2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Louisiana

United Healthcare Community Plan

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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 prior authorization. This manual also includes important phone numbers and websites on the **How to contact us** page. Find operational policy changes and other electronic transactions on our website at **UHCprovider.com.**

Click 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 care provider manual using the following steps

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

If you have questions about the information or materials in this manual, or about out policies, please call **Provider Services** at **1-866-675-1607**.

Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should use the Agreement, instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

- "Member" or "customer" 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 the UnitedHealthcare 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 care provider manual
- Any reference to "ID card" includes both a physical or digital card

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

Table of contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-866-675-1607**
Training	**UHCprovider.com/training**	**1-866-675-1607**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID. Or go to **UHCprovider.com/portal**. New users: **UHCprovider.com/access**	**1-866-675-1607**
One Healthcare ID Support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
Resource library	**UHCprovider.com** > Resources > Resource Library	

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

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Blind and disabled children and adults who are not eligible for Medicare
- Enrollees 19-64 years who are not eligible for another type of Medicaid and who have an income of less than 138% of the federal poverty level
- Medicaid-eligible families

The Louisiana Department of Health (LDH) 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 **1-866-675-1607**.

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **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 the provider network and need to make a change?

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

Our approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan enrollees enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan enrollees with chronic complex conditions who often use health

care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns to help enrollees get the right care from the right care provider in the right place and at the right time.

The program provides interventions to enrollees with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase enrollee engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach helps improve the health and well-being of the individuals, families and communities we serve. Care Model provides:

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Engage enrollees, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Help with appointments with PCP and coordinating appointments. The community health worker (CHW) refers enrollees to an R.N., behavioral health advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping enrollees engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage enrollees

The Care Model goals are to:

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

Community health worker services

To be eligible for CHW services, the enrollee must have one or more of the following:

- Diagnosis of 1 or more chronic health (including behavioral health) conditions
- Suspected or documented unmet health-related social need
- Pregnancy

Covered services include:

- **Health promotion and coaching** – this can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of enrollees' living situations and providing information and/or coaching in an individual or group setting
- **Care planning with the enrollee and their health care team** – this should occur as part of a person-centered approach to improve health by meeting an enrollee's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention
- **Health system navigation and resource coordination services** – this can include helping to engage, re-engage or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions
  - Maximum of 2 hours per day and 10 hours per month per enrollee

Services must be ordered by a physician, advanced practice registered nurse (A.P.R.N.) or physician assistant (P.A.) with an established clinical relationship with the enrollee. Services must be carried out under this provider's general supervision, defined as under the supervising provider's overall direction and control,

but the provider's presence is not required during the performance of the CHW services.

The following services are not covered when provided by CHWs:

- Insurance enrollment and insurance navigator assistance
- Case management
- Providing of transportation for an enrollee to and from services
- Direct patient care outside the level of training an individual has attained

When the CHW provides services to more than 1 enrollee, they are required to document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This should be limited to 8 unique enrollees per session.

Services may be performed at a health care facility, clinic setting, community setting or the enrollee's home. Services can also be delivered via an audio/video telehealth session.

To refer your patient who is a UnitedHealthcare Community Plan enrollee to the Care Model program, call **Member Services** at **1-866-675-1607**, TTY **711**. You may also call **Provider Services** at **1-866-675-1607**.

Compliance

The Health Insurance Portability and Accountability Act (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 health 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 members as required, to provide members with an equal opportunity to access and participate in all health care services.

  If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

  Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

  Any materials you have a member 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 members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.

- **Care for members who are deaf or hard of hearing**

  You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members 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 members.

- **Materials for limited English-speaking enrollees**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to **uhc.com** > **Language Assistance** or find further details at:

- cms.hhs.gov/ocr – supports the Office of Civil Rights
- LEP.gov – maintains importance of language access to federal programs and federally assisted programs
- diversityrx.org – promotes language and cultural competence to improve health care quality for minorities
- ncihc.org – advocates culturally competent health care

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual 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 our **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 interchange (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

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

- 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 admittance advice (ERA/835)

Visit **UHCprovider.com/edi** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi**.

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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 enrollee 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**.
- **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**.
- **Prior authorization and notification**
  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 specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update your demographic data that UnitedHealthcare enrollees see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **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 previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- 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.

Provider Services

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

Provider Services at **1-866-675-1607** can assist you with questions on Medicaid benefits, eligibility, claim decisions, forms required to report specific services and billing questions. They work closely with all departments in the UnitedHealthcare Community Plan.

Privileges

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

How to contact us

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

Topic	Contact	Information
Applied Behavior Analysis (ABA)	**Provider Services: 1-866-675-1607**	Covered for enrollees younger than 21 years who meet specific criteria.
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-800-888-2998** **1-866-675-1607**	Eligibility, claims, benefits, authorization, and appeals. Refer enrollees for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-866-675-1607**	Confirm an enrollee's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** **1-866-675-1607**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care Model (care management/disease management)	**louisiana_caremanagement@uhc.com** **Provider Services: 1-866-675-1607**	Refer high-risk enrollees (e.g., asthma, diabetes, obesity) and enrollees who need private-duty nursing. They may call Member Services for more information.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide enrollees 21 years and older with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	**UHCprovider.com/claims** **1-866-675-1607** 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	Ask about a claim status or about proper completion or submission of claims. Also ask about behavioral claim disputes.

Topic	Contact	Information
Claim overpayments	See the **Overpayment** section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. For information about your recoupment or overpayment request, call the customer service number in your letter. Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental – adult	**1-866-675-1607**	For enrollees age 21 years and older who have adult coverage provided by UnitedHealthcare Community Plan.
Dental – enrollees younger than 21 years old	MCNA: 1-855-701-6292 DentaQuest: 1-800-685-0143	For enrollees younger than 21 years old – provider enrollment, direct deposit issues, reporting changes and ownership, NPI, etc.
Early and Periodic Screening, Diagnostic, and Treatment Personal Care Services (EPSDT-PCS), Pediatric Day Health Care (PDHC) and Private Duty Nursing (Extended Home Health)	Intake Department: **1-866-675-1607**	Request prior authorization or notify us of the procedures and services outlined in the **Prior authorization request/Advance notification requirements** section of this manual. If you need to speak to the case manager for an enrollee already receiving these services, please call 1-800-377-5105.
Electronic Data Intake (EDI issues)	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Ask about claims issues or questions.
Eligibility	To access eligibility information, go to **UHCprovider.com** then Sign In to the UnitedHealthcare Provider Portal or go to **UHCprovider.com/eligibility** **1-866-675-1607**	Confirm enrollee eligibility.

Topic	Contact	Information
Fraud, waste and abuse (payment integrity)	Payment integrity: **UHCprovider.com/lacommunityplan** > 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 fraud, waste and abuse by a care provider or enrollee by phone or online.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics 1-866-697-8378	Labcorp and/or Quest Diagnostics are network laboratories.
Maternity case management	1-800-599-5985	
Medicaid Louisiana	lamedicaid.com 1-800-473-2783 or 1-225-924-5040	Contact Medicaid directly.
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-866-675-1607** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations or appeals,see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31365 Salt Lake City, UT 84131-0364 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.
Member Services	**myuhc.com®** **1-866-675-1607**	Assist enrollees with issues or concerns. Available 7 a.m.–7 p.m. CT, Monday–Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-866-675-1607** TDD **711**	Available 7 a.m.–7 p.m. CT, Monday–Friday, except state-designated holidays.

Topic	Contact	Information
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a NPI.
Network management support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.
NICU/NRS	**1-800-599-5985**	
NurseLine	**1-877-440-9409**	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In at the UnitedHealthcare Provider Portal. **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant enrollees, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer enrollees to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology prior authorization	**UHCprovider.com/oncology** Optum **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-855-819-5909**	Contact us if you have issues with your One Healthcare ID. Available 7 a.m.–9 p.m. CT, Monday–Friday 6 a.m.–6 p.m. CT, Saturday 9 a.m.–6 p.m. CT, Sunday
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** Optum Rx® lamcopbmpharmacy.com Phone number: 1-800-424-1664 (Magellan Medicaid Administration) Fax number: 1-800-424-7402	Louisiana Medicaid will transition to Magellan Medicaid Administration (MMA) to manage all pharmacy benefits.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826** Prior authorization filed under the medical benefit: **UHCprovider.com** **1-866-675-1607**	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 enrollee's ID card (self-service available after hours) and select "Care Notifications" or call **1-866-675-1607**	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/lacommunityplan > Prior Authorization and Notification**
Provider Services	**UHCprovider.com/lacommunityplan** **1-866-675-1607**	Available 7 a.m.–7 p.m. CT, Monday–Friday.
Radiology prior authorization	**UHCprovider.com/radiology** **1-866-889-8054** **1-866-675-1607** (PET Scans)	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-866-675-1607**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/lacommunityplan > Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan enrollees. Visit this site often to view reimbursement policy updates.
Technical support	**UHCprovider.com/contactus** Chat with a live advocate, 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	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transplants	**1-800-418-4994**	
Transportation	1-866-726-1472	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call 2 business days in advance. Call 1-866-886-4081 for hospital discharge NEMT.

Topic	Contact	Information
Utilization management (Acute inpatient)	Use the Prior Authorization and Notification application on the Provider Portal to upload medical notes or other attachments to your request.	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 guidelines or information about the program.
Vaccines for Children program	cdc.gov/vaccines/programs/vfc 1-504-838-5300	Care providers must participate in the VFC program administered by the LDH and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with LDH to bill for the administration of the vaccine.
Vision services	**1-866-675-1607**	Submit routine vision services claims to March® Vision Care.
Website for Louisiana Community Plan	**UHCprovider.com/lacommunityplan**	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**	**1-866-675-1607**
Eligibility	**UHCprovider.com/eligibility**	**1-866-675-1607**
Referrals	**UHCprovider.com/referrals**	**1-866-675-1607**
Provider Directory	**UHCprovider.com/findprovider**	**1-866-675-1607**

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 mental 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.

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 (QI), UM 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 representatives may take part in the planning and implementation of their care. To help ensure enrollees and/or their representatives have this chance, UnitedHealthcare Community Plan requires that 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 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. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
3. Loss or suspension of your license to practice.
4. Departure from your practice for any reason.

5. Closure of practice.

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

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 and care professionals.

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 your Agreement. You may call us to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

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

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- Calling our general provider assistance line at **1-877-842-3210**

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 into your schedule, refer them to an urgent care center.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, 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 the United States government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan 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 10 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 the UnitedHealthcare Community Plan and payer's protocols, including those contained in this care provider manual. You may view protocols at **UHCprovider.com/protocols**.

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 HIPAA and associated regulations. In addition, you will comply with applicable state 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 state 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 state laws on advance directives through member handbooks and other communications.

Care provider bill of rights

You have the following rights under the UnitedHealthcare Community Plan of Louisiana:

- You may act within the lawful scope of practice as you advise or advocate for your patient who is an enrollee about:
  - Their health, care or alternative treatment options
  - Information they need to make decisions about their care
  - The risks and benefits of treatment or non-treatment
  - Their right to take part in decisions about their care. This includes the right to refuse treatment and share preferences about future care
- You may receive information on the grievance, appeal and state fair hearing procedures
- You may access our policies and procedures about service authorizations
- You may be notified of any decision we make to deny an authorization request or to authorize a service in an amount, duration or scope less than requested
- You may challenge the denial on the enrollee's behalf
- We will not discriminate against you if you serve high-risk populations or specialize in high-cost conditions
- We will not discriminate against you for acting within the scope of your license or certification

Appointment standards (LDH access and availability standards)

Comply with the following appointment availability standards:

Primary care

You should arrange appointments for:

- Emergency care – immediately. Schedule follow-up visits with the ER attending care provider's discharge instructions
- Urgent care appointment – within 24 hours
- Non-urgent sick care – within 72 hours or sooner if medical condition deteriorates into an urgent or emergency condition
- Specialty care consultation – within 1 month of referral or as clinically indicated
- Routine, non-urgent and preventive care visits – within 6 weeks

Lab and X-ray services

Arrange lab and X-ray appointments for:

- Lab and X-ray services (usual and customary) – not to exceed 3 weeks for regular appointments and 48 hours for urgent care, or as clinically indicated

Specialty care

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

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester – within 14 days of request
- Second trimester – within 7 days of request
- Third trimester – within 3 days of request
- High-risk – within 3 days of identification of high risk

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

Provider Directory

You are required to tell us, within 5 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help 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.

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive, we will remove you from our directory after 10 business days.

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

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

My Practice Profile

The UnitedHealthcare Community Plan My Practice Profile application helps you view and update your demographic and practice data online. You can also use it to complete your required quarterly attestation of your demographic information. You may also use the application to submit Disclosure of Ownership and Management forms for Medicaid. In addition, you may update demographic information by email:

To help ensure we have your most current information:

- **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

Changing panel status

To change your panel status (i.e., open to new patients, open to existing patients only, or closed), make the request in writing 30 days in advance. Changes to panel status apply to all patients for all lines of business (LOB) and products in which you take part.

You may request a panel status change for 1 LOB or product under certain circumstances. Include the exception in the written request. UnitedHealthcare Community Plan determines the approval.

We may notify you in writing of other panel status changes. This includes closures based on state and/or federal requirements, current market dynamics and patient quality indicators.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-866-675-1607** If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare 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 where a member may make an appointment and see the 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

Advance notification requirements

For a list of the Prior Authorization review requirements, go to **UHCprovider.com/lacommunityplan** > **Prior Authorization and Notification**.

You need prior authorization for the following:

- Medicaid products: CHIP, TANF, ABD, HCBS
- Call: **1-866-675-1607**
- All services rendered by a non-network physician, facility or other care provider must receive prior authorization
- All nonemergency inpatient admissions, including planned surgeries
- Using the Universal Referral Form (URF) does not mean we approve the service
- For behavioral health prior authorizations, see **Chapter 7** of this manual

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.

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

Verify eligibility using the **UnitedHealthcare Provider Portal** at **UHCprovider.com/eligibility** or 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:
  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.

Bill other insurance carriers when appropriate.

If you have questions, please call 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
- **Non-urgent** – 10 business days

Reportable disease surveillance

Reportable disease surveillance is conducted by public health care providers at the local, state and national level to support disease prevention and control. To see reporting tools specific to Louisiana, see the Louisiana Department of Health and search for the following pdfs, forms and reporting tools:

- How to report a disease
- How to report an outbreak
- Pregnancy testing and reporting guidelines
- Reportable diseases in Louisiana (sanitary code)
- Emergency Department disaster surveillance form
- Shelter disaster surveillance form
- IDRIS 2 external user training or for "Quality better on ILinc" email rosemarie.robertson@la.gov for logon
- IDRIS 2 external user manual

You must adhere to Sanitary Code – State of Louisiana

Part II – The Control of Disease LAC 51:II.105 as it relates to Reportable Diseases and Conditions. LAC 51:II.105: outlines all diseases/conditions declared reportable with reporting requirements by the following classes:

- Class A Diseases/Conditions – within 24 hours
- Class B Diseases/Conditions – within 1 business day
- Class C Diseases/Conditions – within 5 business days
- Class D Diseases/Conditions – within 5 business days

All classes must be reported to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health. A complete list of all disease and condition classes is on ldh.la.gov. Reporting requirements and reportable disease reporting forms may be found at: ldh.la.gov/index.cfm/page/1013. You will need to cooperate with the treatment plan developed by the Local Health Department.

Infectious Disease Surveillance
1450 Poydras Street, Ste. 1654
New Orleans, LA 70112

Phone: 1-800-256-2748

Email: Your Regional Contact or oph.idepi@la.gov

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics or obstetrician/gynecology

PCPs are an important partner in the delivery of care and LDH enrollees may seek services from any participating care provider. The LDH program requires enrollees be assigned to PCPs. 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 case 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 (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and P.A.s from any of the following practice areas can be PCPs:

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

N.P.s may enroll with the state as solo care providers, but P.A.s cannot. P.A.s must be part of a group practice.

Enrollees may change their assigned PCP by contacting **Member Services** at any time during the month at **1-866-675-1607**. Member Services is available 7 a.m.–7 p.m., Monday–Friday.

We ask enrollees who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, P.A.s, or N.P.s 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. This includes availability of 24 hours a day, 7 days a week.

During nonoffice hours, access by telephone to a live voice (e.g., 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 UnitedHealthcare Community Plan enrollees with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan to identify enrollees who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- Provide all well-baby/well-child services
- 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-M.D. practice and at least 30 hours per week for a 2-or-more-M.D. practice
- Be available to enrollees by telephone at any time
- Tell enrollees about appropriate use of emergency services
- Discuss available treatment options with enrollees

Responsibilities of PCPs and specialists serving in PCP role

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

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

- Offer office visits on a timely basis, based on the standards outlined in the **Timely filing** section of this guide
- Conduct a baseline exam 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 departments 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 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 (QOC) 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
- Comply with the LDH access and availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in **Chapter 2** of this manual.

