utilization management.

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

Utilization management appeals

Utilization management (UM) appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, other health care services determination or prior authorizations. They do not include benefit appeals, which are appeals for noncovered services. Any enrollee, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

See Appeals in Chapter 12 for more details.

Chapter 5: Long-term services and supports

Long-term care services and supports (LTSS) are a variety of health and social services that offer care for elders and people with disabilities who need support because of their age, physical, behavioral, growing, or long-lasting health conditions that limit their abilities to care for themselves. LTSS is provided in the home, a community-based setting, or in a facility. Daily living activities include eating, bathing, grooming, dressing, walking, toileting, getting up/down from a seated position, preparing meals, and help with telephone use.

Find more about LTSS benefits on **UHCCommunityPlan.com/DC**.

LTSS include:

- Home health services
- Personal care aide services (PCA)
- Private duty nursing services (PDN)
- Personal emergency response system (PERS)
- Nursing facility
- Elderly and Persons with Physical Disabilities (EPD) waiver program
- Adult day health program

Nursing facility

Nursing facility benefits:

- Nursing facility services (Custodial)
- Nursing facility add-on services:
  - Ventilator services
  - Behaviorally complex special needs
  - Bariatric special needs

Nursing facility role and responsibilities

Nursing facilities provide overall care for all enrollees including, but not limited to, the following: room and board, interdisciplinary healthcare needs, and access to hospice services. The following are additional responsibilities:

- Participate with our care management and service coordination efforts on behalf of the enrollee
- Coordinate care with the enrollee's assigned PCP
- Observe necessary notifications to us, including admission and change in enrollee status and/or condition
- Email the 1445 files to UnitedHealthcare Community Plan at **dc_snf_per@optum.com**. Any claims submitted for custodial enrollees are subject to denial if a 1445 form is not on file.

Elderly and Persons Disability waiver program

The Elderly and Persons with Physical Disabilities (EPD) waiver program is authorized under the HCBS waiver program in §1915(c) of the Social Security Act. The EPD waiver program provides services to the enrollees who would otherwise qualify for nursing facility care.

These enrollees are referred to the District to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the enrollee unless/until the enrollee is disenrolled from the Medicaid program.

District of Columbia Dual Choice program enrollees will receive the same benefits as all other District Dual Choice enrollees. For a complete listing of benefits, refer to Chapter 4, Medical Management in this manual. Additionally, the following waiver benefits are available to enrollees who qualify for EPD Waiver enrollment when the services are determined necessary and approved:

- **Adult Day Health Service** -- Adult day health offers a range of therapeutic, rehabilitative and support services, including nursing and rehabilitation services, assistance with life activities, social work services, dietary services and transportation provided for portions of the day during the weekdays. The services are designed to encourage older adults and individuals with physical disabilities to live in the community by offering nonresidential medical

supports and supervised, therapeutic activities in an integrated setting.

- **Assisted living facilities (ALF)** -- An ALF is a licensed facility where participants can live, have access to and receive the services they need to be as independent as possible.
- **Case management services** -- Case management is the coordination of services on behalf of the participant. Case management is a shared process of conducting assessments, planning, counseling and advocating for options and services to meet the participant's and family's total health and social care needs.
- **Chore aide services** - Chore aide services are heavy-duty housecleaning activities that are time-limited and allow for the participant's environment to be made clean and safe in a manner that can be maintained by regular housekeeping.
- **Community transition services** - Community transition services are available for enrollees who are transitioning from an institution or other long-term care facility to a more integrated, community-based setting. Community transition services include nonrepeating household setup expenses that are needed to allow an individual to establish a basic household. Community transition funds must be identified in the person-centered plan, be prior authorized, and not exceed 120 days before discharge and up to 6 months after discharge from an institution or long-term care facility.
- **Environmental accessibility adaptation services (EAA)** - EAA services allow for the physical adaptations (such as ramps, stair-lifts, and grab bars) necessary to help ensure the health, safety and wellness of the enrollee's home.
- **Homemaker services** -- Homemaker services provide general household activities such as meal preparation, housekeeping and running errands. Homemakers do not provide any hands-on personal care. Allowable services include grocery shopping, meal preparation, limited general housecleaning, providing escort services (not transportation) for medical appointments, and running care-related errands such as picking up medication or mailing utility payments.
- **Participant-directed services (Services My Way)** - Services My Way program allows enrollees who live in their natural home the ability to have more choice and control of their Medicaid long term care services. Enrollees have the following two services:
  1. Participant-Directed Community Supports.
  2. Individual-Directed Goods and Services are services, equipment or supplies not otherwise provided through the EPD Waiver or state plan programs. The requested goods or services MUST address an identified need in the enrollee's Person-Centered Service Plan and meet the following requirements:
     - Decrease the need for other Medicaid services; and/or
     - Promote inclusion in the community; and/or
     - Increase the Waiver enrollee's safety in the home environment.
- **Personal care aide services (PCA)** - PCA services are hands-on care such as assistance with bathing, grooming, dressing, walking, toileting, eating, and medication reminders.
- **Respite services** - Respite services allow temporary relief to a primary caregiver by providing temporary PCA services (ADLs) in his/her absence. Respite is provided in the environment where the participant receives care.

