2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Idaho Medicaid Plus (IMPlus)

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® of Idaho care provider manual. This up-to-date reference PDF allows you and your staff to find important information, such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites in the **How to Contact Us** section.

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.
- **Community Plan care provider manuals** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on Idaho

Easily find information in this care provider manual

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

View the **Medicaid glossary** for definitions of terms commonly used throughout the care providers manuals.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-855-857-9753**.

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 a physical or digital card

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com/contactus**	
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com/contactus** New users: **UHCprovider.com/access**	**1-855-857-9753**
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
Resource library	**UHCprovider.com/resourcelibrary**	
One Healthcare ID support	**UHCprovider.com/contactus**	**1-855-819-5909**

UnitedHealthcare Community Plan supports the Idaho Department of Health and Welfare (IDHW) goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to dual-eligible participants who are 21 years of age or older and enrolled in both Medicare (parts A, B and D) and enhanced Medicaid.

Medicare is the primary payor for most services indicated in this manual. For information regarding Medicare-covered services, refer to the **UnitedHealthcare Administrative Guide**.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call **Provider Services** at **1-855-857-9753**.

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**.

Approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes.

Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care services, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns and then provides interventions to help members get the right care.

These interventions address members' specific 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 member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Medical, behavioral and social care management using community resources
- An extended care team
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance making and coordinating appointments. The care coordinator refers members to an RN, behavioral health advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured by inpatient (IP) admission and ER rates
- Identify and discuss behavioral health needs, measured by the number of behavioral health care provider visits within identified time frames
- Improve pharmacy access
- 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 member 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 provider networks to help ensure access to affordable care and the appropriate use of services

To refer a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **1-866-785-1628**, TTY **711**. You may also call **Provider Services** at **1-855-857-9753**.

Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response and authorization request/response) for all care providers who handle business electronically.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. We encourage you to support our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > 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 6 a.m.–6 p.m. MT
  - 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 members**

  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**.

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 the **digital solutions comparison guide**. 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. This includes appeals, prior authorization requests and decisions.

Using electronic transactions is fast and 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 a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. 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 members 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. It makes it possible to:

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

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

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 members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights into their care needs, aligned to their specific member 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

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal.**

You can complete tasks online, get updates on claims, reconsiderations, appeals, complaints and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

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**.

- **CoverMyMeds**

  CoverMyMeds streamlines the medication prior authorization process, electronically connecting providers, pharmacists and plan/PBMs to improve time to therapy and decrease prescription abandonment with electronic prior authorization. Access CoverMyMeds at **professionals.optumrx.com**.

- **Prior authorization and notification**

  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.

- **My Practice Profile**

  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.

- **Document Library**

  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

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

Direct Connect

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

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

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

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

Privileges

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

Provider Services

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

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

More information is available at:

UHCprovider.com/IDcommunityplan

1-855-857-9753

How to contact us

We no longer use fax numbers.

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-800-888-2998**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A referral is not required.
Benefits	**UHCprovider.com/benefits** **1-855-857-9753**	Confirm a member's benefits and/or prior authorization.
Claims	**UHCprovider.com/claims** **1-855-857-9753** 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** 709 Grant Avenue - North Lobby Lake Katrine, NY 12449	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-855-857-9753** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** **1-855-857-9753**	Confirm member eligibility.
Enterprise Voice Portal	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality. Call to speak with a contact center agent.

Topic	Contact	Information
Fraud, waste and abuse (payment integrity)	**UHCprovider.com/IDcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** FWA hotline: **1-844-359-7736**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics 1-866-697-8378	Labcorp and Quest Diagnostics are network laboratories.
Medicaid (Idaho Department of Health and Welfare)	idmedicaid.com 1-866-686-4272	Contact Medicaid directly.
Medical claim, reconsideration and appeal (provider)	**UHCprovider.com/claims** **1-855-857-9753** 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 one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan** Attn: Complaint and Appeals Department 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®** **1-866-785-1628**/TTY **711** for help accessing member account	Helps members with issues or concerns. Available 24 hours a day, 7 days a week.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).

Topic	Contact	Information
Network management support	Chat is available 24/7 at **UHCprovider.com/contactus**.	Self-service functionality for medical network care providers to update or check credentialing information.
NurseLine	**1-855-873-2377**	Available 24 hours a day, 7 days a week.
Oncology prior authorization	**UHCprovider.com/oncology** **1-888-397-8129** Monday–Friday, 8 a.m.–5 p.m. MT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat is available 24/7 at **UHCprovider.com/contactus**. Email: **optumsupport@optum.com** **1-855-819-5909**	Contact if you have issues with your ID.
Pharmacy services	**professionals.optumrx.com** **1-855-857-9753**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** CoverMyMeds: **professionals.optumrx.com** **1-855-857-9753**	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. CoverMyMeds streamlines the medication prior authorization process, electronically connecting providers, pharmacists and plan/PBMs to improve time to therapy and decrease prescription abandonment with electronic prior authorization.
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/priorauth** • Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-855-857-9753**	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/IDcommunityplan** > Prior Authorization and Notification