Assistance with locating specialists for UnitedHealthcare Community Plan enrollees

We're committed to supporting the care you provide to your patients who are our enrollees. That's why we've made some changes to help minimize the challenges PCPs experience locating specialists for UnitedHealthcare Community Plan enrollees.

PCPs can request assistance with locating specialists by sending an email to **la_spc_rep_asst@uhc.com** or by calling our Provider Customer Service line at **1-866-675-1607**, 7 a.m.–7p.m. CT, Monday–Friday.

Please provide the following information:

- The type of specialist required
- The enrollee's geographical location
- The required time frame for the appointment
- The PCP's contact information

Our Provider Services representative will:

- Locate 3 specialists within the UnitedHealthcare Community Plan Provider Network
- Ensure the enrollee can secure an appointment within the required time frame
- Provide the PCP with the specialist's contact information and appointment availability
- The Provider Services representative can't book the appointment since the enrollee needs to confirm their availability.

If you have questions, please call **1-866-675-1607**, 7 a.m.–7 p.m. CT, Monday–Friday.

Rural health clinic, federally qualified health center or primary care clinic

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

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare enrollees in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **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 state and local laws
- Comply with the LDH access and availability standards for scheduling routine visits. Appointment standards are covered in this chapter.
- 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.

PCP checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-866-675-1607.**
2. Check the enrollee's ID card at the time of service. Verify enrollee with photo identification. Plan participating specialists when needed.
3. Get prior authorization from UnitedHealthcare Community Plan, if required by visiting **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 enrollee either electronically or on a CMS 1500 claim form.

Ancillary care provider responsibilities

Ancillary care providers include:

- Freestanding radiology and clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment (DME)
- 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** at **1-866-675-1607.**
2. Check the enrollee's ID card at the time of service. Verify enrollee with photo identification.
3. Get prior authorization from UnitedHealthcare Community Plan, if required, by visiting **UHCprovider.com/paan**.
4. Identify and bill other insurance carriers when appropriate.

Chapter 3: Care provider office procedures and enrollee benefits

Key contacts

Topic	Link	Phone number
Enrollee benefits	**UHCCommunityPlan.com/la**	**1-866-675-1607**
Member handbook	**UHCProvider.com/la** > > Plan Details > Member Resources > View Available Resources	
Provider Services	**UHCprovider.com**	**1-866-675-1607**
Prior authorization	**UHCprovider.com/paan**	**1-866-675-1607**
D-SNP	**UHCProvider.com/la** > Medicare > **Dual Complete Special Needs Plan**	**1-866-675-1607**

Benefits

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

The following benefits are not all-inclusive.

Benefit	Services included	Limitations
Acute inpatient rehabilitation	Short-term acute rehabilitation	Covered. Prior authorization is required.
	Skilled nursing facility (SNF)	This is not a Medicaid covered benefit. However, UnitedHealthcare Community Plan may approve short-term skilled care in an appropriate setting. Prior authorization is required.
	Long-term custodial care	Not covered.
	Long-term acute care (LTAC)	Covered. Prior authorization is required.
Acupuncture services	Medically necessary for pain management	Covered for enrollees 21 and older (value-added).

Benefit	Services included	Limitations
Ambulance services	Emergent and nonemergent transportation	Covered. PCP should coordinate.
	Air ambulance	Prior authorization not required.
ABA	Behavioral treatment that seeks to change social behaviors	Covered for enrollees younger than 21 years who meet specific criteria. Behavioral health care professional or PCP must coordinate care. Prior authorization required.
Bariatric surgery	Inpatient and outpatient bariatric surgery and specific obesity-related service	Covered. Prior authorization required. Enrollees must meet criteria to be approved for this procedure, including documentation of participation and failure in legitimate weight loss program.
Behavioral health crisis response system	• **Mobile Crisis Response (MCR)** – a mobile service available as an initial intervention for individuals in crisis. Teams go to the individual where they are located in the community. • **Behavioral Health Crisis Center** – a facility-based walk-in center providing short-term behavioral health crisis intervention • **Community Brief Crisis Support (CBCS)** – an in-person ongoing crisis intervention response. Available to enrollees who have received an initial intervention by either Mobile Crisis Response or Behavioral Health Crisis Center. For more information or to access help 24 hours a day, 7 days a week dial **1-866-232-1626**, TTY **711**.	• Must be 21 or older • Experiencing emotional distress and need help • Not be legally committed
Behavioral health inpatient (hospital)	See Hospital – Inpatient Behavioral health is available 24 hours a day to help with emergency crises. Select option 1 for emergency crisis.	Call **Provider Services: 1-866-675-1607**
Behavioral health – outpatient	Screening, prevention, early intervention, medication management and referral services	Covered. PCP to coordinate. For specialty care: • Call **Provider Services: 1-866-675-1607** • **la.beh.auths@uhc.com**

Benefit	Services included	Limitations
Cancer-related treatment	Access to any related medically necessary service. This includes hospitalization, doctor services, other practitioner services, outpatient hospital services, chemotherapy and radiation.	Covered. Potential prior authorization required.
Chiropractic services	Medically necessary manual manipulation of the spine to correct spinal alignment	Covered for enrollees younger than 21 years old. Covered for enrollees 21 and older (value-added).
Chronic renal disease/End stage renal disease	Services related to chronic renal disease	Covered.
Circumcision	Inpatient or outpatient service	Covered without prior authorization if performed before discharge from the newborn nursery or in the care provider's office within 30 days after birth. All others will be reviewed for medical necessity.
Cosmetic and/or reconstructive surgery	Services or supplies provided in connection with cosmetic surgery are not covered, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member	Potentially covered. Prior authorization required.
Dental services	Limited coverage	Children are covered through the state's benefit (MCNA or DentaQuest). Adults are eligible for our value-added dental services.
	For dental services performed in an outpatient setting, UnitedHealthcare Community Plan will cover the facility and anesthesia services when deemed as medically necessary. The facility services require a prior authorization.	Covered. Prior authorization required.

Benefit	Services included	Limitations
Diabetic supplies	Effective Dec. 1, 2023, glucose monitors and diabetic supplies will be covered as a pharmacy benefit only. Pharmacies must file claims to Magellan Medicaid Administration (MMA). Examples of diabetic supplies: **1.** Diabetes glucose meters **2.** Lancets and devices **3.** Continuous glucose meters For claims prior to Oct. 28, 2023, please contact Optum Rx at **1-877-305-8952.** For claims on or after Oct. 28, 2023, please contact Magellan Medicaid Administration at 1-800-424-1664.	Covered. Prior authorization is required on all DME equipment valued at more than $500 per line item.
Diagnostic tests	**Radiology:** Radiology (imaging studies) require prior authorization from UnitedHealthcare Community Plan Clinical for: • CT; X-ray • MRI (magnetic resonance imaging) • MRA (magnetic resonance angiogram) • PET scan (positron emission tomography) • Nuclear medicine SPECT MPI (Myocardial perfusion imaging) • Select nuclear medicine studies • Nuclear cardiology Call UnitedHealthcare Clinical for care providers.	Covered for specific diagnoses. Some diagnostic tests require a prior authorization and must always be medically necessary.
	Laboratory: Labcorp is the preferred lab provider. Care providers must have a NPI # on file or claims will deny.	Covered.

Benefit	Services included	Limitations
DME and medical supplies	Obtain routine DME supplies through in-network pharmacies. All other pharmacy is carve-out (not covered by UnitedHealthcare Community Plan). Enrollees and care providers should call the Louisiana Medicaid Agency for pharmacy benefits. DME may be rented, purchased or repaired based on the enrollee's duration and use needs. Determination on which one (purchase, rental, etc.) is applicable is made by either Medical Management or the Prior Notification team using the following criteria: • Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment • Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment • DME repair will be considered based on the age of the item and cost to repair it • Medicaid beneficiaries younger than 21 years are entitled to all medical necessary DME	Covered. An M.D. or D.O. must be the ordering care provider type. Per Louisiana, P.A.s and N.P.s cannot be the ordering care provider type for these services. A prior authorization is required on all DME equipment valued at more than $500 per line item.

Benefit	Services included	Limitations
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	EPSDT service is Medicaid's comprehensive preventive child health service for individuals younger than 21 years old. Preventive services for children younger than 21 years old must meet EPSDT criteria. Preventive screenings and interperiodic screenings must include: • Care provider exam • Comprehensive health history • Vision screen • Health and developmental history • Hearing screenings • Measurements • Blood pressure • Vital signs • Nutritional counseling • Laboratory procedures • Health education/anticipatory guidance • Immunizations • Lead screenings • Environmental investigation • Dental screening	Covered.
EPSDT Organ and Tissue Transplantation Services	Medically necessary and approved non-investigational solid organ and tissue transplantation	EPSDT-covered services for enrollees younger than 21 years old. PCP to coordinate services.
EPSDT Psychological and Behavioral Services (PBS) – Specialty Care	Services provided by a psychiatrist, psychologist and/or mental health rehabilitation/habilitation care provider for enrollees with a primary diagnosis of a mental and/or behavioral disorder	Covered for enrollees younger than 21 years old who meet the criteria for Pervasive Development Disorder (PDD). PCP to coordinate. For services requiring prior authorization: Call Customer Service: **1-866-675-1607**

Benefit	Services included	Limitations
EPSDT Physical and Occupational Therapy Services	Physical therapy (PT) for enrollees to restore, maintain or improve muscle tone, joint mobility or physical function. Occupational therapy (OT) for EPSDT enrollees to improve and restore functions that have been impaired by illness or injury or have been permanently lost or reduced by illness or injury.	Covered for enrollees younger than 21 years old. The condition for which PT is prescribed must have the potential for improvement due to rehabilitation. The condition for which OT is prescribed must have the potential to improve the enrollee's ability to perform tasks required for independent functioning. PCP to coordinate.
EPSDT supplemental nutritional feedings	Supplemental nutritional feedings, provided on either an enteral, parenteral or oral basis, when determined medically necessary	Our medical director determines medical necessity for enrollees younger than 21 years old on an individual basis. Documentation must show unsuccessful trials in using alternatives such as blenderized foods. PCP to coordinate.
EarlySteps program	Medicaid services include: • Family support coordination • OT • PT • Speech/language therapy • Psychology • Audiology Additional services covered under EarlySteps include: • Nursing services/health services (only to enable an eligible child/family to benefit from the other EarlySteps services) • Medical services for diagnostic and evaluation services only • Special instruction • Vision services • Assistive technology devices and services • Social work • Counseling services/family training • Transportation • Nutrition • Sign language and cued language services	Covered for children up to 3 years old with a development delay. All enrollees must meet developmentally disabled qualifications. PCP to coordinate. Call 1-225-342-0095 for more information about referrals. Vision services performed by an optometrist are reimbursable for routine and non-routine services. Claims must be submitted to March Vision for processing due to the expanded scope of services the Louisiana Board of Optometry allows optometrists to perform in the office setting.

Benefit	Services included	Limitations
Family planning	Preventive health, medical, counseling and educational services that help enrollees manage their fertility and achieve the best reproductive and general health	Covered for female enrollees 10–60 years old.
FQHC	Professional medical services furnished by physicians, N.P.s, P.A.s, certified nurse midwives (C.N.M.s), clinical social workers, clinical psychologists and dentists; Immunizations are covered for recipients younger than 21 years old; Includes regular encounter visits, EPSDT screening services; EPSDT dental	Covered. Enrollees may choose a local FQHC as their PCP.
Femoroacetabular impingement syndrome (FAI)	All planned elective hip arthroscopy for CPT codes 29914, 29915 and 29916	Prior authorization required.
Habilitation services	Provided in the home or community. Services assist with getting, keeping and improving self-help, socialization and adaptive skills necessary to live successfully in the home- and community-based (HCBS) settings.	Covered. PCP to coordinate.
Hearing services	Includes diagnostic screening, preventive visits and hearing aids	Covered.
	Adults: As part of the Adult Health Screening Services, audiometry sweeps are covered once every 4 years for adults 21 years and older.	Covered. No prior authorization required when service is given by a participating physician in an outpatient setting.
	Hearing aid services and repairs	Covered for enrollees younger than 21 years old with prior authorization.
	Hearing aid batteries	Covered, but limited to 32 per month.
Hemodialysis Services – see OP	Includes routine lab, dialysis, medically necessary non-routine lab work, and medically necessary injections	Covered. PCP to coordinate.
Home health services	Effective Jan. 1, 2024, Electronic Visit Verification (EVV) is required.	Covered. PCP to coordinate. Prior authorization required.
Hospice	In-home hospice and short-stay inpatient hospice	Covered. PCP to coordinate.
	Residential inpatient hospice services are covered.	

Benefit	Services included	Limitations
Hospital – Inpatient	Inpatient hospital care includes medical, surgical, post-stabilization, acute and rehabilitative services	Covered. Elective and scheduled admissions require prior authorization. Urgent/ emergent admissions require notification within 1 business day of admission to obtain authorization for inpatient days. PCP to coordinate.
	Maternity services	We don't require notification for normal deliveries and cesarean sections if enrollees are discharged within 2 days from vaginal deliveries or within 4 days from C-section deliveries. Any additional days will require notification for authorization.
Hospital – outpatient	Outpatient professional/medical services professional component (in/outpatient) of surgical services, including: • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care • Administration of anesthesia by care provider (other than surgeon) or C.R.N.A. • Second surgical opinions • Same-day surgery performed in a hospital without an overnight stay • Invasive diagnostic procedures such as endoscopic examinations Electroconvulsive therapy (ECT) does not require a prior authorization.	Covered for outpatient, habilitation and rehabilitation services. Prior authorization required for some services. ECT does not require a prior authorization.
	Out of network: Not covered except in situations where enrollees require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.	Prior authorization required for nonemergent/non-urgent hospital services.
	ER prescription. Contact the state Medicaid Agency customer service line at 1-888-342-6207 for pharmacy benefits.	Not covered.
Immunizations	Covered for adults.	Covered.
	Coverage for children, birth through 18 years, is through the VFC program.	Covered.

Benefit	Services included	Limitations
Injectable medications	Outpatient basis. Please visit **UHCprovider.com** to view the current notification requirements for Louisiana for the list of injectable medications requiring a prior authorization.	Covered. Prior authorization is required.
Laboratory tests and radiology services	Most testing services the attending or consulting physician orders. Portable (mobile) X-rays are covered only for recipients who cannot leave their residence without special transportation.	Covered. Prior authorization may be required for some services. PCP to coordinate.
Mid-level practitioners services	Includes care P.A.s, advanced registered nurse practitioners (A.R.N.P.), family practice nurse practitioner (F.P.N.P.), pediatric nurse practitioner (P.D.N.P.), certified registered nurse anesthetists (C.R.N.A.), and C.N.M.s.	Covered.
Neuropsych testing	No prior authorization required if in-network	Covered.
Newborn services	Facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section	Covered. Notification is required.
	Non-routine newborn care, i.e., care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review.	Authorization is required.
	Out of network: Not covered except when enrollees require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization. UnitedHealthcare Community Plan receives a daily unborn notification file. These unborn, potential enrollees will not be loaded into our system. UnitedHealthcare Community Plan will outreach to the mother to provide education about prenatal care and to contact ACCESS Louisiana as soon as the baby is born to have the baby enrolled in coverage.	Prior authorization required for nonemergent/non-urgent hospital services.
Nutritional counseling	Services include outpatient education	Covered.
Observation	48-hour observation. For more information about the observation process, refer to Healthy Louisiana Informational Bulletin 18-7.	Covered.

Benefit	Services included	Limitations
Orthotics and prosthetics	Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than $500	Prior authorization required.
Outpatient and care provider visits	Services at a hospital or care center when an enrollee stays less than a day. Doctor, other care provider visits, family planning, preventive services and clinic visits. Specialty care provider visits. ER visits including both hospital and care provider charges.	Covered.
Outpatient surgery	Services include: Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and hospital ASC) Covered when medically necessary and not otherwise excluded	Covered. Some surgeries require pre-authorization. Ambulatory surgical procedures performed in an outpatient hospital setting are reimbursed at a flat rate. Hospitals bill all outpatient surgery charges for ambulatory surgery procedures with revenue code 490. All other charges associated with the surgery (e.g., observation, labs, radiology) must be billed on the same claim as the ambulatory surgery charges. The only revenue code that will be paid is the flat fee for the ambulatory surgery. Minor medically necessary surgeries performed in the hospital operating room and the associated CPT code not listed on the Louisiana Medicaid Outpatient Ambulatory Surgery Fee Schedule require revenue code 361-Operating Room Services-Minor Surgery. When more than 1 surgical procedure is performed on the same date of service, we pay only the primary surgical procedure.
PDHC	Nursing care, respiratory care, PT, speech/language therapy, OT, personal care services and transportation to and from PDHC facility	Covered for enrollees younger than 21 years old who have a medically fragile condition. Prior authorization required. PCP to coordinate.