Adult Day Health Program

Adult Day Health Program is designed to encourage older adults to live in the community by offering nonresidential medical supports and supervised, therapeutic activities in an integrated community setting; Foster opportunities for community inclusion; and deter more costly facility-based care.

District of Columbia Dual Choice program enrollees will receive the same benefits as all other District Dual Choice enrollees. For a complete listing of benefits, refer to Chapter 4, Medical Management in this manual. Additionally, the enrollees are eligible for Adult Day Health Services when the services are determined necessary and approved.

Electronic visit verification system

Electronic Visit Verification system (EVV) is a

system that electronically captures details of home visits and services provided by caregivers while ensuring enrollees are receiving the support they require, and the rendered services are billed accurately.

Benefits of an electronic visit verification system

It captures individual caregiver's activity (i.e., check-in, check-out and service performed), which reduces the likelihood for error or fraud. It increases efficiency because reporting is automated and claims submission is cleaner. It improves quality of care by making workers' activities transparent and measurable. It provides more visibility on an enrollee's current health status by using tracking and support.

Do I have to use electronic visit verification?

Yes, all Medicaid-enrolled service care providers who provide in-home assistance through a personal care assistant or skilled/certified care, are required to use EVV to track the time in the enrollee's home. If you do not use this system, claims submitted outside of this system will be denied.

Find more information on the District web portal at dc-medicaid.com > Provider Hotlink > Electronic Visit Verification-EVV.

Credentialing for Home and Community-Based Services

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

Participation in the Long-Term Services & Supports (LTSS) Provider Network requires satisfaction of application and credentialing/verification requirements. We credential Home and Community-Based Services (HCBS) care providers by verifying licensure and/or certification. We check for compliance with policies and procedures identified during credentialing, including, critical incident reporting and management, use of the EVV, and compliance with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5)

To request participation and credentialing for LTSS care providers, please email UnitedHealthcare Community Plan at **hcbsprovidernetwork@uhc.com**

Onsite assessments visits are required for assisted living facility providers.

Long-term care provider visits

Provider advocates provide direct support to long term care providers as needed to support questions or training needs.

Prior authorization for Long-Term Services and Supports/ Home and Community-Based Services

The authorization process begins when a care manager assessing the enrollee's needs and working with the enrollee, family, and care providers creates a plan of care that specifies which services will be authorized to support their ongoing need(s). The care manager then arranges for the services by contacting the care provider and entering an authorization into our system.

Sometimes a plan of care may need to be adjusted during the year to accommodate a change in the enrollee's condition. A change in condition means a significant change in an enrollee's health, informal support or functional status that will not normally resolve itself without further intervention and requires review and revision to the current person-centered care plan. At that time a service may be added, changed, or deleted from the plan of care. The enrollee can initiate this by calling call care management at 1-855-409-7073.

Before providing services, please make sure the service(s) you provide are authorized.

Confirm that the authorization is for the correct enrollment and includes the correct billing codes with modifiers and units. Please also verify the enrollee's eligibility at the Provider Portal through **UHCprovider.com/eligibility** or by calling **1-888-350-5608**.

Compliance with Critical Incident & Adverse Event reporting

Every care provider must follow the Critical Incident & Adverse Event reporting and related requirements. You also must do criminal background checks on all employees who provide direct care to enrollees in our LTSS program.

Any of the following people may report critical incidents:

- Care provider
- Provider staff
- Case manager
- Enrollee representative
- UnitedHealthcare employee
- District agency representative

We require you to follow the mandatory training and reporting requirements listed in your LTSS Contract. Contracted LTSS care providers are required to report critical incidents to UnitedHealthcare Community Plan within 24 hours or the next business day of the incident and conduct an internal critical incident investigation and submit a report on the investigation to UnitedHealthcare Community Plan within 48 hours of the incident. Critical Incidents and Adverse Events should be reported by the care provider to **critical_incidents@uhc.com**. UnitedHealthcare Community Plan will review your report and follow-up with you as necessary to help ensure an appropriate investigation was conducted, and corrective actions were implemented within 30 calendar days of the incident.

For additional information about this process, please refer to Chapter 2.

Chapter 6: Behavioral health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-888-350-5608**
Provider Services	**UHCprovider.com**	**1-888-350-5608**

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

The National Optum Behavioral Health manual is located on **providerexpress.com**.

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

You must have an NPI number to see Medicaid enrollees and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the Department of Social Services website at dc-medicaid.com/dcwebportal/registration > go to the section titled "Apply to be a Medicaid Provider."

How to Join Our Network: Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Covered services

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

liveandworkwell.com, accessed through a link on **myuhc.com**, includes behavioral health and well-being information, articles on health conditions, addictions and coping, and provides an option for enrollees to take self-assessments on a variety of topics, read articles and locate community resources.

For enrollee resources, go to **providerexpress.com** > Clinical Resources > Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency. This page includes tools to help enrollees address behavioral health and substance use issues.

Benefits covered by UnitedHealthcare Community Plan include:

- Crisis stabilization services
- Inpatient psychiatric hospital
- Coordination of benefits and care with services authorized or covered by DBH
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours d 59 minutes in duration)

  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services

Benefits covered/funded by DBH include:

- Community-based interventions
- Multi-systemic therapy (MST)
- Assertive community treatment (ACT)
- Transitional assertive community treatment (TACT)
- Community support
- Recovery support services
- Vocational supported employment
- Clubhouse services
- Trauma Recovery Empowerment Model (TREM)
- Trauma systems therapy (TST)
- Functional family therapy (FFT)
- Outpatient Alcohol and Drug Use Treatment Rehabilitation services

Eligibility

Verify the UnitedHealthcare Community Plan enrollee's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application in the Provider Portal at **UHCprovider.com/eligibility**.

Authorizations

Enrollees may access all behavioral health outpatient services (behavioral health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial and inpatient care. Help ensure prior authorizations are in place before rendering nonemergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **1-888-350-5608**.

Collaboration with other care providers

Coordination of care

When an enrollee is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the enrollee:

- Is prescribed medication,
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition.

Please talk to your patients about the benefits of sharing essential clinical information.

Portal access

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at **1-888-350-5608** to verify eligibility and benefit information.

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at **1-888-350-5608**.

Claims

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

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

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

Increasing education and awareness of opioids

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

Access these resources at UHCprovider.com > Resources > **Drug Lists and Pharmacy**. Click “Opioid Programs and Resources - Community Plan” to find a list of tools and education.

Prescribing opioids

Go to **UHCprovider.com/pharmacy** to learn more about which opioids require prior authorization and if there are prescription limits.

Drug management program

Pharmacy lock-ins minimize drug use. Pharmacy lock-ins identify and manage enrollees who meet criteria indicative of potential prescription medication misuse or use, and specific therapeutic categories with the potential for high use, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central

nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, an enrollee is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Expanding medications for opioid use disorder / medications for alcohol use disorder access and capacity

Evidence-based medications for opioid use disorder / medications for alcohol use disorder (MOUD/MAUD) treatment is central to OUD treatment. MOUD/MAUD takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MOUD/MAUD access and help ensure we have an adequate enrollee MOUD/MAUD network.

To find a behavioral health MOUD/MAUD care provider in District of Columbia:

1. Go to **UHCprovider.com.**
2. Select “Our Network,” then “Find a Provider”.
3. Select under “Specialty Directory and Tools”. the option of Optum Behavioral Health, EAP, Worklife & Behavioral Health Services.
4. Click on “Search for a Behavioral Health Provider”
5. Enter “(city)” and “(state)” for options
6. If needed, refine the search by selecting “Medication Assisted Treatment”

To find medical MOUD/MAUD health care providers, see the MOUD/MAUD section in Chapter 4.