Benefit	Services included	Limitations
Personal care services	Toileting and grooming activities; eating and food preparation; household chores; and accompanying, not transporting, recipient to medical appointments	Covered for Medicaid enrollees 65 or older, or enrollees 21 or older with disabilities. Does not cover medical tasks such as medication administration, tube feedings. For more information about the waiver program for adults, call the Healthy Louisiana Program at LDH at 1-888-342-6207.
Podiatry services	Covered for medically necessary services only; typically associated with severe circulatory disease or loss of sensation of feet or enrollee has been diagnosed with a systemic condition by a care provider that there is medical necessity for professional foot care, such as: • Debridement of non-mycotic nails • Diabetes mellitus • Arteriosclerosis • Buerger's disease • Chronic thrombophlebitis • Peripheral neuropathies	Covered.
Pregnancy-related services	UnitedHealthcare Community Plan covers all OB services through the enrollee's pregnancy. Services include pre- and post-natal care, tests, doctor visits and other services that affect pregnancy outcomes.	Covered.
	UnitedHealthcare Community Plan recommends, but does not require, hospitals notify us of a maternity admission. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review. If the enrollee is inpatient longer than the federal requirements, a prior authorization is required. Please call **Provider Services** at **1-866-675-1607** for prior authorizations.	Authorization required.
	Non-routine newborn care, i.e., care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress)	Prior authorization required.

Benefit	Services included	Limitations
Prescription drugs, including certain prescribed over-the-counter drugs	Obtain routine DME supplies through participating pharmacies. Pharmacies must file claims with Optum Rx through Oct. 27, 2023. Beginning Oct. 28, 2023, pharmacies must file claims with Magellan Medicaid Administration. BIN: 025986 Processor Control Number: 1214172240 Group: LAMCOPBM	Covered. DME may be dispensed by a pharmacy licensed as a DME provider and that has a DME taxonomy.
	Obtain prescription drugs, including certain prescribed over-the-counter drugs.	Covered. Refer to the Preferred Drug List at **UHCprovider.com.**
Rehabilitation therapies	Includes physical, occupational, speech and therapies Must be restorative in nature and be related to an injury or acute episode Physical, occupational, and speech therapy benefits limited to 60-combined visit per calendar year for enrollees age 21 and older Maintenance PT is not covered	Covered.
Sexually transmitted diseases	Screening, diagnosis and treatment coordinated by PCP	Covered service when medically necessary.
Sleep studies	Either an outpatient hospital setting or sleep study clinic	Covered when medically necessary.
	ATTENDED sleep studies typically performed in a sleep clinic, facility or lab	Prior authorization required.
	UNATTENDED sleep studies performed in the enrollee's home	Prior authorization not required.
	Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1 to 4 lead electroencephalogram (EEG), electro-oculogram (EOG) and a submental electromyogram (EMG)	
	For a sleep study to be reported as a polysomnography, sleep must be recorded and staged	
Spinal surgery	Inpatient and outpatient spinal surgeries	Covered. Prior authorization required.

Benefit	Services included	Limitations
Sterilization and hysterectomies	The plan covers once requirements are met. Requirements include, but are not limited to: Sterilization: The regulations require a written consent form (MMS-110), male or female, must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is performed. The individual must be at least 21 years of age at the time the consent form is signed by the enrollee.	Covered. All inpatient services require a prior authorization in addition to the appropriate state consent form. Ancillary care providers (anesthesia, radiology, pathology) claims can be paid if a sterilization form is provided with the claim, or if the form was received on the surgeon's claim that was paid.
	Reversal of voluntary sterilization	Not covered.
	Hysterectomies: Services cannot be reimbursed if performed for sterilization purposes. Enrollees undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result. Per Louisiana Administrative Code, "All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101 Informed Consent Form," signed and dated by the enrollee in which she states that she was informed before the surgery was performed that this surgical procedure will result impermanent sterility.	All inpatient services require a prior authorization, in addition to the appropriate state consent form.
Synagis (drug)	File claims with Magellan Medicaid Administration.	Covered. Prior authorization required.
Tobacco education and prevention	The Louisiana Tobacco Quitline and website offer free, confidential phone counseling and online support programs. We encourage you to assist enrollees with setting a quit date and developing a quit plan. Free nicotine gum or patches are available.	Covered.
	Call **1-800-784-8669** or enroll at quitwithusla.org.	Some limitations may apply.
	You may suggest one of these programs to enrollees. For more information, call Provider Services at **1-866-675-1607**, TTY **711**.	Covered.

Benefit	Services included	Limitations
Transportation nonemergency	All nonemergent transportation services are provided by Modivcare. They provide nonemergent transportation services to our enrollees. Enrollees must make transportation arrangements at least 2 business days before their medical appointment. Call **1-866-726-1472** to schedule a trip. We cannot dispatch trips to out-of-region transportation providers without documentation supporting that all providers willing and available in the region where the enrollee lives are unavailable or that the out-of-region provider is the least costly option. Hospital discharges will be transported within 3 hours of notification by a medical facility. Value added nonemergent transportation will only be covered by Modivcare to: • Women, Infants and Children Supplemental Nutrition (WIC) visits • Parenting classes • Lamaze classes • Pregnancy classes • Substance use support groups • Routine vision for adults 21 years and older • Respite care • Pain management providers (chiropractic/acupuncture) • Pharmacy, when combined with a medical appointment trip **Attendants:** In some cases, attendants may be allowed to accompany the enrollee to and from the medical appointment. Attendants are permitted when the enrollee being transported meets 1 or more of the following criteria: • Sensory deficits • Need for human assistance for mobility • Dementia or other cognitive impairments • At risk of elopement • Behavioral disorders	Prior authorization may be required for some trips.

Benefit	Services included	Limitations
Transportation nonemergency	• Need for interpretation or translation assistance • Special needs such as: – Convalescence from surgical procedures – Decubitus ulcers or other problems that prohibit sitting for a long period of time – Incontinence or lack of bowel control – Assistance with toileting – Artificial stoma, colostomy or gastrostomy An attendant shall be required when the enrollee is under the age of 17. This attendant **must:** • Be a parent, legal guardian or responsible person designated by the parent/legal guardian; and • Be able to authorize medical treatment and care for the enrollee **This attendant may not:** • Be under the age of 17 • Be a Medicaid provider or employee of a Medicaid provider that is providing services to the enrollee being transported, except for employees of a mental health facility in the event an enrollee has been identified as being a danger to themselves or others or at risk for elopement • Be a transportation provider or an employee of a transportation provider Exclusions: We will not reimburse for transportation to or from the following locations (not an exhaustive list): • Pharmacies • Nursing facilities • Hospice care • WIC service appointments at the Office of Public Health We **may,** in certain situations, authorize reimbursement for transportation to or from a pharmacy, WIC appointment, respite, pain management (chiropractic/acupuncture) or other value-added benefit as an approved transport, regardless if it is a stand-alone trip or as an additional stop.	

Benefit	Services included	Limitations
Transplant evaluations	**Organ Transplant Services** Transplant surgery and after care are covered.	Covered. Prior authorization required.
	Kidney Transplant Services Services covered only when provided by a certified end-stage renal disease facility (recipient may become Medicare-eligible after 3 months facility treatment or 1 month home dialysis). Services covered as an outpatient only.	
Vision services	Vision exams, prescription lens and eyeglasses or contacts	Covered for enrollees younger than 21 years old. For vision care for enrollees age 21 and older, refer to Value-added services. **Same day or subsequent day follow-up office visit** There is separate reimbursement for the fitting of eyeglasses on the same day or the following day as an optometrist or ophthalmologist office visit. Reimbursement for the fitting of eyeglasses is only covered if there are final adjustments to the visual axes and anatomical topography. If the enrollee returns to the office only to pick up eyewear, billing for the fitting of eyeglasses is considered inappropriate. Enrollees can access the services of any vision care provider, or eyewear vendor in the March Vision network. Call **1-866-675-1607**. Polycarbonate lenses, contact lenses and custom frames require preauthorization.
	Eye exams: • 1 every calendar year for enrollees younger than 21 years old • 1 every calendar year for ages 21 and older • Diabetic eye exams, for any age, every calendar year	Enrollee must use a participating March Vision care provider. Note: Diabetic screenings/tests including vision exams are covered yearly, when performed by an ophthalmologist and/or optometrists.

Benefit	Services included	Limitations
Vision services	Eyeglasses (lenses and frame) or contacts: • 1 pair every calendar year if there is a significant change in prescription • If an enrollee has additional exams/eyeglasses in the same calendar year, a prior authorization is required from March Vision	Prior authorization required.

Noncovered services

Services not covered by Medicaid include:

- Services provided by non-approved physicians or health care providers
- Services or items furnished solely for beauty or cosmetic reasons
- For persons 21 or older, hearing aids
- Services defined by Louisiana Medicaid as experimental or provided solely for the purpose of research
- Sex-change operations
- Care not deemed medically necessary by Louisiana Medicaid, UnitedHealthcare Community Plan or the physician, and/or care not covered under Medicaid
- Medical services provided to an enrollee who is an inmate or who is in the care of a state mental health center
- Man-made hearts or xenografts
- Organ transplants, except those identified in this manual or the state plan
- Services provided in a center or facility or in an area of a center or facility that is not Medicare/Medicaid certified for such services
- For adults 21 and older, foot and ankle services provided by a podiatrist

Assignment to PCP panel roster

Once an enrollee is assigned a PCP, view the panel rosters electronically at **UHCprovider.com** then select Sign In on the top right. The UnitedHealthcare Provider Portal requires a unique user name and password combination to gain access.

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

1. Go to **UHCprovider.com.**
2. Select Sign In on the top right.
3. Log in.
4. Click on Community Care.

The Community Care Roster has enrollee contact information, clinical information to include HEDIS measures/gaps in care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use **Document Library** for enrollee contact information in a PDF at the individual practitioner level.

You may also find the Document Library quick user guide at **UHCprovider.com** > Resources > UnitedHealthcare Provider Portal Resources > Document Library > **Self-Paced User Guide**.

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 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
- Obstetrics

If the enrollee changes the initial PCP assignment, the effective date will be the day 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 request date.

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary services are those health care services based on generally accepted, evidence-based medical standards. They include those that most physicians (or other independent licensed practitioners) consider within respective professional organizations and communities to be the standard of care.

Enrollee assignment

Assignment to UnitedHealthcare Community Plan

LDH assigns eligible enrollees to UnitedHealthcare Community Plan daily. We manage the enrollee's care on the date the enrollee is enrolled until the enrollee is disenrolled from UnitedHealthcare Community Plan. LDH makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end but may occur mid-month.

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

Download a copy of the member handbook online at **UHCCommunityPlan.com/la**. Go to Plan Details > Member Resources > View Available Resources.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for enrollees, including newborns, may change from fee for service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, check the payer assignment of newborns daily.

Get eligibility information by calling **Provider Services** at **1-866-675-1607**.

Unborn enrollment changes

Encourage your enrollees to notify the LDH when they know they are expecting. The LDH notifies managed care entities (MCEs) daily of an unborn when Lousiana Medicaid learns a woman associated with the MCE is expecting. The MCE or you may use the online change report through the Lousiana website to report the baby's birth. With that information, the LDH verifies the birth through the mother. The MCE and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify the LDH when the baby is born.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled their baby in a managed care plan.

PCP selection

Although unborn children cannot be enrolled with an MCE 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.

Verifying and validating PCP assignments

We're working with the LDH to help ensure the PCP assigned to UnitedHealthcare Community Plan enrollees is

correctly updated in our records. The enrollee may not be aware of their assigned PCP and may be seeing a different PCP. This will help ensure enrollees are notified in case of PCP changes, and also that claims are paid to you correctly.

Each quarter:

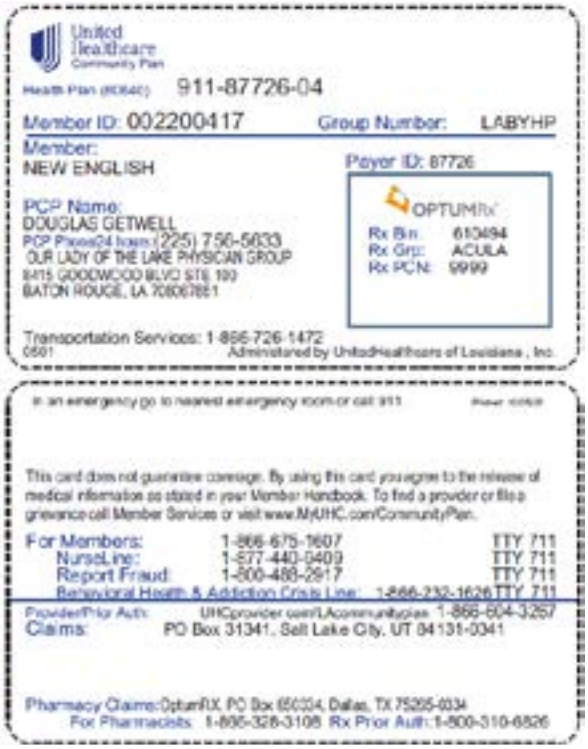
- We'll run a report to show which enrollees have not seen their assigned PCP in the past 12 months
- Enrollees who have seen a different PCP in that time will be assigned to that PCP
- You'll be able to see if an enrollee has been assigned to you or transitioned from you using your panel reports, available in Document Library

Enrollee identification numbers

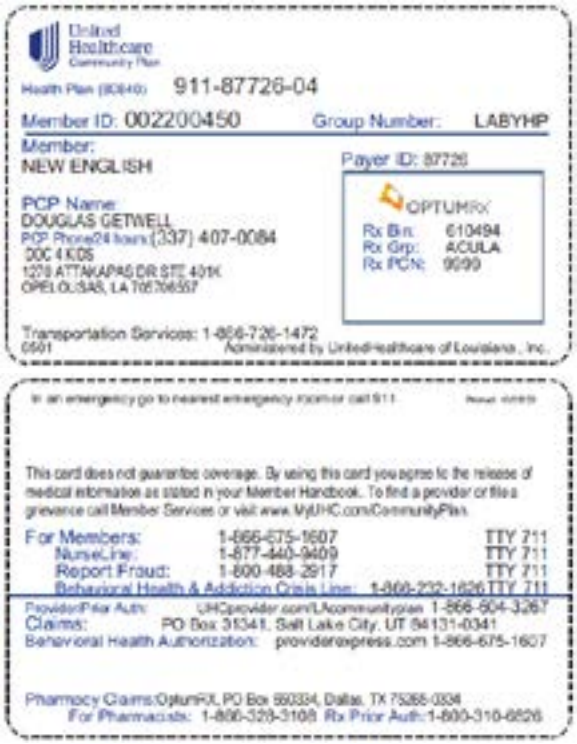
Each enrollee receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with us about a specific subscriber/enrollee. The LDH Medicaid Number is also on the enrollee ID card.

Sample health enrollee ID cards

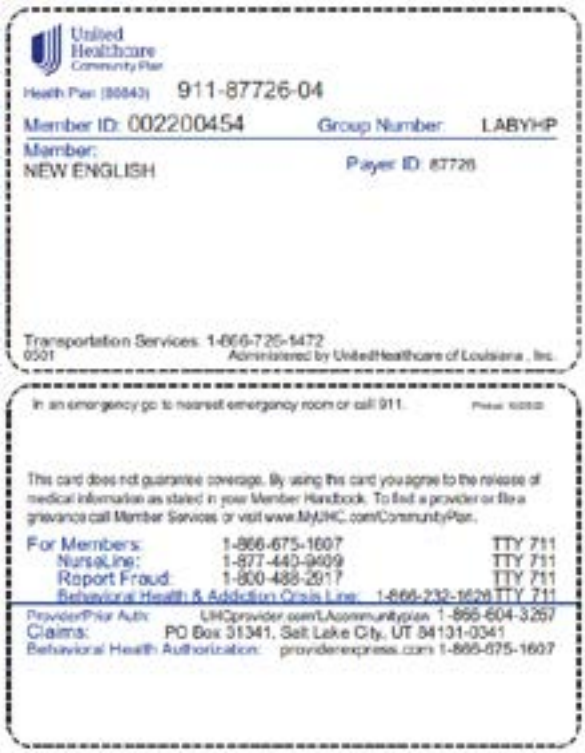
Medical only



Medical and behavioral



Behavioral health only



Re-evaluating enrollee removals

If you feel an enrollee is incorrectly removed from your panel, you can ask us to reconsider that change before the enrollee is moved. You'll have 15 business days to contact us with documentation of a visit from that enrollee in the 12 months covered in the report. Contact information will be included in the letter we send to PCPs, along with the list of enrollees being removed from their panel.