Chapter 7: Enrollee rights and responsibilities

Key contacts

Topic	Link	Phone number
Member services	UHCCommunityplan.com/DC	1-888-350-5608

Privacy regulations

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

Access to Protected Health Information

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

Amendment of Protected Health Information

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

Accounting of disclosures

Our enrollees have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To enrollees or pursuant to enrollee's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Enrollees have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, enrollees may request to restrict disclosures to family enrollees or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

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

Enrollee rights and responsibilities

For enrollee information, go to **UHCCommunityPlan.com/DC**.

Native American access to care

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

Enrollee rights

Enrollees have the right to:

- Request information on advance directives
- Be treated with respect and recognition of their dignity and right to privacy
- Receive courteous and prompt treatment
- Receive culturally competent assistance, including having an interpreter during appointments and procedures
- Receive information about the organization, its services, its practitioners and care providers and enrollee rights and responsibilities
- Know the qualifications of their health care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way UnitedHealthcare or our network providers or the state agency treat the enrollee
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Voice complaints or appeals about the organization or the care it provides
- Appeal any payment or benefit decision we make
- Request and receive a copy of his or her medical records, and request that they be amended or corrected
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Get a second opinion with an in-network care provider
- Participate with practitioners in making decisions about their health care
- Make recommendations regarding the organization's enrollee rights and responsibilities policy
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

UnitedHealthcare may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee who is his or her patient for the following:

1. The enrollee's health status, medical care or treatment options including any alternative care that may be self-administered.
2. Any information the enrollee needs to decide among all relevant treatment options.
3. The risks, benefits, and consequences of treatment or non-treatment.
4. The enrollee's right to participate in decisions regarding his or her health care including the right to refuse treatment and to express preferences about future treatment decisions.

Enrollee has the right to be furnished health care services in accordance with §§438.206 through 438.210. These standards cover access and availability of services, coordination of care, and authorization of services.

Enrollee responsibilities

Enrollees should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid enrollee ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- Give you and us information that could help improve their health

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

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Chapter 8: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality enrollee care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

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

Topic	Contact
Procedural elements	**Medical records are readable*** • Sign and date all entries • Enrollee name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the enrollee's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

***Critical element**

Topic	Contact
History	An initial history (for enrollees seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare enrollees for functional status assessment and pain
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 • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with medical and behavioral health care provider • Education, including lifestyle counseling, is documented • Enrollee input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

***Critical element**

Keeping medical records

An enrollee or their representative may request 1 free copy of their medical record from their provider once a year. Additional copies may be available at the enrollee's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and TB records required for lifetime).

Chapter 9: Quality management program/compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Chat with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat** Chiropractic: **myoptumhealthphysicalhealth.com**	**1-888-350-5608**
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-800-455-4521** (NAVEX)

What are the quality assessment and performance improvement programs?

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

The program consists of:

- Identifying the scope of care and services given, including long-term care and home and community based services
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our enrollees based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of enrollee health care and services
- Monitoring and enhancing patient safety
- Tracking enrollee and care provider satisfaction and taking actions as appropriate

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

The quality assessment and performance improvement (QAPI) program helps improve quality of health care and services with a review using established continuous quality improvement (CQI) principles.

We use our QAPI program to:

- Identify the type of care and services given
- Use clinical guidelines and service standards to monitor clinical performance
- Review the quality and appropriateness of services given to our enrollees
- Review the medical qualifications of participating care providers
- Continue to improve enrollee health care and services
- Improve patient safety and confidentiality of enrollee medical information
- Resolve identified quality issues

Annually, we publish an evaluation of our QAPI program. We use the findings of this evaluation to improve the program in the subsequent years.

Cooperation with quality-improvement activities

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

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

We require your cooperation and compliance to:

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

Care provider satisfaction

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

- Annual provider satisfaction surveys
- Regular visits
- Town hall meetings

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making - **UHCprovider.com/cpg.**

Credentialing standards

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

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)

- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral health clinicians (psychologists, clinical social workers, Masters prepared therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities, ancillary providers and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

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

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

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

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

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

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

Meet the credentialing and recredentialing standards to be eligible to enroll with the District's Medicaid program. As a condition of network participation, you must be enrolled with the District as a Medicaid provider.

Peer review

Credentialing process

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

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care providers performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes enrollee complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/ recredentialing application. This excludes personal or professional references or

peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application, Chat with a live advocate 7 a.m.–7 p.m. CT from the **UHCprovider.com/chat**.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Failure to meet recredentialing requirements

If you don't meet our recredentialing requirements, we will end your participation with our network. We will send you a written termination notice in compliance with applicable laws, regulations and other requirements.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

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

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If an enrollee has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the enrollee appeals process as outlined in Chapter 12 of this manual.

Health Insurance Portability Accountability Act compliance – your responsibilities

Health Insurance Portability Accountability Act (HIPAA) aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest

impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all care providers who conduct business electronically.

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet all the following basic security measures:

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

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

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

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

Compliance program

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

- Oversight of the Ethics and Integrity program
- Development and implementation of ethical standards and business conduct policies

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

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

Reporting and auditing

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

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

To report questionable incidents involving enrollees or care providers, call our Fraud, waste, and abuse line at **1-800-455-4521** or 1-877-401-9430 or go to **uhc.com/fraud.**

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

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the District of Columbia to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (District and federal funding) as well as District-funded programs, as requested by the District.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our enrollees. Records must be kept for at least 10 years from the close of the D.C. program agreement between the District and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the District any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The District may also

perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

You must cooperate with the District or any of its authorized representatives, the District, CMS, the Office of Inspector General, or any other agency prior-approved by the District, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

External Quality Review Organization

Each year, UnitedHealthcare Community Plan and the Department of Health Care Finance partner with a third-party entity called an External Quality Review Organization (EQRO). The EQRO conducts an annual review and ongoing activities to ensure that we maintain fiscally sound contracts, policies and procedures that are compliant with District and Federal laws and regulations. During the annual quality review, the EQRO also conducts off-site and on-site reviews and provide technical validation of our Performance Improvement Projects (PIPs).

The audits may include reviewing:

- Staff and enrollee interviews
- Medical record reviews (paper or electronic)
- Claims payment systems
- Care/case management software systems
- Customer relations system
- Quality policies and procedures
- Reports
- Committee activities
- Credentialing and re-credentialing activities
- Adverse benefit determinations
- Grievances and appeals activities
- Corrective action and follow-up plans
- Survey results
- Staff and provider qualifications.

In addition to findings from the EQRO's annual review and actvities, we incorporate performance data from a variety of other sources (i.e.HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, Medical management committee reports and minutes, customer service performance data, performance data submitted by the beneficiary support systems) into our annual Quality Assessment and Performance Improvement (QAPI) plan.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of service and care (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that enrollees receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam room(s) for providing enrollee care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record 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, we conduct a site visit according to UnitedHealthcare Community Plan policy.

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

Chapter 10: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-888-350-5608**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-866-633-4449**

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP on **UHCprovider.com/guides**.

Claims process from submission to payment

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

If you think we processed your claim incorrectly, please see the **Claims reconsiderations, appeals and grievances** chapter in this care provider manual for next steps.

National Provider Identifier

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

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

Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Enrollee ID card for billing

The enrollee ID card has both the UnitedHealthcare Community Plan enrollee ID and the District's Medicaid ID. UnitedHealthcare Community Plan prefers you bill with the enrollee ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

Form type setup for provider types can differ based on their contract with UnitedHealthcare Community Plan. Review your contract to determine which form to bill for services.

Clean claims and submission requirements

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

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

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

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

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the enrollees you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies**. Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

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

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

For more information, see EDI Claims.

Electronic data interchange companion documents

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

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

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

The companion documents are located on **UHCprovider.com/edi** > Go to companion guides

Clearinghouse and status reports

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

For clearinghouse options, use our EDI at UHCprovider.com > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options.**

e-Business support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

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

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

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for payment. You will have the option of signing up for Automated Clearing House (ACH)/ direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/ direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks. To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**.
- If your practice/healthcare organization is

already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.

- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

Completing the CMS 1500 claim form

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

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form. List the taxonomy code in box 19.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:

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

Capitated services

Capitation is a payment arrangement for care providers. If you have a capitation agreement with us, we pay you a set amount for each enrollee assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term "medical group/IPA" interchangeably with the term "capitated care providers." Capitation payment arrangements apply to participating physicians, clinicians, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for enrollees:

10. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such enrollee, and
11. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care provider may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated health care profefssionals are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when an enrollee is admitted to the hospital, they received ER treatment, observation, or other outpatient hospital services.

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

Form reminders

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

Subrogation and coordination of benefit

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

- **Subrogation --** We may recover benefits paid for a enrollee's treatment when a third party causes the injury or illness
- **COB --** We coordinate benefits based on the enrollee's benefit contract and applicable regulations

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

Hospital and clinic method of billing professional services

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

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com**/policies > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan.

Correct Coding Initiative

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

Comprehensive and component codes

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

- **Separate procedures:** Only report these codes when performed independently
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards:** Services part of a larger procedure are bundled
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately

Clinical laboratory improvements amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at **1-410-786-3531** or go to the cms.gov.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, nonexperimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the enrollee is a possible candidate.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state or District, and ZIP.

National drug code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

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

Provider Services

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

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

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

UnitedHealthcare Community Plan Provider Portal

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

The Provider Portal lets you move quickly between

applications. This helps you:

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

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

Find Provider Portal training at **UHCprovider.com/training**.

Provider Portal training course is available using the **Provider Portal User Guide**.

Resolving claim issues

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

Mail paper claims and adjustment requests to:

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

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

For paper claims

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

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

Timely filing

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

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

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

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

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

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

Timely filing limits can vary based on District requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

Do not balance bill enrollees if:

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

As noted previously, according to C.5.25.9.6.2, providers may not balance bill enrollees even if the enrollee has agreed to it. If you have questions,

please contact your provider advocate - chat with a live advocate 7 a.m.–7 p.m. CT **UHCprovider.com/contactus**.

Third-party resources

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

Enrollees in the District Dual Choice program have their Medicare and Medicaid services paid by UnitedHealthcare Community Plan. Providers are not required to submit any UnitedHealthcare Medicare EOB for the Medicaid payment.

Chapter 11: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on District and federal regulatory requirements and your provider Agreement. Nonnetwork care providers should refer to applicable appeals and grievances laws, regulations and District Medicaid contract requirements. For claims, billing and payment questions, go to **UHCprovider.com**. We no longer use fax numbers. Please use our online options or phone number. The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for fax or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care Provider Claim Correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270	**UHCproviders.com/claims**	**1-800-600-9007**	UWithin 335 days of initial receipt date to help ensure claims can be processed in accordance with timely filing. Claims must be fully processesed 365 days from the original receipt date	Must receive within 45 days	30 business days
Care Provider Claim Reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims.	Within 320 days of initial receipt date to help ensure claims can be processed in accordance with timely filing. Claims must be fully processed 365 days from the original receipt date.	45 business days
Care Provider Claim Formal Appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims.	60 calendar days from reconsideration determination. Claims must be processed within 365 days of initial receipt date.	30 calendar days
Member Appeal	A request to change an adverse benefit determination that we made	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-895- 2017,** TTY **711**		60 calendar days	Urgent - within 72 hours Standard - 30 calendar days
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-895- 2017,** TTY **711**		Grievance can be filed at any time.	30 calendar days

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

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Use the claims reconsideration application in the Provider Portal. To access the Provider Portal, sign in to **UHCprovider.com** using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

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

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

- Errors in enrollee demographic data – name, age, date of birth, sex or address
- Errors in provider data
- Wrong enrollee 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. To mail your resubmission, provide all claim information to:

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

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

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

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

For medical necessity denials --

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

How to use:

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

Electronically -- Use the Claim Reconsideration application in the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.

- **Phone:** Call Provider Services at **1-888-350-5608** or use the number on the back of the enrollee's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

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

  Available at **UHCprovider.com/claims**.