Enrollee eligibility

UnitedHealthcare Community Plan serves enrollees enrolled with Louisiana's Medicaid program. The LDH determines program eligibility. An individual who becomes eligible for the LDH program either chooses or is assigned to one of the LDH-contracted health plans.

Enrollees must meet Louisiana eligibility requirements. We are not involved in eligibility determination or enrollment/disenrollment.

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 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 missed appointments

Sometimes enrollees may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact an enrollee who has not attended or canceled an appointment without rescheduling. Contact the enrollee by phone to:

- Educate them about the importance of keeping appointments
- Encourage them to reschedule the appointment as soon as practicable

For enrollees who frequently cancel or fail to attend appointments, please call **Provider Services** at **1-866-675-1607** to address the situation and discuss our case management program.

Our goal is to help enrollees recognize the importance of maintaining preventive health visits and adhere to a plan of care recommended by their PCPs.

Non-compliant enrollees

Contact Provider Services at **1-866-675-1607** if you have an issue with an enrollee regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the enrollee to provide education and counseling to address the situation, and report to you the outcome of counseling efforts.

Verifying enrollee enrollment

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

- The **UnitedHealthcare Provider Portal** or access the link Portal through **UHCprovider.com/eligibility**
- UnitedHealthcare Community Plan Provider Services is available from 7 a.m.–7 p.m. CT, Monday–Friday

UnitedHealthcare Community Plan Welcome Packet

Upon enrollment with UnitedHealthcare Community Plan, new enrollees will receive a Welcome Packet and enrollee ID card. This packet includes information about how to:

- Use their enrollee ID card
- Call their doctor and schedule a checkup
- Discover their health plan online
- Register on **myuhc.com/communityplan** for more information about their benefits
- Complete a Health Risk Assessment (HRA)
- View, download or request a copy of the member handbook or care provider directory

- Access the member handbook online, or call to request a paper copy. The handbook includes enrollee rights and responsibilities. It also includes Notice of Privacy Practices.

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (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 D-SNP, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. For state-specific information, go to **UHCprovider.com/la** > Medicare > **Dual Complete Special Needs Plans**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-866-675-1607**
Prior authorization	**UHCprovider.com/paan**	
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Pharmacy	**professionals.optumrx.com** lamcopbmpharmacy.com (Magellan Medicaid Adminstration)	**1-877-305-8952** (Optum Rx) 1-800-424-1664 (Magellan Medicaid Administration)

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

Allergy testing and immunotherapy

Coverage includes allergy testing and allergen immunotherapy relating to hypersensitivity disorders caused by generalized systemic reactions and by localized reactions in any part of the body.

Covered allergy services include:

- In vitro specific IgE tests
- Intracutaneous (intradermal) skin tests
- Percutaneous skin tests
- Ingestion challenge testing
- Allergen immunotherapy

Allergy testing

Testing will be covered for enrollees who have symptoms of allergic reactions, such as:

- Respiratory symptoms
- Skin symptoms
- Other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite

Allergen immunotherapy

The following immunotherapy doses will be covered every calendar year, per enrollee. This includes supervision of preparation and provision of antigens:

- Up to 180 doses for antigens other than stinging or biting insects
- Up to 52 doses for antigens related to stinging or biting insects

Additional doses exceeding the listed quantities may be covered if deemed medically necessary.

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)
- Echocardiograms
- Stress echocardiograms

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

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants)

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**. Select the Go to Prior Authorization and Notification Tool
- **Phone** – **1-866-889-8054**, Monday–Friday

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**.

Cardiovascular services

Elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) treatment for cardiovascular conditions are covered under specific circumstances.

This policy only applies to enrollees age 18 and older. It does not apply to:

- Enrollees younger than 18 years
- Pregnant enrollees
- Enrollees with cardiac transplants
- Solid organ transplant candidates
- Survivors of sudden cardiac arrest
- ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Durable medical equipment

DME is equipment that provides therapeutic benefits to an enrollee because of certain medical conditions and/or illnesses. DME consists of items that 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

Ventilators

All non-invasive and invasive ventilators must be prior authorized for a period of 12 months. A rental trial period of up to 3 months is allowed when deemed necessary.

See our Coverage Determination Guidelines at **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > 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 and sore throats.

Covered services include:

- Hospital emergency department room , ancillary and other care by in- and out-of-network care providers
- Medical exam
- 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 care providers 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.

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

After the enrollee has received emergency care, and they cannot be safely discharged, the hospital must determine if the enrollee will move to an observation or inpatient status. If the enrollee will transition to observation, we do not require authorization. If the enrollee is transitioning to inpatient, the hospital has 1 business day to notify UnitedHealthcare Community Plan.

Hospitals notify us of admission by:

- Calling **1-866-675-1607**
- Using the online Prior Authorization and Notification tool at **UHCprovider.com/paan**

Depending on the need, the enrollee may be treated in the ER, in an inpatient hospital room or in another setting. These are called post-stabilization services.

Enrollees do not pay for these services. This applies whether the enrollee receives emergency services in or outside their service area.

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-866-675-1607**.

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 on the UnitedHealthcare Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services 1-866-675-1607**.

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

The criteria are available in writing upon request or by calling **Provider Services** at **1-866-675-1607**.

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 the enrollee presented to the ER.

When an emergency visit results in an inpatient admission, bill all charges associated with the emergency visit on the inpatient bill. This policy applies to enrollees admitted from the ER or if the enrollee has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. Bill the ER charges as a separate line. Include all associated charges for the emergency visit by revenue code with the total charges for the inpatient stay.

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

Electronic visit verification

Per the Louisiana Department of Health Informational Bulletin 23-14, EVV requirements will extend to all home health and personal care services effective January 1, 2024. EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices.

Home Health providers should use the EVV system designed by LDH and the Louisiana Service Reporting System (LaSRS), to electronically report begin and end times for home health services. Providers have access to this system at no cost and should schedule training for the EVV system by calling LDH's EVV contractor, Statistical Resources Incorporated (SRI) at 1-225-767-0501. If a home health provider fails to use LDH's EVV system or complete the attestation, claims will deny effective Feb. 1, 2024.

Home Health providers that would like to continue to use their current EVV vendor may do so by completing the Attestation-for-Providers-Utilizing-Their-Own-EVV-System1.27.23.pdf (la.gov).

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 exam
- Annual Pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services
- Morning-after pill

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/childbirth education programs

- Childbirth education is covered
- Parenting education is not 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 LDH regulations for more information on sterilization.

Women's health

Women's health care providers provide direct access to enrollees for core benefits and services necessary for women's routine and preventive health care services. This access is in addition to the enrollee's PCP if that care provider is not a women's health specialist.

Care coordination/ health education

Work with us to help enrollees receive care coordination services. 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 enrollees' 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
- Collaborate with other 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 enrollee's conditions and comorbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send care coordination 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 case 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 health education program.

Programs are based upon the findings from our Health Risk Assessment and will identify the health education, cultural and linguistic needs.

Diabetic supplies

Effective Dec. 1, 2023, glucose monitors and diabetic supplies will be covered as a pharmacy benefit only.

Examples of diabetic supplies:

- Diabetic glucose meters
- Lancets and devices
- Continuous glucose meters

Contact Magellan Medicaid Administration for questions at 1-800-424-1664. Prior authorization is required on all diabetic supplies and equipment equipment valued at more than $500 per line item.

Continuous glucose monitoring devices

Continuous glucose monitoring (CGM) devices are covered as DME, and prior authorization is required. Beneficiaries must meet one of the following eligibility criteria:

- Diagnosis of any type of diabetes with the use of insulin more than 2 times daily
- Evidence of level 2 or level 3 hypoglycemia
- Diagnosis of glycogen storage disease type 1a

CGM devices require a prescription and documentation of medical necessity. In addition, beneficiaries who receive this coverage are required to attend regular follow-up visits with a health care professional at a minimum of every 6 months to assess the ongoing benefits. Short-term CGM devices will not be considered as a covered device.

Health Home

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of the state's highest-need individuals. Health Home helps improve coordination of care and quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable ER visits, inpatient psychiatric admissions and the need for nursing home admissions. We work with area hospitals to provide transitional care services to enrollees enrolled in Health Home.

Hospitals and care providers may refer individuals to us for potential Health Home enrollment. The program determines Health Home eligibility. The program provides services beyond those typically offered by care providers, including:

- Comprehensive care management
- Care coordination and health promotion
- Individual and family support
- Referral to community services

For more information about Health Home, call **Provider Services** at **1-866-675-1607**.

Hearing services

Monaural and binaural wearable hearing aids are covered. This includes fitting, follow-up care, batteries and repair.

Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for enrollees younger than 21 years old.

Unilateral or bilateral cochlear implants are covered when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in enrollees younger than 21 years of age. Any implant must be used based on FDA guidelines. Implants, parts, accessories, batteries, charges and repairs are covered.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice.

Home hospice

We cover benefits for routine home care every day the enrollee is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the enrollee's home during a medical crisis. A medical crisis is when an enrollee requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the 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. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

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

Enrollees receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. The LDH covers residential inpatient hospice services. The LDH will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

Labcorp and Quest are the preferred lab providers. Contact Labcorp or Quest directly.

Use an in-network laboratory when referring enrollees for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentists 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/findprovider** > **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 care providers rendering clinical laboratory and certain other diagnostic services.

Genetic counseling policy

Genetic counseling is required before and after all covered genetic testing procedures. Counseling consists of structured family genetic history as well as genetic risk assessments and counseling about

diagnosis, prognosis and treatment. A licensed genetic counselor must perform the counseling using the genetic counseling procedure code.

Genetic counseling is reimbursed as "incident to" the services of a supervising physician. It is limited to 90 minutes on a single day of service. If performed by other providers, the service is reimbursed under the applicable evaluation and management (E/M) code.

Urine drug testing

Presumptive and definitive urine drug testing is covered under the following parameters:

- Presumptive drug testing is limited to 24 total tests per enrollee per calendar year
- Definitive drug testing is limited to 12 total tests per enrollee per calendar year
- Definitive drug testing is limited to individuals with an unexpected findings on presumptive drug testing or if there is a clinical reason to detect a specific substance or metabolite that would be detected through presumptive drug testing
- We do not reimburse for testing more than 14 definitive drug classes in 1 test
- We reimburse no more than 1 presumptive test and 1 definitive test per day per enrollee, from the same or different care provider
- We do not cover universal drug testing (screening) in a primary care setting
- We do not cover drug testing without signs or symptoms of substance use or without current controlled substance treatment

See the **Billing and submission** chapter for more information.

Maternity/pregnancy/well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of an enrollee's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Access the digital Notification of Pregnancy form through the UnitedHealthcare Provider Portal or at **UHCprovider.com**. You may also call Healthy First Steps at **1-800-599-5985** or fax the notification form to 1-877-353-6913.

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the enrollee's risk level and provide enrollee-specific needs that support the care provider's plan of care
- Help enrollees understand the importance of early and ongoing prenatal care and direct them to receiving it
- Provide multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the enrollee's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-enrollee collaboration before and after delivery as well as for nonemergent settings
- Encourage enrollees to stop smoking with our Quit For Life tobacco cessation program
- Help identify and build the mother's support system, including referrals to community resources and pregnancy support programs

Program staff act as a liaison between enrollees, care providers and UnitedHealthcare Community Plan for care coordination.

Prenatal visits

Bill the initial pregnancy visit as a separate office visit. You may bill maternity care globally only if the pregnant enrollee has commercial coverage that requires it.

Two initial prenatal visits per pregnancy (270 days) are covered. These 2 visits may not be performed by the same attending care provider.

The enrollee is considered a new patient for each pregnancy whether or not the enrollee is a new or

established patient to the provider/practice. The appropriate level E/M CPT procedure code is required to be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Along with the TH modifier, reimbursement for the initial prenatal visit will include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the following ultrasound policy.)
- Identification of patient at risk for complications including those with prior pre-term birth
- Health and nutrition counseling
- Routine dipstick urinalysis

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E/M without the TH modifier.

Obstetrical ultrasounds

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. For OB/GYN providers, we allow up to 3 obstetrical ultrasounds per pregnancy. Obstetrical ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.

The fourth and subsequent ultrasound procedures will only be allowed for identified high-risk enrollees. High-risk enrollee claims must include the corresponding diagnosis code. When an ultrasound is performed for an individual with multiple gestations leading to more than 1 procedure code being submitted, this will only count as 1 obstetrical ultrasound. Maternal fetal providers can be reimbursed for detailed fetal anatomic examinations (76811/76812) in addition to standard ultrasounds, with no limit on the number of OB ultrasounds.

Fetal non-stress test

Fetal non-stress tests are covered when medically necessary as determined by meeting one of the following criteria:

- The pregnancy is post-date/post-maturity (after 41 weeks gestation)
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy
- The pregnancy is high risk, including but not limited to, diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations and previous intrauterine fetal death

Fetal biophysical profile

Biophysical profiles are covered if considered medically necessary, as determined by meeting at least 2 of the following criteria:

- Gestation period is at least 28 weeks
- Pregnancy must be high risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy

For prior authorization maternity care, including out-of-plan and continuity of care, call **Provider Services** at **1-866-675-1607**or go to **UHCprovider.com/paan**. For more information about prior authorization requirements, go to **UHCprovider.com/lacommunityplan** > **Prior Authorization and Notification**.

39-week initiative

All professional delivery claims must report a maternity modifier as outlined:

Modifier	Description	Claims process rules
GB	Delivery is 39 weeks or more	Claim will be adjudicated
AT	Delivery is less than 39 weeks and medically indicated/ spontaneous	Claim will be adjudicated

Modifier	Description	Claims process rules
GZ	Delivery is less than 39 weeks and **not** medically indicated	Claim will be adjudicated (deny)
None	Claim will be denied for incomplete information	Claim will deny

Pregnant UnitedHealthcare Community Plan enrollees should receive care from network 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.

We 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

UnitedHealthcare Community Plan recommends, but does not require, hospitals notify us of maternity admissions. 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** at **1-866-675-1607**.

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

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the mother's discharge require separate notification and will be subject to medical necessity review. The C.N.M. must be a licensed R.N. recognized by the Board of Nurse Examiners as an A.P.N. in nurse-midwifery and certified by the American College of Nurse-Midwives. A C.N.M. 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 an N.P., P.A. or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

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

Tobacco cessation counseling

Tobacco cessation counseling is now covered for all Louisiana Medicaid enrollees. Reimbursement for tobacco cessation counseling shall be a flat fee based on the appropriate current procedural terminology (CPT) code. The CPT codes are time-based, and the documentation of these services must include the amount of time spent with the patient.

If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E/M visit, supported by clinical documentation, an appropriate modifier to indicate a separate service is required.

Include the TH modifier on claims for tobacco cessation counseling within the prenatal period. Do not use the TH modifier for postpartum services.

Human donor milk

Human donor milk is covered under the DME benefit as an outpatient service for use by medically vulnerable infants.

Breast pump

Personal use, double and electric breast pumps are now covered at the gestational age of 32 weeks. A new breast pump is allowed with each pregnancy. DME providers are required to complete the Breast Pump Request Form at lamedicaid.com > Resources > Forms/Electric Breast Pump Request Form and Instructions.pdf and submit all required documentation. Please note single, manual and hospital-grade breast pumps are still not covered.

Human milk storage bags

Human milk storage bags are covered under the DME benefit (HCPCS K1005) for lactating enrollees. To be covered, the enrollee must have a prescription and supporting documentation (which can be the prescription itself) that enrollee is lactating. Enrollees get 100 bags per month, a 1-month supply (1 unit).

For additional pregnant enrollee and baby resources, see Healthy First Steps Rewards in **Chapter 6.**

Post-maternity care

We cover post-discharge care to the mother and her newborn. A case manager completes a postpartum assessment by phone 2 weeks after discharge and follows up as needed. If the infant is admitted into the neonatal intensive care unit (NICU), a NICU case manager is assigned to the mother to coordinate care for the newborn. Prior authorization is required for home health care visits for post-partum followup. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital is responsible to notify the parish of all deliveries, including our enrollees.

If the mother delivers out of state, the enrollee should contact LDH's Enrollment Department to provide birth notification. The Enrollment Department would then add the baby to the health plan.