Tips for successful claims resolution

To help process claim reconsiderations:

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

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing may be required when the enrollee gives incorrect insurance information at the time of service. It includes:

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

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

How to use:

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

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

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

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

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

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

Where to send:

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

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

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

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

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

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

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/24	$279.34	$27.19	Contract states $50, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/24	$131.41	$99.81	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

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

- **Electronic claims --** Use the Provider Portal. Click Sign in on the top right corner of **UHCprovider.com/claims**. You may upload attachments.
- **Mail --** Send the appeal to:

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

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

Enrollee appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Enrollee appeals

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You, with an enrollee's written consent, or an enrollee may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services

- Fails to provide services in a timely manner, as defined by the District or CMS
- Doesn't act within the time frame CMS or the District requires

When to use:

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

We do not take punitive action against care providers who help enrollees file appeals.

Where to send:

You or the enrollee may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
PO Box 6103, MS CA124-0187
Cypress, CA 90630-0023

Phone: **1-800-587-5187** (TTY **711**)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the enrollee to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

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

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the enrollee's health
- Ask for continuation of services during the appeal. However, the enrollee may have to pay for the health service if it is continued or if the enrollee should not have received the service. As the care provider, you cannot ask for a continuation. Only the enrollee may do so.

We resolve a standard appeal 30 calendar days from the day we receive it. We resolve an expedited appeal 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

- Enrollee requests we take longer
- We request additional information and explain how the delay is in the enrollee's interest

A copy of the form is online at **UHCprovider.com**.

Second level of appeals

Second-level appeals are dependent on whether the benefit denial at least partially upheld through the first-level health plan appeal

Independent Review Entity

What is it?

The Independent Review Entity (IRE) is the second level of the Medicare appeals process. The IRE applies to Medicare-only benefits and those covered by both Medicare and Medicaid.

When is it used?

Regulations require that case files be automatically forwarded to the IRE as follows:

- UnitedHealthcare Community Plan fails to provide an appeal decision within the given time frame
- The appeal decision at least partially upholds the initial denial

How to use:

Enrollees don't need to do anything. Once the IRE receives the request, it sends an acknowledgement letter to the enrollee. The letter summarizes the review process. Once the IRE makes a decision, it notifies the enrollee and the health plan as well as any next steps available to the enrollee.

For additional Medicare/Medicaid benefit appeals, the health plan tells enrollees how to request a fair hearing.

Medicaid-only benefits: If a decision is at least partially upheld, the notification letter forwarded to the appellant explains how to request a fair hearing.

District fair hearings

What is it?

A District fair hearing lets enrollees share why they think D.C. Medicaid services should not have been denied, reduced or terminated.

When to use:

Enrollees have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan enrollee may ask for a District fair hearing by writing a letter to:

UnitedHealthcare Community Plan
655 New York Ave. NW
Washington, DC 20001

- The enrollee may ask UnitedHealthcare Community Plan Enrollee Services for help writing the letter
- The enrollee may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the District fair hearing outcome is to not deny, limit, or delay services while the enrollee is waiting on an appeal, then we provide the services:

- As quickly as the enrollee's health condition requires or
- No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal

If the District fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Independent Review Entity

If the IRE reverses the health plan's decision in whole or in part, the plan must authorize or provide the services or benefits as expeditiously as the enrollee's health condition requires. However, this must occur no later than the following time frames:

- Standard pre-service: Provide no later than 14 calendar days or authorize within 72 hours
- Expedited pre-service: Provide or authorize no later than 72 hours
- Payment: Provide no later than 30 calendar days

If the fair hearing decision and the IRE decision conflict, the decision in the best interest of the enrollee will prevail.

Enrollee grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider's or employee's rudeness.

Enrollees may also file an expedited grievance when:

1. A request for an expedited coverage decision or a request for an expedited appeal is lowered to the standard time frames.
2. We take an extension for a coverage determination or an appeal.

When to use:

You may act on the enrollee's behalf with their written consent. We do not take punitive action against care providers who help enrollees file grievances.

Where to send:

You or the enrollee may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
PO Box 6103, MS CA124-0187
Cypress, CA 90630-0023

Phone: **1-800-587-5187** (TTY **711**)

We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance or as quickly as the enrollee's health condition requires. We resolve expedited grievances within 24 hours of receipt.

Fraud, waste and abuse

Call the toll-free Fraud, waste, and abuse hotline at **1-800-455-4521** or 1-877-401-9430 to report questionable incidents involving plan enrollees or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan enrollees. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to District and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, enrollees, care providers, government programs and the public. In addition, it aims to protect enrollee health.

UnitedHealthcare Community Plan includes applicable federal and District regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize District and Federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its enrollees and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and District regulations around false claims at **UHCprovider.com/DCcommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and District fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

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

Exclusion checks

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

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)
- General Services Administration (GSA) System for Award Management > Data Access

What you need to do for exclusion checks

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

Chapter 12: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-888-350-5608**
News and bulletins	**UHCprovider.com/news**	**1-888-350-5608**
Care provider manuals	**UHCprovider.com/guides**	**1-888-350-5608**

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits
- **UHCprovider.com** - This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/DCcommunityplan** - The UnitedHealthcare Community Plan of the District of Columbia page has District-specific resources, guidance and rules
- **Policies and protocols** - **UHCprovider.com/policies** > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **District health plans** - **UHCprovider.com/DC** is the fastest way to review all of the health plans UnitedHealthcare offers in the District. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **Social media** - Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (Twitter)
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal** - This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in Chapter 1 of this manual or by visiting **UHCprovider.com/portal**

  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal. UnitedHealthcare Provider Portal
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
  - This includes the communication formerly known as the Network Bulletin. Receive personalized Network News emails twice a month by subscribing at **UHCprovider.com/subscribe**.
  - You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the **UnitedHealthcare Provider Portal**, plan and product overviews, clinical tools and state-specific training.

View the **training resources** where content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider manual

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

District websites and forms

Find the following forms on the District's website at **dc-medicaid.com**:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Glossary

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

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

Adverse benefit determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the District.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
6. For a resident of a rural area, the denial of an enrollee's request to exercise his or her right, to obtain services outside the network.
7. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Acute inpatient care
Care provided to enrollees sufficiently ill or disabled requiring:

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

Advance directive
Legal papers that list an enrollee's wishes about their end-of-life health care.

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

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

Ancillary care provider services
Extra health services, like laboratory work and physical therapy, which an enrollee gets in the hospital.

Appeal
An enrollee request that their health insurer or plan review an adverse benefit determination.

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

Billed charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan enrollee.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned enrollees made to a care provider for providing covered services for a specific period.

Care manager
The individual responsible for coordinating the

overall service plan for an enrollee in conjunction with the enrollee, the enrollee's representative and the enrollee's primary care provider (PCP).

Centers for Medicare & Medicaid Services
CMS - A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and CHIP programs.

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

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

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

Covered services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

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

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

Delivery system
The mechanism by which health care is delivered to an enrollee. Examples include hospitals, provider offices and home health care.

Disallow amount
Amt - Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the enrollee. Examples are:

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

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

Disenrollment
The discontinuance of an enrollee's eligibility to receive covered services from a contractor.

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

District fair hearing
An administrative hearing requested if the enrollee does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

Durable medical equipment
DME -Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Electronic data interchange
EDI - The electronic exchange of information between two or more organizations.

Electronic funds transfer
EFT - The electronic exchange of funds between two or more organizations.

Electronic medical record
EMR - An electronic version of an enrollee's health record and the care they have received.

Eligibility determination
Deciding whether an applicant meets the requirements for federal or District eligibility.

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

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to District Medicaid. The District audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term enrollee. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

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

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

Expedited appeal
An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or behavioral health, or ability to attain, maintain, or regain maximum function.

Fee for service
FFS A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

Federally funded nonprofit health centers or clinics

FQHC - Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay.

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute). Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set
HEDIS® - A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

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

Home health care (home health services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with nonmedical tasks, such as cooking, cleaning or driving.

In-network care provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to enrollees under the terms of their Agreement.

Long Term Services and Supports
LTSS- are a variety of health and social services that offer care for elders and people with disabilities who need support because of their age; physical, behavioral, growing or long-lasting health conditions that limit their abilities to care for themselves.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The

federal government pays for part of Medicaid and sets guidelines for the program. States and the District pay for part of Medicaid and have choices in how they design their program.

Medical emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if an enrollee did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

National Provider Identifier

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

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

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

Primary care provider
PCP - A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under District law and the terms of the plan who provides, coordinates or helps enrollees access a range of health care services.

Prior authorization (notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

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

Quality management
QM - A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Service area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by the District of Columbia Department of Health Care Finance.

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

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

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

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

Utilization management

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