Bright Futures assessment

Bright Futures™ is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP). It is supported by the U.S. DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

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

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Settings for Bright Futures implementation include:

- Private practices
- Hospital-based or hospital-affiliated clinics
- Resident continuity clinics
- School-based health centers
- Public health clinics
- Community health centers
- Indian Health Service clinics
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

The discharge planner ordering home care should call **Provider Services** at **1-866-675-1607** 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 they were told before the surgery the procedure will result in permanent sterility.

Find the form on lousiana.gov.

See **Sterilization consent form** section below for more information. LDH 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 Louisiana 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 care provider network.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures is 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 State Medical Assistance 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. The enrollee must be at least 21 years old when they sign the form.

The enrollee must not be mentally incompetent or live in a facility treating mental 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 LDH Medical Assistance 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 Louisiana Medical Assistance 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 after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the enrollee within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on louisiana.gov.

Have 3 copies of the consent form:

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

Neonatal intensive care unit case management

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

The NICU case management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High-risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and UM nurses, health plan R.N.s and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Patient-centered medical home

The patient-centered medical home (PCMH) is how we approach providing complete primary care. The PCMH is a health care setting that helps develop relationships between enrollees, their family, and you. A medical home is accessible, continuous, complete, family-centered, coordinated, compassionate and culturally effective primary care.

This clinical model is at the heart of health care reform and delivery system. Engaging patients in communities of care will improve the efficiency and effectiveness of the health care system. This model expands our relationship with care providers from a payment model to clinical, value-added services in delivering more efficient and effective care to our enrollees. It also improves trust and satisfaction with our network community.

UnitedHealthcare Community Plan supports activities such as risk stratification, evidence-based interventions and advanced analytics. The core principal characteristics of a PCMH are based on:

- Physician-directed practice
- Whole-person care orientation
- Coordinated care
- Quality and safety
- Enhanced care access
- Optimization through health information technology integration (e.g., pharmacy, patient registry)
- Practice operates as a team
- Comprehensive scope of services

Oncology

Prior authorization

To help ensure our enrollee benefit coverage is medically appropriate, we regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence, published clinical guidelines and specialty society guidance. For information about our oncology prior authorization program, including radiation and/or chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology**.
Or call Optum at **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its Prescription Drug List (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of Lousiana enrollees. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe Medicaid enrollees drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If an enrollee requires a nonpreferred medication, call Pharmacy Prior Authorization at **1-800-310-6826**. You may also fax a Pharmacy Prior Notification Request form to 1-866-940-7328.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Brand-name and generic drugs

Claims for multi-source brand-name products not included in the PDL/NPDL process (i.e., drugs not listed on the PDL), are not subject to prior authorization.

Filling a brand-name product without a prior authorization is allowed in the following situations:

- DAW "1" – Brand-name medically necessary from prescriber
- DAW "5" – Substitution allowed-brand drug dispensed as a generic (should be allowed when the brand drug is less expensive for 340B providers)
- DAW "8" – Substitution allowed, generic drug not available in marketplace
- DAW "9" – Preferred brand over generic drugs

Pharmacy prior authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start before prior authorization is secured, and the prescriber cannot be reached. The rules apply to nonpreferred PDL drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826**. You may also fax your authorization request to 1-866-940-7328. We provide notification for prior authorization requests within 24 hours of request receipt.

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** > Prior Authorization > **Clinical Pharmacy and Specialty Drugs**.

Requirement of specialty pharmacy and home infusion care providers to be a network care provider

We have contracted care providers for the distribution of specialty pharmacy and home infusion medications.

They distribute specialty medications covered under an enrollee's medical benefit. This national network provides specialty medication fulfillment and distribution to meet the needs of our enrollees and our participating care providers. The contracted specialty pharmacy or home infusion care provider's agreement identifies their full program participation requirements.

We may deny, in whole or in part, any claim when you use a non-participating specialty pharmacy provider, wholesaler or direct purchase from the manufacturers without prior approval from us. Hospitals may also be subject to other administrative actions based on their Agreement.

Requirement to use a participating specialty pharmacy provider for certain medications

Hospitals contracted with UnitedHealthcare Community Plan are required to obtain certain specialty pharmacy medications from a participating specialty pharmacy when they are administered in an outpatient hospital setting, unless otherwise authorized by us. The specialty pharmacy will dispense these drugs in compliance with the corresponding drug policy and the enrollee's benefit plan and eligibility, and bill us for the medication.

The hospital only needs to bill UnitedHealthcare Community Plan for medication administration and should not bill for the medication itself. Enrollees cannot be billed for the medication.

For a list of the medications and participating specialty pharmacy care provider(s), go to: **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Community Plan Drug Lists for Limited Supplier Protocol**.

This requirement does not apply in situations in which the enrollee has Medicare or another health benefit plan as the primary payer and UnitedHealthcare Community Plan is the secondary payer.

We anticipate that all hospitals should be able to procure the medications from a participating specialty pharmacy provider. If a hospital does not obtain the specialty medication through the indicated specialty pharmacy, we will issue a denial of payment for the medication, in whole or in part, for failure to follow the protocol. Hospitals may not bill enrollees for medication that is denied for failure to follow the protocol.

Please contact your UnitedHealthcare Community Plan provider advocate if you have questions.

Physician-administered medication

Physician administered medications that are included on the PDL shall have the same preferred status and prior authorization criteria as the PDL, even when billed and paid as a medical benefit.

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:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- 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 8 a.m.–5 p.m. CT, Monday–Friday. Make sure the medical record is available.
- For PET Scan prior authorizations please contact UHC direct at **1-866-675-1607**.

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**.

Screening, brief interventions and referral to treatment services

SBIRT services are covered when:

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

What is included in SBIRT?

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 registered behavioral health agency for assessment and treatment of a substance use disorder (SUD). **This includes coordinating with the alcohol and drug program in the county where the enrollee resides for treatment.**

SBIRT services will be covered when all are met:

- The billing care provider and servicing care provider are SBIRT-certified
- The billing care 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 mental 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 (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The FDA-approved medications for OUD include buprenorphine, methadone and naltrexone.

To prescribe buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health 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 MAT care provider in Louisiana:

1. Go to **UHCprovider.com**.
2. Click "Our Network," then "Find a Provider." Click on "Search for Doctors, Clinics or Facilities by Plan Type."
3. Select "Search for Care Providers in the General UnitedHealthcare Plan Directory."
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 **1-866-675-1607** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Sinus procedures

Balloon ostial dilation and functional endoscopic sinus surgery are covered for the treatment of chronic rhinosinusitis when certain criteria are met. This includes uncomplicated chronic rhinosinusitis; persistent sinonasal symptoms after maximal medical therapy has been attempted and objective evidence of sinonasal inflammation.

The procedure is not covered for the:

- Presence of sinonasal symptoms with no evidence of sinonasal disease
- Treatment of obstructive sleep apnea and/or snoring absent additional criteria
- Treatment of headache absent additional criteria and for balloon ostial dilation only, when sinonasal polyps are present

Skin substitutes

Skin substitutes for Chronic Diabetic Lower Extremity Ulcers are covered and considered medically necessary for the treatment of partial and full thickness diabetic lower extremity ulcers when certain criteria are met. Coverage is limited to a maximum of 10 treatments within a 12-week period.

Transportation services

UnitedHealthcare Community Plan provides emergency and nonemergency medical transportation for enrollees. Transportation is covered to and from network providers for Medicaid-covered services within Geo Access Standards.

Provider type	Urban miles	Rural miles
Specialist	60	60
PCP	10	30
OB/GYN	15	30
Radiology/ diagnostics/lab	20	30
Behavioral/ mental health	15	30

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep enrollees from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Nonemergent air ambulance requires prior authorization.

For authorization, go to **UHCprovider.com/paan** or call **Provider Services** at **1-866-675-1607**.

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. The mileage payment would be based on the enrollees point of origination (pick up) and should be billed with the appropriate origination and destination modifier in the first position. 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.

Meals and lodging

Hotel stays and meals will be paid for long-distance trips that require an overnight stay with prior approval for eligible enrollees. "Long distance" means the total travel time and duration of the appointment exceeds 12 hours.

Nonemergent ambulance transportation

Enrollees may get nonemergent stretcher/ambulance transportation services for covered services. Enrollees may get transportation when they are bed-confined before, during and after transport. A Certification of Ambulance Transportation form is required and must be completed.

Nonemergent stretcher/ambulance transportation must be requested at least 2 business days in advance. Requests can be made by calling 1-866-726-1472.

If enrollees need help scheduling rides, a transportation customer service representative (CSR) can assist. Services may be scheduled up to 14 days in advance.

Call 1-866-886-4081 for all nonemergency hospital discharge transportation requests:

- Press 1 for a hospital discharge, including a same day or next day discharge, or a facility-to-facility transfer for higher level of care
- Press 2 to schedule a nonemergency ambulance trip, including a same day or next day request
- Press 3 to speak with a care manager

Nonemergency medical transportation

NEMT services are available through Modivcare. Transportation is provided by van, bus or public transit, depending on an enrollee's medical needs. Wheelchair service is provided if required by medical necessity.

For non-urgent appointments, enrollees must call 1-866-726-1472 for transportation at least 2 business days before their appointment.

Opioid treatment

UnitedHealthcare Community Plan covers transportation to Medicaid-covered opioid treatment program locations. Enrollees are not restricted to services offered in their geographic region.

Tuberculosis screening and treatment

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 coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance and follow-up. PCPs must comply with all applicable state 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.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering care provider name and TIN/NPI number
- Rendering care provider and TIN/NPI number
- 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 number, when applicable

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

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of request	Decision turn-around time	Practitioner notification of approval	Written practitioner/ enrollee notification of denial
Non-urgent preservice	Within 5 working days of receipt of medical record information required but no longer than 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited preservice	Within 3 days of request receipt	Within 3 days of the request	Within 3 days of the request
Concurrent review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and enrollee notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and enrollee notification within 2 business days

Prior authorization adverse determinations

UnitedHealthcare Community Plan will ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease determines service authorization request denials or approval of a service in an amount, duration or scope that is less than requested.

UnitedHealthcare Community Plan will include in all final adverse determination notices all of the following available and applicable information:

- Medical criteria name
- Website link to access the criteria; the page number and section/paragraph the criteria can be found

Case management

We provide case management services to enrollees with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses enrollees who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Case managers use a holistic approach to assess enrollees. They consider Medicaid-covered services and other community resources as applicable. Case managers are expected to:

- Respect the enrollee's rights
- Provide adequate information and training to help the enrollee and their representative/family make informed decisions about their care
- Provide service options that support the care plan
- Coordinate access to non-Medicaid covered services available throughout the community
- Educate the enrollee and their representative/ family on how to report issues with service delivery to UnitedHealthcare Community Plan so they can be addressed as quickly as possible
- Advocate for the enrollee/family/representative and others as the need occurs
- Allow the enrollee and their representative/family to identify their role in the service system
- Provide enrollees with flexible service delivery options
- Provide you with information about changes in enrollee's functioning to assist the provider in planning, delivering and monitoring services

- Coordinate across all facets of the service system to maximize the efficient use of resources and minimize any negative impact to the enrollee

We offer specialized case management for EPSDT PCS, PDN and/or PDHC recipients by calling **1-800-377-5105**.

Refer enrollees for case management by emailing Care Management at **lacaid_cm_referrals@uhc.com**. Alternatively, providers can call **Provider Services** at **1-866-675-1607**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk pregnancies.

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 conduct reviews by phone, record review and EMR exchange for each day's stay using InterQual®, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings.

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 on site, or by phone or record review.

Your cooperation is required with all our requests for information, documents or discussions related to concurrent review and discharge planning. This includes:

- Primary and secondary diagnosis
- Clinical information
- Care plan
- Admission order
- Enrollee status
- Discharge planning needs
- Barriers to discharge
- Discharge date

When available, provide clinical information by access to 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 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
- LTAC
- Acute rehabilitation
- SNFs
- Home health care
- Ambulatory facilities

Utilization management guidelines

Call **1-866-675-1607** to discuss the guidelines and 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 an FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on an FFS 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

UM appeals are considered medically necessary appeals. They contest the UnitedHealthcare Community Plan UM decision. This includes such things as admission, extension of stay, level of care or other health care services determination. 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.

Continuance of higher level of care

UnitedHealthcare Community Plan will not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless we can provide the service through an in-network or out-of-network care provider for a lower level of care.

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
- Not experimental treatments

Determination process

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

Discharge planning coordination

Effective and timely discharge planning is a key part of using appropriate services and preventing re-admissions. The hospital staff and the attending physician develop the discharge plan. This plan involves the enrollee, family and the UnitedHealthcare Community Plan case manager.

Our concurrent review nurse works with the hospital discharge team and attending physicians to help ensure cost-effective and quality services are provided at the appropriate level of care. This may include:

- Assuring early discharge planning
- Facilitating or attending discharge planning meetings for enrollees with complex discharge needs
- Providing hospital staff and attending physician with names of participating care providers
- Informing hospital staff and attending physician of covered benefits

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan**.

UnitedHealthcare Community Plan encourages all hospitals, physicians, and other care providers to adopt certified electronic health record technology (CEHRT). Please comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).

Medical policies and procedures updates or changes

Before adopting, approving, amending or implementing a policy or procedure, UnitedHealthcare Community Plan will submit the proposed policy or procedure to LDH for approval. LDH will publish the policy on a publicly accessible LDH website page for no less than 45 days to solicit public comments. The proposed policy or procedure will be published in a format determined by LDH, and will include both the existing policy or procedure and the proposed policy and procedure, with the proposed language in the text printed in boldface type and underscored. All present policy or procedure language and punctuation, which are to be deleted, will be struck through.

UnitedHealthcare Community Plan will not implement the proposed policy or procedure unless LDH has provided its written approval after the expiration of the public notice period.

Physician medical review

Our concurrent review nurse or the prior authorization nurse reviews the documentation for medical necessity based on InterQual criteria. When the criteria are not met, the case is referred to the medical director. The medical director reviews the documentation and discusses the case with the nurse. The medical director may call the attending or referring physician for more information. The requesting physician may be asked for more information. Based on the discussion, the medical director may approve, deny, modify, reduce, suspend or end a pending service.

For inpatient denials, the attending physician and hospital are notified in writing. They may dispute the medical director's finding by filing a formal grievance. For denial of outpatient authorizations, the referring physician, the PCP (if not the referring physician) and the enrollee are notified in writing. The care provider or enrollee may ask for an expedited appeal for any treatment denial, suspension or reduction in services.

Our prior authorization requirements are outlined in the Louisiana Revised Prior Authorization List. The list is on **UHCprovider.com**. If we are the enrollee's primary payer, we may require prior authorization. If we are the secondary payer, we may be responsible for enrollee copays and deductibles.

Prior authorization is not required if we are the secondary payer. You may not balance bill a UnitedHealthcare Community Plan enrollee, per Louisiana Medicaid guidelines.

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. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the enrollee is eligible on the date of service by using the UnitedHealthcare Provider Portal or **UHCprovider.com**, or call **Provider Services** at **1-866-675-1607**, or the Louisiana 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 LDH. 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. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward 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 contact UnitedHealthcare Community Plan at **1-866-675-1607**.
- 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 requiring prior authorization

For a list of services that require prior authorization, go to **UHCprovider.com/lacommunityplan** > **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
- **Observation** – after a maximum of 48 hours of observation, hospitals have 1 business day from the transition to inpatient status to notify us of the admission. Notifications received after 1 business day will be administratively denied. Approval must be obtained within 1 business day of the admission. Approval for inpatient days subsequent to the notification will be based on medical necessity.
- **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

Telemedicine/Telehealth

UnitedHealthcare allows for telehealth and telemedicine for many common health care services. Treatment-in-place service is a telehealth appointment by an ambulance provider. UnitedHealthcare Community Plan does not allow payment for both emergency transport to the hospital and treatment-in-place for the same incident.

Billing instructions

Providers must indicate the appropriate place of service (either 02 [other than home] or 10 [home]) based on the enrollee's location at the time of service and must append modifier -95. Services delivered via an audio/video system and via an audio-only system are to be coded the same way.

Reimbursement for these services in an FQHC/RHC will be at the all-inclusive prospective payment rate on file for the date of service.

Refer to the **Telehealth and Telemedicine Policy**.

In lieu of services

In lieu of services (ILOS) are services or settings of care determined to be acceptable substitutes for covered state plan services on a case-by-case basis, based on medical necessity and what is deemed appropriate by the medical director. ILOS are typically provided in alternative settings and/or by non-traditional providers and are developed with the intention of promoting greater access to services. Enrollees are not required to use the alternative service or setting but may choose to do so.

Physical health in lieu of services

UnitedHealthcare Community Plan offers the following authorized physical health ILOS:

- Doula services

Behavioral health in lieu of services

UnitedHealthcare Community Plan offers the following authorized behavioral health ILOS:

- Freestanding psychiatric hospitals for adults ages 21–64
- Injection services provided by licensed nurses to adults aged 21 and older
- Mental health intensive outpatient programs
- Therapeutic day center for ages 5–20
- Integrated behavioral health homes

Chapter 5: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/prevention

Key contacts

Topic	Links	Phone number
EPSDT	**UHCprovider.com**	Intake phone number **1-866-675-1607**
Vaccines for Children	cdc.gov/vaccines/programs/vfc	1-504-568-2600

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is a complete health care program for eligible children younger than 21 years old who are enrolled in Medicaid. All Medicaid enrolled providers that provide EPSDT well-child preventive screenings must be enrolled in the VFC program and utilize VFC vaccines for recipients aged birth through 18 years of age.

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan enrollees younger than 21 years old, including pregnant women.

Early and Periodic Screening, Diagnostic and Treatment preventive screening

Perform a full screen according to the most current AAP/Bright Futures periodicity schedule for enrollees younger than 21 years old. Include:

- Complete health and developmental history (including physical, nutritional, and behavioral)
- Unclothed yet suitably draped, comprehensive physical examination
- Health education, to include anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- The blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on site on the same medical date of service as the screening visit
- Lead risk assessment
- Psychosocial/behavioral assessment
- Developmental assessment and objective screening (including global developmental screening at 9, 18 and 30 months; autism screening at 18 and 24 months)
- Hearing and vision assessment and objective testing
- Documentation of BMI for children 2 years and older
- Dental/oral health

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

If an abnormality or problem is encountered and treatment is significant enough to require an additional E/M service on the same date, by the same provider, no additional E/M of a level higher than CPT code 99212 is reimbursable.

The physician, A.P.R.N., or P.A. listed as the rendering provider must be present and involved during a preventive visit. Any care provided by an R.N. or other ancillary staff in a provider's office is subject to the "Incident to" Services policy and must only be providing services within the scope of their license or certification. Claims for preventive screening visits submitted with modifier "TD" will be denied.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule. They are often used for sports physicals, Head Start enrollment and to rule out alternate causes for behavioral issues such as ADHD. Office visits and screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the enrollee's record.

An interperiodic screening may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the EPSDT preventive periodic screening.

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology or other procedures may also be performed and may be billed separately. A well diagnosis is not required.

Developmental and autism screening

Developmental and autism screenings administered during EPSDT preventive visits are based on the AAP/Bright Futures periodicity schedule. We will only reimburse the use of age-appropriate, caregiver-completed and validated screening tools as recommended by the AAP.

If an enrollee screens positive on a developmental or autism screen, you must give appropriate developmental health recommendations, refer the enrollee for additional evaluation, or both, as clinically appropriate. Also document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the enrollee's medical record.

Developmental screening and autism screening are currently reimbursed using the same procedure code. You may only receive reimbursement for 1 developmental screen and 1 autism screen per day of service. To receive reimbursement for both services performed on the same day, submit claims for 2 units of the relevant procedure code.

Developmental and autism screening are reimbursed separately when performed based on the AAP/Bright Futures periodicity schedule or when medically indicated. Use a standardized tool referenced by the AAP/Bright Futures.

Perinatal depression screening

Administer perinatal depression screening to an enrollee's caregiver based on the AAP/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an EPSDT preventive visit, interperiodic visit, or E/M office visit. This service is a recommended part of well-child care.

Perinatal depression screening must employ one of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9

You must document the tool used, the results and any follow-up actions taken. If an enrollee's caregiver screens positive, refer the caregiver to available resources, such as their PCP, obstetrician or mental health professionals. Document the referral. If screening indicates possible suicidality, concern for the safety of the caregiver or enrollee, or another psychiatric emergency, you must refer them to emergency mental health services.

Though the screening is administered to the caregiver, we reimburse this service under the child's Medicaid coverage. If 2 or more children younger than 1 year present to care on the same day (e.g., twins or other siblings both younger than 1 year), you must submit the claim under only one of the children. When performed on the same day as a developmental screening, you must append modifier-59 to claims for perinatal depression screening.

Developmental disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the enrollee reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment.

The Office for Citizens with Developmental Disabilities (OCDD) serves is the entry into the developmental disabilities service system. OCDD services and programs include EarlySteps, Flexible Family Fund, Individual and Family Support, Supported Living, Resource Centers, Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) and Waiver Services.

Referral

If you determine supportive services would benefit the enrollee, refer the enrollee to an OCDD local human services district or authority. The OCDD Resource Center's mission is to collaborate with care providers to help identify and support needs. It also helps develop activities, interventions and products that strive to achieve positive outcomes for persons with disabilities. Find out more about the EarlySteps referral form and resources at ldh.la.gov/ocdd.

Continuity of care

The regional center will determine the most appropriate setting for eligible HCBS Waiver services and will coordinate these services for the enrollee in collaboration with the PCP and health plan coordinator. The PCP will continue to provide and manage primary care. If the enrollee does not meet criteria for the program or placement is not currently available, UnitedHealthcare Community Plan will provide care coordination as needed to support the enrollee's screening, preventive, medically necessary and therapeutic covered services.

EarlySteps program

EarlySteps, an OCDD program, provides early intervention services to infants and toddlers aged birth to 3 years with delays in cognitive, motor, vision, hearing, communication, social, emotional or adaptive development. Services are provided in the child's natural environment, such as the child's home care setting, or other community setting typical for infants to toddlers.

Referral

Refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. State and federal regulations require care providers who serve infants/toddlers from birth to age 3 make referrals to the OCDD for early intervention services. Make referrals within 7 days of determining an infant/toddler may need early intervention services due to a developmental delay or a disability likely to result in a developmental delay if early intervention services are not provided. After contacting the regional center or local office, a service coordinator will be assigned to help the child's parents through the process to determine eligibility for needed intervention services. For more information, the EarlySteps referral form and referral resources, go to ldh.la.gov.

Continuity of care

Support the development of the Individualized Family Service Plan (IFSP) created by the EarlySteps program through either the local regional center or LEA. This helps ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP.

Lead screening/treatment

All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the 24 months and 72 months of age must receive a screening blood lead test if they have not been previously screened. A blood lead test result equal to or greater than 5 ug/dLl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months to 6 years to assist in determining risk.

The CDC Lead Poisoning Management Summary Chart provides management guidelines. Find out more at lead.dhh.la.gov.

Healthy Louisiana applied behavioral analysis program

UnitedHealthcare Community Plan is one of the selected managed care plans providing coverage to Healthy Louisiana enrollees. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Healthy Louisiana enrollees. Your participation in our network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled enrollees.

To assist you in your participation in this program, learn more about the process for applying to the network, and the clinical protocols required in this unique network, please review the resource materials at **providerexpress.com** > Clinical Resources > Autism/ Applied Behavioral Analysis > **abaLAMedicaid**.

Vaccines for Children program

The VFC program provides immunizations. Immunizations offered in the state VFC program must be ordered at no cost to children through VFC-enrolled care providers. We do not reimburse for the vaccine ordered by the VFC program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.

Contact VFC if you have questions.
Phone: 1-504-568-2600

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured. (These children have health insurance, but the benefit plan does not cover immunizations. Children in the uninsured category may not only receive vaccinations from an FQHC or RHC; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Additional resources

UnitedHealthcare Community Plan does not require specific EPSDT documentation forms. For more details information, risk assessments, forms and information, please visit the following sites:

- American Academy of Pediatrics – aap.org
- The Advisory Committee on Immunization Practices – cdc.gov/vaccines/recs/acip
- The American Academy of Family Physicians – aafp.org
- Louisiana Immunization Network for Kids Statewide (LINKS) – lalinks.org/linksweb/main.jsp
- Bright Futures – brighfutures.aap.org

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-866-675-1607**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/la** > View plan details	**1-866-675-1607**

We offer the following services to our UnitedHealthcare Community Plan enrollees. If you have questions or need to refer an enrollee, call **Provider Services** at **1-866-675-1607** unless otherwise noted.

- **Unlimited visits** offered to enrollees with participating PCPs and specialists if deemed necessary by their PCP
- **$20 gift card** offered for enrollees completing a PCP visit within 90 days of enrollment
- **$20 gift card** offered for 1 well-child visit each year between the ages of 1 and 17
- **$10 gift card** offered for completing a health needs assessment within 90 days of enrollment
- **Asthma home assessment** offered for moderate to severe asthmatics when referred by your PCP or care manager with a certified in-network asthma educator. One visit per year.

Adult access to health

- **Adult dental benefit** – Enrollees 21 years and older are eligible to receive 2 routine dental exams and cleanings per calendar year, and X-rays once per year with an in-network provider, limited to $500 per calendar year.
- **Adult vision benefit** – Enrollees 21 years and older will be provided additional vision services to complement the limited Medicaid vision benefits. Services include 1 routine eye exam every calendar year and $100 allowance for frames/lenses or $105 toward contact lenses every year. Note: Vision services performed by an optometrist are reimbursable for routine and non-routine services and must be submitted to March Vision for processing. This is due to the expanded scope of the services the Louisiana Board of Optometry now allows optometrists to perform in the office setting.
- **Adult pain management** – Enrollees 21 years and older are allowed 24 visits per calendar year to an in-network chiropractor or acupuncturist (can be a combination, but not to exceed a total of 24 visits per year)
- Epidurals are covered that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, as professional services. Please refer to Professional Services Fee Schedule for covered codes.

Adult pain management/ chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

We provided enrollees 21 years and older with up to 24 visits per calendar year with an in-network chiropractor or acupuncturist (can be a combination, but not to exceed a total of 24 visits per year). This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

1. Go to **myoptumhealthphysicalhealth.com.**
2. Enter your care provider ID and password.
3. Click “Tools & Resources.”
4. Click “Plan Summaries” or “Fee Schedules.”

For more information on chiropractic and acupuncture care, go to **myoptumhealthphysicalhealth.com** or call **1-800-873-4575.**

Chronic condition management

We use educational materials and newsletters to remind enrollees to get their immunizations, check-ups and screenings. For those enrollees with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring and self-care through our disease management

UnitedHealthcare Community Plan provides enrollee case management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

For more information, go to earlysteps.dhh.louisiana.gov.

Healthy First Steps

Healthy first steps (HFS) is a specialized case management program designed to provide assistance to all pregnant enrollees and those experiencing an uncomplicated pregnancy. It also helps manage medical, behavioral and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant enrollees. Care management staff are board-certified in maternal and neonatal medicine.

Enrollees self-enroll on a smartphone or computer. They can go to **uhchealthyfirststeps.com** and click on "Register" or call **1-800-599-5985**.

How it works

Care providers and UnitedHealthcare Community Plan reach out to enrollees to enroll them.

Enrollees enter information about their pregnancy and upcoming appointments online. They get reminders of upcoming appointments and record completed visits.

How you can help

1. Identify UnitedHealthcare Community Plan enrollees during prenatal visits.
2. Share the information with the enrollee to talk about the program.
3. Encourage the enrollee to enroll in Healthy First Steps Rewards.

Hypoallergenic bedding

Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can help to lower asthma-related hospitalizations and ER visits.

Hypoallergenic bedding is limited to individuals with asthma in case management. It is limited to $150 annually per enrollee. The program requires prior authorization and documentation stating they have severe asthma. The enrollee's service coordinator will decide eligibility.

Mobile apps

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

- **SMART Patient** – allows users to track important numbers such as blood pressure, record appointments and record doctors' orders. It also helps them view educational videos.
- **DocGPS** – lets users search the UnitedHealthcare Community Plan provider network and obtain travel directions to a care provider's location. The app lets them call a care provider by tapping on the search result.

NurseLine

NurseLine is available at no cost to our enrollees 24 hours a day, 7 days a week. Enrollees may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate enrollees about staying healthy. Call **1-877-440-9409** to reach a nurse.

Quit For Life

The Quit For Life® program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavorial strategies to help enrollees take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching and web-based learning tools, the Quit For Life program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% enrollee satisfaction. Quit For Life is for enrollees 13 years and older.

Substance use disorder recovery coaching

Our SUD recovery coach works with enrollees to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible enrollees are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

UHC Latino

Latino | UnitedHealthcare (uhc.com) our award-winning Spanish language site, provided more than 600 pages of health and wellness information and reminders on important health topics.

Women, Infants and Children Supplemental Nutrition

State-funded program

The state also has programs such as the women, infants and children supplemental nutrition (WIC) program to help with nutritional needs for low-income families. For more information about WIC, call 1-504-568-8229 or (toll-free) 1-800-392-8209. Or go to ldh.la.gov.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-800-888-2998**
Provider Services	**UHCprovider.com**	**1-866-675-1607**

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

The National Optum Behavioral Health manual is located on **providerexpress.com**. This resource is accessible by selecting Our Network > State-Specific Provider Information > **Louisiana**.

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.

The UnitedHealthcare Community Plan Behavioral Health Provider manual is located on **providerexpress.com**. This resource is accessible by selecting Our Network > State-Specific Provider Information > Louisiana.

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

To request an ID number, go to louisiana.gov.

How to join our network:
Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Care providers must, at a minimum, be registered by Addictive Disorders Regulatory Authority (ADRA), to be a substance use treatment provider.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, 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 mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in 1 place.

liveandworkwell.com, accessed through a link on **myuhc.com**, includes mental health and well-being information plus articles on health conditions, addictions and coping. It also 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 (LAW) clinician center > Mind & Body > Recovery and Resiliency. This page includes tools to help enrollees address mental health and substance use issues.

Benefits include:

- Crisis intervention and stabilization services
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment:
  - Social detoxification
  - Substance use intensive outpatient treatment
  - 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 48 hours of medically necessary care for an enrollee to be in an observational status. Note: Observation and ancillary services do not require notification, precertification or authorization. They are covered up to 48 hours. However, observation lasting more than 48 hours requires authorization.)
  - Child-parent psychotherapy
  - Multi-systemic psychotherapy
  - Functional family therapy
  - ECT
  - Telemental health
- Rehabilitation services
- Homebuilders
- Assertive community treatment
- Dual-disorder (MH and SU) residential
- ASAM 3.7 WM Medically Monitored Inpatient Withdrawal Management
- ASAM 3.7 Medically Monitored High Intensity Inpatient Services
- ASAM 3.5 Clinically Managed High Intensity Residential Services
- ASAM 3.3 Clinically Managed Population Specific High Intensity Residential Services
- ASAM 3.2 WM Clinically Managed Residential Withdrawal Management
- ASAM 3.1 Clinically Managed Low-intensity Residential Services

UnitedHealthcare Community Plan case manager

The case manager coordinates behavioral health services within our network. Case managers work with the enrollee, their family, significant other or authorized decision-maker, PCP, medical case manager and any community resources that may be serving the enrollee.

To help ensure coordination of care, we provide a referral for specialized behavioral health. If an enrollee needs emergency behavioral health services and notifies us or you, we help them access the nearest emergency medical care provider. A case manager follows up with the enrollee within 48 hours. Payment for the emergency service is the responsibility of UnitedHealthcare Community Plan as well as any follow-up care.

If you or the enrollee identifies a need for behavioral health services, contact their case manager. If you do not know the case manager's name, call **Provider Services** at **1-866-675-1607** and select the behavioral health option.

Personal Care Services

Personal care services for enrollees with mental illness are limited to 20 hours per week. An exception may be to exceed this limit with documentation that services are medically necessary, and the member does not qualify for personal care services under another Medicaid-funded program.

Psychotropic medication management

Enrollees who need psychotropic medications that cannot be managed by a PCP should be referred to medical psychologists, a psychiatrist or an NP with psychiatric care experience. For detailed information on behavioral health services, refer to the behavioral health care provider manual at **providerexpress.com**.

Eligibility

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

Authorizations

Enrollees may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient, inpatient or residential care. Ensure prior authorizations are in place before rendering nonemergent services. Get prior authorizations by going to **providerexpress.com** > Our Network > State-Specific Provider information > Louisiana > Authorization Templates. Request authorizations for PRTF, ECT, ACT, Crisis Intervention/Stabilization, IOP, and TGH by email at **la.beh.auths@uhc.com**.

Submit authorizations for CPST, PSR, FFT, MST and Homebuilders using the Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form. Find this and other request forms on the

Louisiana Resource Page. Go to **providerexpress.com** > Our Network > State-Specific Provider information > **Louisiana** > Authorization Templates.

You must request all authorizations for mental health inpatient, substance use inpatient, and residential substance abuse by calling **Provider Services** at **1-866-675-1607**.

Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

Claims

Submit claims using the 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.

For more information on Louisiana-specific resources visit **providerexpress.com**.

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- **Prevention**
  Prevent OUD before they occur through pharmacy management, care 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 enrollees and their children**
  Prevent neonatal abstinence syndrome and supporting birth parents 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 on the **UnitedHealthcare Provider Portal** to help ensure you have the information you need, when you need it. For example, state-specific behavioral health toolkits are developed to provide access to clinical practice guidelines, free SUD/OUD assessments and screening resources, and other important state-specific resources.

Additionally, pain management toolkits are available and provide resources to help you identify our 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 Abuse Epidemic." While resources are available, we also work to help ensure you have

the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing and key resources.

Access these resources at **UHCprovider.com/pharmacy.** Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and enrollee and care provider education is central to our strategy.

Pharmacy lock-in

The Pharmacy/Prescriber Home Program (lock-in) identifies and manages enrollees with potentially inappropriate patterns of medication use. Enrollees with high abuse (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances) are identified using pharmacy and medical claims data. The program limits enrollees to fill their prescriptions at 1 pharmacy and only from their assigned prescriber(s). When lock-in is determined appropriate, an enrollee is placed into the program for at least 1 year.

Expanding medication-assisted treatment access and capacity

Evidence-based MAT is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other comprehensive services, such as counseling, cognitive behavioral therapies and recovery support. We expand MAT access and help ensure we have an adequate enrollee MAT network.

SUD providers, when clinically appropriate, shall:

- Educate enrollees on the proven effectiveness, benefits and risks of FDA approved MAT options for their SUD
- Provide on-site MAT or refer to MAT off site
- Document enrollee education, access to MAT and enrollee response in the progress notes

Residential SUD providers shall provide MAT on-site or facilitate access to MAT off site, which includes coordinating with the enrollee's health plan for referring to available MAT provider and arranging Medicaid NEMT if other transportation is not available for the patient.

To find a behavioral health MAT care provider in Louisiana:

1. Go to **UHCprovider.com.**
2. Select "Our Network", then "Find a Provider."
3. Click on **liveandworkwell.com** under Locate Providers: Mental Health or Substance Abuse.
4. Enter "(city)" and "Louisiana" for options.
5. If needed, refine the search by selecting "Medication Assisted Treatment" under Treatment Options.

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

Tobacco/gambling resources

Enrollees in case management are provided with a screening focused on gambling/tobacco.

For more information on this contact the Louisiana Tobacco Quitline at 1-800-QUIT-NOW (24/7) or visit quitwithusla.org. The quit line offers a quit coach who will work with the enrollee to develop a customized quit plan, which includes counseling sessions and a quit kit.

Free information and referral assistance is available from experienced problem gambling counselors 24/7 from the state's helpline at 1-877-770-7867, or helpforgambling.org

Chapter 8: Enrollee rights and responsibilities

Key contacts

Topic	Link	Phone number
Enrollee website	**UHCCommunityPlan.com/la**	**1-866-675-1607**
Enrollee portal	**myuhc.com/communityplan**	
Member handbook	**UHCCommunityPlan.com/la** > Community Plan > Enrollee benefits	**1-866-675-1607**

Our member handbook has a section on enrollee rights and responsibilities. In it, we ask that enrollees treat you with respect and courtesy.

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 the 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

The following information is in the member handbook at **UHCCommunityPlan.com/LA**.

Native American access to care

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

Enrollees rights

Enrollees have the right to:

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

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
- Follow the agreed-upon treatment plan

- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the 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
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

Our 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 for Quality Assurance (NCQA) are to:

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

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records 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 health 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
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 abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare enrollees for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise, nutrition and counseling, as appropriate
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (measurement of height, weight and BMI annually) – **Chief complaint*** – **Physical assessment*** – **Diagnosis*** – **Treatment plan*** • Tracking and referral of age and gender-appropriate preventive health services consistent with preventive health guidelines • Documentation of all elements of age appropriate federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence-based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – Time frame for follow-up visit as appropriate – Appropriate use of referrals/consults, studies and tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Enrollee input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, ER care and practitioner are documented

***Critical element**

Enrollee copies

An enrollee or their representative is entitled to 1 free copy of their medical record. 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 (e.g., immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our enrollees' medical records. We expect you to achieve a passing score of 90% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for enrollees seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or note the enrollee does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)
- Lab and other studies as appropriate
- Enrollee education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies, including follow-up plans

Enrollee hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Acupuncture and chiropractic: **myoptumhealthphysicalhealth.com**	
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

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

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our 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 enhance patient safety
- Tracking enrollee and care provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our QI committee and your Provider Services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all QI 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 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, email or secure email.
- Completing practitioner appointment access and availability surveys

Care provider satisfaction

Every year, we conduct care provider satisfaction assessments as part of our QI efforts. We assess and promote your satisfaction through:

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

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

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

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 **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Lousiana statutes and the NCQA. The following items are required to begin the credentialing process:

- 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

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

UnitedHealthcare Community Plan will completely process credentialing applications from all provider types within 60 calendar days of receipt of a completed credentialing application. The application should include all necessary documentation and a signed care provider Agreement.

"Completely process" means UnitedHealthcare Community Plan will:

- Review, approve and load approved applicants to our provider files in our claims processing system
- Submit on the weekly electronic Provider Directory to LDH or LDH's designee
- Deny the application and assure that the provider is not used by UnitedHealthcare Community Plan

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- Behavioral health clinicians (psychologists, clinical social workers, master's prepared therapists)

Excluded from this process are:

- Practitioners who practice only in an inpatient setting
- Hospitalists employed only by the facility
- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan care provider
- Any care provider who is a member of the medical staff at an RHC or FQHC
- Any care provider who maintains hospital privileges or is a member of a hospital medical staff with a licensed hospital

Health facilities

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

- State 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.

For chiropractic and acupuncture credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

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

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

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 ensure you update time-limited documentation and identify legal and health status changes. We also verify that you follow the UnitedHealthcare Community Plan guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for 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 QOC 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 NMRT 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 NMRT representative provided.

You also have the right to receive the status of your credentialing application, please connect with a live advocate via chat. It is available 7 a.m.-7 p.m. CT at **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.

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 31365
Salt Lake City, UT 84131

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 you have a concern about your agreement with us, send a letter with the details to the address in your contract. A representative will look into it. If you disagree with the outcome, you may file for arbitration. If your concern is about UnitedHealthcare Community Plan procedures, such as credentialing or care management, follow the dispute procedures in your agreement. If one of us is dissatisfied after following those procedures, 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 for arbitration as described in your agreement. Your agreement states where arbitration proceedings are held. The dispute must state the factual and legal basis for the dispute and the relief requested. Not meeting these requirements will result in a denial. All arbitration requests must be in writing and mailed to the American Arbitration Association. See **Chapter 12** for more information. For further instructions on how to request binding arbitration, refer to adr.org.

If an enrollee asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the enrollee's benefit contract or handbook. Locate the member handbook at **UHCCommunityPlan.com/LA**.

HIPAA compliance – your responsibilities

Health Insurance Portability and 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 health 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 agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the 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 states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic 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 on 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.

The UnitedHealthcare Community Plan 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. Please refer to the **Fraud, waste and abuse** section of this manual for more details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

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

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

Extrapolation audits of corporate-wide billing

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

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 Louisiana program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including Optum Health) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

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

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for QOC and service 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	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	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
NPPES	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-866-675-1607**

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) 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 enrollee 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 an NPI, contact NPPES. Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services** at **1-866-675-1607**. 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.

Fee schedule updates

We will update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or LDH. Code set updates will be complete no later than 30 days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

We will notify you as to when the updates will be in production, and the time frame to recycle all claims denied due to the system update delays.

All denied claims will be automatically recycled no later than 15 days after the system update. You will not be required to resubmit impacted claims.

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.

Acceptable claim forms

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

- Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services
- Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers

Initial claims filing time limits

Submit initial claims within 365 days of the date you render services. For non-participating care providers, the timely filing limit is 365 days from the date of service.

We are always the payer of last resort. This means you must bill any other insurance, including Medicare, first before submitting your claim to us.

Claims involving coordination of benefits must be submitted within 365 days from the date of the explanation of benefits (EOB) from the primary and/or secondary payer for contracted care providers. Non-participating care providers have 365 days from the date of service.

Attach a copy of the payer's EOB with your claim, even if we originally denied the claim. Refer to your Agreement for more information.

For prior period coverage (PCC) and Retroactive Eligibility, submit claims within 180 days from the enrollee's linkage date to the MCE.

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 state requirements.

Submit any services completed by N.P.s or P.A.s who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims according to their agreement.

Prompt pay requirements

- 90% of all clean claims must be paid within 15 business days of the date of receipt
- 100% of all clean claims must be paid within 30 calendar days of the date of receipt
- UnitedHealthcare Community Plan will pay you interest at 12% per annum. This is calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed to you must be paid the same date that the claim is paid.
- At a minimum, UnitedHealthcare Community Plan will run 1 care provider payment cycle per week, on the same day each week
- Pay or deny one hundred percent (100%) of Pended Claims within sixty (60) Calendar Days of the date of receipt.

Prior period coverage or retroactive eligible claims

PPC is the period, before our notification of an enrollee's enrollment, during which we are retroactively liable for paying their covered services. You may bill

UnitedHealthcare Community Plan for medically necessary services enrollees used during the PPC period if the service is a PPC-covered benefit. Prior authorization is not required during the PPC period for medically necessary services that are a Louisiana Medicaid PPC-covered benefit. You must have a valid Louisiana Medicaid ID number.

Submit claims using a CMS 1500 or UB-04 claim form. Please contact the enrollee's UnitedHealthcare Community Plan case manager for more information. You may also call **Provider Services** at **1-866-675-1607** to verify the enrollee's PPC eligibility status.

We have a timely filing exception for PCC or Retroactive Eligibility. Submit claims within 180 days from the enrollee's linkage date to the MCE. Eligible PPC services include medications, physician visits, hospitalizations, therapies, DME, medical supplies, HCBS and SNF care. For enrollees who have HCBS in place before enrollment (during the PPC enrollment), document a retrospective to determine whether those services are medically necessary, cost-effective and if a registered Louisiana Medicaid care provider rendered them. If so, develop a care service plan to show that services will be retroactively authorized and reimbursed by the program contractor.

Send PPC claims to:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

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 UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) 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 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 8772
- 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 CMS 1500 and UB-04 forms

For more information, see the **EDI claims** section.

EDI companion documents

The UnitedHealthcare Community Plan 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
- Provide general information and specific details pertinent to each transaction

Share these documents with your software vendor for any programming and field requirements.

The companion documents are located on **UHCprovider.com/edi** > **EDI 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, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** at **1-866-675-1607** 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, see **Chapter 1** under **Online resources.**

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

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for automated clearinghouse (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment. 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/health care 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/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- 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 states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

All regulated entities have a Management Agreement with UnitedHealthcare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

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.

Completing the UB-04 form

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

- Include ICD-10-CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

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

Form reminders

- Note the attending care 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 care provider NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending care provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefits

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

- **Subrogation**
  We may recover benefits paid for an 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 (EOB) or remittance advice with the claim.

For the LaHIPP enrollee claims we process as the secondary payer for Act 421 Children's Medical Option, we pay at the full patient responsibility (copay, coinsurance and/or deductible) regardless of Medicaid's allowed amount, billed charges or primary carrier's payment amount.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services on a CMS 1500. Place the servicing care provider's name in box 31 and the servicing care provider's group NPI number 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 or another 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.

National Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the National Correct Coding Initiative (NCCI) 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, reporting only 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, including CLIA-waived tests. The number must include the "X4" qualifier, followed by the CLIA certification number which includes the 2-digit state code, followed by the letter "D" and the unique CLIA number assigned to the care provider.

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 cms.gov.

Refer to the CMS1500 Billing Instructions at lamedicaid.com > Claims and Billing > Billing Information > CMS 1500 Billing Instructions. The CLIA number is not required for UB-04 claims.

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

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state 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, 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 Provider Services and the **UnitedHealthcare Provider Portal.**

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 30 days to solve your concern.

UnitedHealthcare Community Plan Provider Portal

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

The **UnitedHealthcare Provider Portal** also 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 1 click away.

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

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

Resolving claim issues

To resolve claim issues, contact Provider Services through the **UnitedHealthcare Provider Portal**, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

The complaint resolution analyst acknowledges your complaint either immediately by phone or within 3 business days from when we receive the complaint.

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

For paper claims

Submit a screenshot from your accounting software that shows when you submitted the claim. The screenshot 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 EOB
- 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.

Timely filing limits can vary based on state 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

You may balance bill the enrollee for noncovered services if the enrollee provides written consent prior to getting the service. If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible enrollees. Therefore, you must bill and obtain an EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, you may submit the claim 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.

Chapter 12: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCproviders.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

Please refer to LDH Informational Bulletin 19-3, which outlines the options for pursuing issue resolution with managed care entities (MCE). We encourage you to seek resolution with us directly before engaging with LDH or other third parties.

For issues about claims or services rendered under fee-for-service Medicaid, contact:

DXC Technology (formerly Molina Medicaid Solutions)
P.O. Box 91024
Baton Rouge, LA 70821

Phone: 1-800-473-2783

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Enrollee appeal	A request to change an adverse benefit determination that we made	• Enrollee • Authorized representative or care provider on behalf of an enrollee with the enrollee's written consent	**UnitedHealthcare Community Plan Appeals and Grievance Unit** P.O. Box 31364 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	**1-866-675-1607,** TTY **711**	We accept enrollee appeals by phone or in writing. They cannot be submitted online.	60 calendar days from the date of adverse determination	Urgent/expedited appeals: 72 hours Standard appeals: 30 calendar days May be extended up to 14 calendar days if: • The enrollee requests the extension; or • The MCE shows (to the satisfaction of LDH, upon its request) a need for more information and how the delay is in the enrollee's interest
Enrollee grievance	An enrollee's written or oral expression of dissatisfaction regarding the plan and/or care provider, including QOC concerns	• Enrollee • Authorized representative or care provider on behalf of an enrollee with the enrollee's written consent	**UnitedHealthcare Community Plan Appeals and Grievance Unit** P.O. Box 31364 Salt Lake City, UT 84131	Forms may be found on **UHCprovider.com**	**1-866-675-1607,** TTY **711**	We accept enrollee grievances by phone or in writing. They cannot be submitted online.	N/A	90 calendar days
Care provider claim resubmission	Creating a new claim. If a claim was denied, and you resubmit the claim as if it were a new claim, you will receive a duplicate claim rejection.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31365 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	**1-866-675-1607** TTY **711**	Use the claims management application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com.** Sign In or go to **UHCprovider.com/claims**.	365 days from the date of service	30 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for 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 reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations,see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following addresss: **UnitedHealthcare Community Plan** P.O. Box 31365 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	**1-866-675-1607**	Use the claims management application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com.** Sign In or go to **UHCprovider.com/claims**.	180 calendar days from the denial date	30 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	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals,see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following addresss: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	**1-866-675-1607**	Use the claims management application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com.** Sign In or go to **UHCprovider.com/claims**.	60 calendar days from the first-level claim dispute determination letter	30 calendar days
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or enrollee	Care provider	**UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	**1-866-675-1607**	Use the claims management application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com.** Sign In or go to **UHCprovider.com/claims**.	File a complaint at any time. This excludes requests for reconsideration or appeal for specific claims.	30 calendar days
Independent review provider reconsideration	A process to resolve dispute options (e.g., claims payment, reconsideration, appeal, medical claims review) before seeking an external review through LDH	Care provider	Submit Independent Review Reconsideration requests through secure email **cs_la_ag_iro@uhc.com**		**1-866-675-1607** **cs_la_ag_iro@uhc.com**		180 days from the date a claim denied in whole, partially or recoupment date of a claim or the MCE failed to issue an RA within 60 calendar days	45 calendar days from the date of the receipt of the request for reconsideration

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 contracted providers may agree to more stringent requirements within provider agreements than described in the standard process.

Denial

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

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  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**
  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 is 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 on the UnitedHealthcare Provider Portal.

To access the UnitedHealthcare 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 31341
Salt Lake City, UT 84131-0341

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.

If UnitedHealthcare Community Plan, the LDH or its subcontractors discover an error when UnitedHealthcare Community Plan adjudicates a claim, we will reprocess the claim within 15 calendar days of discovery. If UnitedHealthcare Community Plan cannot meet this time frame, the LDH will approve a specified date. UnitedHealthcare Community Plan will automatically recycle all affected claims. We will not require you to resubmit those claims.

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:

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 care provider data
- Wrong enrollee insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

Claim reconsideration

What is it?

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

When to use:

Reconsiderations can be requested as often as necessary but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed. You must submit your request within 180 days from the date of the EOB or Provider Remittance Advice (PRA).

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 on the UnitedHealthcare Provider Portal. Select Claim Status > Act On Your Claim > Claim Reconsideration > Create Claim Reconsideration. Include electronic attachments. You may also check the reconsideration status using the **UnitedHealthcare Provider Portal**.
- **Phone** – Call **Provider Services** at **1-866-675-1607** 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 31365
  Salt Lake City, UT 84131

Form available at **UHCproviders.com/claims**

To learn more, access the Claim/Clinical Request Reference Guide at **UHCprovider.com/lacommunityplan**.

Claim dispute time frame

The resolution analyst acknowledges your reconsideration request by phone immediately or in writing within 3 business days from when we receive the reconsideration.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs 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. 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 or by mail with the following information:

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

Additional information

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

Questions about your appeal or need a status update? Call Provider Services at **1-866-675-1607.**

If you filed your appeal online, you should receive a confirmation email or feedback through the secure **UnitedHealthcare Provider Portal**.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-866-675-1607** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- Submit a letter withdrawing the dispute if you file about nonpayment, but payment is made before a decision is made
- 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 us.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

UnitedHealthcare Community Plan will provide you with written notification if we seek to recoup any overpayment within 1 year of the claim paid date following an audit or review, including an automated review. Overpayments discovered due to an FWA audit or an examination, audit or inspection by a governing entity may be recouped more than 1 year following the claims paid date.

The UnitedHealthcare Community notification will include:

- The enrollee's name
- Date of birth or Medicaid identification number
- The date or dates of services rendered

- A list of the claims and amounts subject to the recoupment
- The date the recoupment will be executed
- The mailing address or electronic mail address where you may respond
- The date LDH notified UnitedHealthcare Community Plan of the enrollee's disenrollment through the ASC X12N 834 Benefit Enrollment and Maintenance Transaction, when applicable
- Effective date of disenrollment
- The specific reason for each claim's recoupment

Before the recoupment is executed, you will have 60 days from receipt of recoupment notification to write a response saying why the recoupment should not be put into effect on the specified date. If you do not reply within that time frame, UnitedHealthcare Community Plan may execute the recoupment as stated.

Upon receiving your response, we will consider the statement, including any pertinent additional information submitted within 30 days.

UnitedHealthcare Community Plan will provide a written notice of determination to each written response with determination rationale. If a recoupment is valid, you will remit the amount to us or permit us to deduct the amount from future payments due.

LDH reserves the right to review and prohibit any recoupment for enrollees disenrolled due to the invalidation.

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, 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 PRA. When more 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.**

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

Payment adjustments and recoupments

If an enrollee's aid category and/or type case changed from UnitedHealthcare Community Plan eligible to excluded, LDH will recoup all previous capitation payments for the excluded months from UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will initiate recoupments of payments to you within 60 days of the date LDH notified of the change. You will be instructed to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable).

In cases of a retroactive effective date for Medicare enrollment of an enrollee, UnitedHealthcare Community Plan will recoup payments made to you within 60 days of the date LDH's notification. You will need to resubmit the claim(s) to Medicare and the payer with financial responsibility for the claim(s) (if applicable).

If an enrollee is disenrolled due to the invalidation of a duplicate Medicaid ID, UnitedHealthcare Community Plan will not recoup payment under the invalid duplicate Medicaid ID if both the valid and invalid Medicaid IDs are linked to UnitedHealthcare Community Plan.

Appeals

In LA, providers can file an appeal then a reconsideration OR a reconsideration then an appeal. Only a reconsideration is needed to file for an independent review.

What is it?

An appeal is a review of a previous claim, determination or 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, determination or reconsideration decision, use the claim appeal process. Send appeals 60 calendar days from the first-level reconsideration decision date or the PRA.

How to file:

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

- **Electronic claims:** Use the Claims Management application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In. Select Check On The Status Of A Claim > Act On Claim > File Appeal/Dispute. 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

Do not fax in appeals for claims submitted electronically. Please use our online option instead.

Appeal resolution time frame

The appeals analyst acknowledges your appeal receipt in writing within 3 business days from when we receive the appeal. Allow up to 30 days to process Level 2 disputes and appeals.

Arbitration

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If we have a concern about your Agreement, we'll send you a letter containing the details.

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 by a private, independent arbitrator.

Submit arbitration requests either at adr.org or in writing to any of the Regional American Arbitration Association offices. Send Louisiana cases to:

American Arbitration Association
Atlanta Regional Office
2200 Century Parkway, Suite 300
Atlanta, GA 30345

Once the case is registered, and all fees are paid, the office sends a notice to:

United Healthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0341

The request must state the factual and legal basis for the dispute. It must also list the relief requested. Otherwise, the request will be denied. You must exhaust the UnitedHealthcare Community Plan claim dispute process before making a request. You may not ask for a state fair hearing for claim issues.

Mail the request to the American Arbitration Association. The arbitrator will be certified by a nationally recognized association (American Arbitration Association) and provide training and certification in dispute resolution. For more information, visit adr.org.

If the request is approved, the arbitrator conducts a hearing. Then they issue a ruling within 90 calendar days, unless we both agree to extend the time frame. All arbitration costs, not including attorney's fees, are shared equally. Arbitration is binding on all parties.

Unless otherwise agreed to in writing by the parties, the party pursuing the dispute must initiate the arbitration within 1 year after the date on which notice of the dispute was given.

Independent review requests

In reference to the 2017 Regular Session ACT No. 349, HOUSE BILL NO. 492 relative to the Louisiana Medicaid program; effective Jan. 1, 2018, the LDH has developed and implemented a process to allow health care providers the right to request an independent review of claims submitted to Medicaid managed care entities; to provide for review of claim payment determinations which are adverse to care providers.

Before requesting an independent review, you must first request an Independent Review Claims Reconsideration from UnitedHealthcare Community Plan by completing the Independent Review Provider Reconsideration Form. The form is on **UHCprovider.com**.

Complete the form within 180 days from the adverse determination. Email it to **cs_la_ag_iro@uhc.com**. UnitedHealthcare Community Plan will acknowledge in writing its receipt within 5 calendar days. UnitedHealthcare Community Plan will render a final decision and provide a response within 45 calendar days from the date of receipt of the request for reconsideration. The exception is if a longer time is needed. An agreed-upon date will be decided in writing.

If UnitedHealthcare Community Plan reverses the adverse determination following the review of the reconsideration, claim payment will be paid no later than 20 days from the decision date.

If UnitedHealthcare Community Plan upholds the adverse determination or does not respond to the request within the time frames allowed, you may file a written notice with the LDH requesting the adverse action be submitted to an independent reviewer.

If you are not satisfied with the Independent Review Provider Reconsideration's result, you may request an independent review within 60 days from the reconsideration decision date or if UnitedHealthcare Community Plan does not respond to the appeal request within the time frames allowed.

For more about the independent review process and how to request an independent review, go to LDH's Independent Review website. A separate Independent Review Request Form must be obtained from LDH. The Independent Review Committee will provide the appropriate address for submission of the independent review. Along with a completed Independent Review Form, include a copy of the Independent Review Provider Reconsideration Form and decision letter with the request for an Independent Review to the LDH's Independent Review Committee.

Upon receipt of a notice of request for independent review and all required supporting information and documentation, the LDH will refer the adverse determination to an independent reviewer.

In the event the Independent Reviewer upholds the adverse determination the provider shall reimburse UnitedHealthcare the $750 invoice fee within 10 days of the notification. Please remit the payment to:

UnitedHealthcare Community Plan of Louisiana
3838 N Causeway Blvd.
Suite 2500
Metairie, LA 70002

Note: If the care provider fails to submit the payment within the 10 days from the date of this letter, UnitedHealthcare will withhold the $750 invoice fee from future claim payments equal to the amount of the fee.

For more about the Independent Review process and to learn how to submit a request, call **Provider Services** at **1-866-675-1607**. You may also refer to HOUSE BILL NO. 492; ACT No. 349. This bill outlines the policy and procedure of this act or the LDH's Independent Review website at ldh.la.gov.

Care provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations
- Eligibility and enrollment of an enrollee or care provider
- Enrollee issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to an enrollee
- Delivery of health services
- Quality of service

How to file:

File verbally, in writing or in person.

- **Phone** – Call **Provider Services** at **1-866-675-1607**
- **Mail** – Send care provider name, contact information and your grievance to:

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

- **In person** – Contact your provider advocate to file in person

You may only file a grievance on an enrollee's behalf with the written consent of the enrollee. See Enrollee appeals and grievances definitions and procedures.

Enrollee appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Enrollee appeals

What is it?

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

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

- Denies or limits a requested services. This includes the type or level of service.
- 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 state or CMS
- Doesn't act within the time frame CMS or the state 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. Expedited appeals do not need be in writing.

Where to send:

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

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

Toll-free – **1-866-675-1607** (TTY **711**)

How to use:

Whenever a service is denied, 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.

We must resolve a standard appeal 30 calendar days from the day we receive it.

We must resolve an expedited appeal within 72 hours from when we receive it. The health plan may extend the processing time for either expedited or standard enrollee appeal requests if the following conditions apply:

1. Enrollee requests can take longer.
2. We request additional information and explain how the delay is in the enrollee's interest.

If submitting the appeal by mail or fax, you must complete the Authorization of Review (AOR) form – Claim Appeal.

A copy of the form is online at **providerforms.uhc.com**.

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 QOC or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

You may file a grievance on the enrollee's behalf as their representative with their written consent.

Where to send:

You, with the enrollee's written consent, or the enrollee may file a grievance verbally by calling **Member Services** at **1-866-675-1607** or writing to UnitedHealthcare Community Plan:

Mailing address:

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

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance.

The enrollee may also file a grievance in writing to the state of Louisiana.

State fair hearings

What is it?

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

When to use:

Enrollees have 120 calendar days from the date of the Notice of Adverse Action letter.

How to use:

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

Division of Administrative Law Health and Hospitals
P.O. Box 4189
Baton Rouge, LA 70821-4189

The enrollee may also call 1-225-342-5800 or 1-225-342-0443.

- The enrollee may ask UnitedHealthcare Community Plan Member 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.

Continuance of care

If the enrollee wishes to have continuation of benefits during the state fair hearing, they must make the request within 10 calendar days of the date on the notice of action.

Processes related to reversal of our initial decision

If the state fair hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the enrollee's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, waste and abuse

Call the toll-free UnitedHealthcare Special Investigations hotline at **1-800-455-4521** to report enrollee or care provider fraud, waste or abuse. Or go to **uhc.com/fraud**. You can also call the Louisiana Medicaid Fraud Hotline at 1-844-359-7736. In addition, please write to **UnitedHealthcare Community Plan, Attention: Compliance/Fraud and Abuse Officer,** 3838 N Causeway Blvd., Suite 2600, Metairie, LA 70002. Or go to **uhc.com/fraud**.

The UnitedHealthcare Community Plan Anti-Fraud, Waste and Abuse program focuses on prevention, detection and investigation of false and abusive acts.

Care provider training and awareness

You are encouraged to take the training on the Louisiana Medicaid website, "Fraud Awareness for Providers." It covers:

- Billing educational opportunities
- New care provider education
- Ongoing training

On medicaid.gov, you can find information about how to report and how to fight fraud.

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

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

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

Exclusion checks

You must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. You may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month and report immediately to UnitedHealthcare Community Plan any exclusion information discovered. 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
- Louisiana Adverse Actions List Search (LAALS)

What you need to do for exclusion checks

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

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com** > Resources > **Resource Library**	**1-866-675-1607**
News and bulletins	**UHCprovider.com/news**	**1-866-675-1607**
Care provider manuals	**UHCprovider.com/guides**	**1-866-675-1607**

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 in the following ways.

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/lacommunityplan**
  The UnitedHealthcare Community Plan of Louisiana page has state-specific resources, guidance and rules. Be sure to check back frequently for updates.
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **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 (formerly Twitter)
- **Louisiana health plans**
  UHCProvider.com/la is the fastest way to review all of the health plans UnitedHealthcare offers in Louisiana. 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.
- **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 care provider 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 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.

Enrollee reassignment

To ensure enrollees are assigned to the most appropriate PCP, a claims analysis is performed to identify enrollees who have not seen their PCP in the previous 12 months but have seen another PCP instead.

We publish the previous quarter's enrollee reassignments on the UnitedHealthcare Provider Portal on the 15th day (or next business day after the 15th day) of the 2nd month of each quarter on the UnitedHealthcare Provider Portal. To dispute an enrollee reassignment, please email **lamemberreassignment@uhc.com** with documentation that you have seen the enrollee at least once in the previous 12 months.

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 at **UHCprovider.com/training**. 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**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. We offer on-site visits to help you gain a better understanding of our policies and procedures. Our provider education includes orientation for all care providers new to United Healthcare Community Plan and those who have enrolled with new UnitedHealthcare Community Plan products. The orientations take place monthly through webinars. You will receive emailed invitations as well as outreach from an advocate to validate participation.

Care provider education sessions also include monthly town halls, mobile service centers, spring and fall provider expos, and participation at quarterly/annual association meetings. Examples include Louisiana Hospital Association, La MGMA, and RHC conferences.

If your practice is new to our network, or if you would like to schedule an on-site orientation to learn more about our policies and procedures, chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.

Discussion topics may include:

- Claim submission procedures
- Timely filing guidelines
- Billing and prior authorization policies
- Dispute and resolution process

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online. It includes an overview of the program, a toll-free number for **Provider Services** at **1-866-675-1607** 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.

State websites and forms

Find the following forms on the state's website at lamedicaid.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. 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

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

Adverse benefit determination

- 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
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- 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
- 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
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

Ambulatory surgical facility

- A state 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 PT, which an enrollee gets in the hospital

Appeal

An enrollee request that their health insurer or plan to 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 on the number of enrollees assigned to a care provider for providing covered services for a specific period

Case 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 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

Children's Health Insurance Program

CHIP – a federal program that provides medical coverage to those 18 years old or younger

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 care 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 2 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 code** – a code assigned to a task or service a 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, care provider offices and home health care

Disallow amount (Amt)

Medical charges for which the network care 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 NCCI 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

Durable medical equipment

- **DME** – equipment and supplies ordered by a care provider for everyday and extended use, for medical reasons other than convenience or comfort
- May include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics

Early and Periodic Screening, Diagnostic, and Treatment

- **EPSDT** – a package of services in a preventive (well-child) exam covered by Medicaid as defined in Social Security Act Section 1905 (R)
- Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing
- They also include any medically necessary services found during the preventive exam

Electronic data interchange

EDI – the electronic exchange of information between 2 or more organizations

Electronic funds transfer

EFT – the electronic exchange of funds between 2 or more organizations

Electronic medical record

EMR – an electronic version of an enrollee's health record and the care they have received

Eligibility determination

A process of determining whether an applicant meets the requirements for federal or state eligibility

Emergency care

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

Encounter

- A record of health care-related services by care providers registered with Louisiana 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 state Medicaid
- The state audits encounter submission accuracy and timeliness on a regular basis

Enrollee

An individual who is eligible and enrolled with UnitedHealthcare Community Plan

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 mental 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

FHC

Family Health Center

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 QOC or service concerns
- Does not include adverse benefit determination (see **appeals/dispute**)
- May include, but is not limited to, the quality of care or services provided, relationships such as rudeness of a care provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested
- 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 – 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 provider

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

Louisiana Department of Health

LDH - Louisiana Department of Health, the state agency mandated to serve the public health needs of all Louisiana residents

Louisiana Medicaid

The state Medicaid program managed by LDH. Louisiana Medicaid uses a competitive bid process to select prepaid program contractors such as UnitedHealthcare Community Plan to provide services to eligible enrollees. Louisiana Medicaid is composed of the Administration, contractors and other arrangements through which health care services are provided to an eligible person defined by LDH.

Medicaid

- A federal health insurance program for low-income families and children, eligible pregnant enrollees, people with disabilities and other adults
- The federal government pays for part of Medicaid and sets guidelines for the program
- State pay for part of Medicaid and have choices in how they design their program
- Medicaid varies by state and may have a different name in your state

Medical 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
- They would have serious problems with their bodily functions
- 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

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan

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 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. or D.O., N.P., clinical nurse specialist or P.A., as allowed under state 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

Rural health clinic

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

Service area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by the LDH

Specialist

- A care provider licensed in the state of Louisiana who 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

State 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

Temporary Assistance to Needy Families

TANF – a state program that gives cash assistance to low-income families with children

Third-party liability

- **TPL** – a company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to 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

Title XIX

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

UnitedHealthcare Community Plan

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

Utilization management

- **UM -** Involves coordinating how much care enrollees get
- Determines each enrollee's level or length of care
- The goal is to help ensure enrollees get the care they need without wasting resources