Topic	Contact	Information
Provider Services	**UHCprovider.com/IDcommunityplan** **1-855-857-9753**	Available 8 a.m.–6 p.m. MT, Monday–Friday.
Referrals	**UHCprovider.com/referrals** **1-855-857-9753**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/IDcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	Chat is available 24/7 at **UHCprovider.com/contactus.**	Contact us 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.
Transportation	MTM 1-877-503-1261	To arrange nonemergent transportation, members must contact MTM at least 48 hours in advance.
Utilization management	**1-855-857-9753**	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.
Vision services	March Vision Care 1-844-416-2724	Medical necessity must be documented. Please refer to the vendors website for medically necessary criteria.
Website for Idaho Community Plan	**UHCprovider.com/IDcommunityplan**	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/IDcommunityplan**	**1-855-857-9753**
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	
Provider Directory	**UHCprovider.com/findprovider**	

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

- Age
- Sex
- Race
- Physical
- Mental handicap
- National origin
- Religion
- Type of illness or condition

You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

UnitedHealthcare Community Plan members and/or their representatives may take part in the planning and implementation of their care. To help ensure members and/or their representatives have this chance, UnitedHealthcare Community Plan requires that you:

1. Educate them 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 they have the right to choose the final course of action among treatment options.
5. Collaborate with the care coordinator in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

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

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.

3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

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

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members 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 members with the transition.

Arrange substitute coverage

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

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

Administrative terminations for inactivity

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

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

Enrolling with IDHW

You must be enrolled with IDHW. Visit healthandwelfare.idaho.gov for more information.

Care provider claims and pharmacies' prescription claims written by IDHW non-enrolled prescribers cannot be paid by UnitedHealthcare under state and federal law.

Changing an existing TIN or adding a 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 on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > Practice Management > 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

Urgent care can provide quick after-hours treatment and is appropriate for infections, fever and symptoms of cold or flu. If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

If the member is in a life-threatening situation, refer them to the ER.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member 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 state's 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 members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

You must comply with 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 members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members 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 members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member 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 member 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. The safeguards include shredding information with PHI and all confidential conversations. All staff members are trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for **medical record standards**.

Inform members 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 members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through member handbooks and other communications.

Your Agreement

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

After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

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

in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the member handbook at **UHCcommunityplan.com/ID**.

Reference **Chapter 12** for information on care provider claim reconsiderations, appeals and complaints.

Appointment standards (IDHW access and availability standards)

Comply with the following appointment availability standards:

- Preventative care appointments for wellness exams and immunizations - within 42 calendar days
- Urgent care appointments for the treatment of unforeseen illnesses or injuries requiring immediate attention – within 24 hours
- Routine assessment appointments for follow-up evaluations of stable or chronic conditions – within 30 calendar days
- Non-urgent medical care appointments for the treatment of stable conditions – within 7 calendar days

In addition, care providers must adhere to the following standards:

- 24-hour physician coverage, provided by the physician or by an on-call arrangement – 24 hours, 7 days a week (routine referral to the local emergency room is not acceptable)
- In-office waiting for a scheduled appointment, for emergency care, or for lab and X-ray services – less than 45 minutes

Behavioral health

- Crisis coverage, provided by a behavioral health clinician with at least a master's degree - 24 hours, 7 days a week
- Non-urgent behavioral health care appointments for the treatment of stable conditions - within 7 calendar days

Specialty care

Specialists should arrange appointments for routine appointments within 30 calendar days.

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

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. 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

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider**.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-855-857-9753**. 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 health care provider.

On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. 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 members:

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-855-857-9753**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from the UnitedHealthcare Provider Portal:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.
- Identify and bill other insurance carriers when appropriate.

Rural health clinic and federally qualified health clinic

Members may choose a care provider who performs services within a rural health clinic (RHC) or federally qualified health center (FQHC).

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members 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

Ancillary care provider responsibilities

Ancillary care providers include:

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

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

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-855-857-9753**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/ID**	**1-866-785-1628**
Member handbook	**UHCCommunityPlan.com/ID** > Plan Details > Member Resources > View Available Resources	
Provider Services	**UHCprovider.com/IDcommunityplan**	**1-855-857-9753**
Prior authorization	**UHCprovider.com/priorauth**	

Benefits

Go to **UHCCommunityPlan.com/ID** or **UHCprovider.com** > **Eligibility** for more information.

Coinsurance/copayments

Coinsurance and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. Medically necessary health care services or supplies are:

- Medically appropriate
- Necessary to meet members' basic health needs
- Cost-efficient and appropriate for the covered services

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

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

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members 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.

Get eligibility information by calling **Provider Services** at **1-855-857-9753**.

Member eligibility

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

Member ID card

Check the member'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.

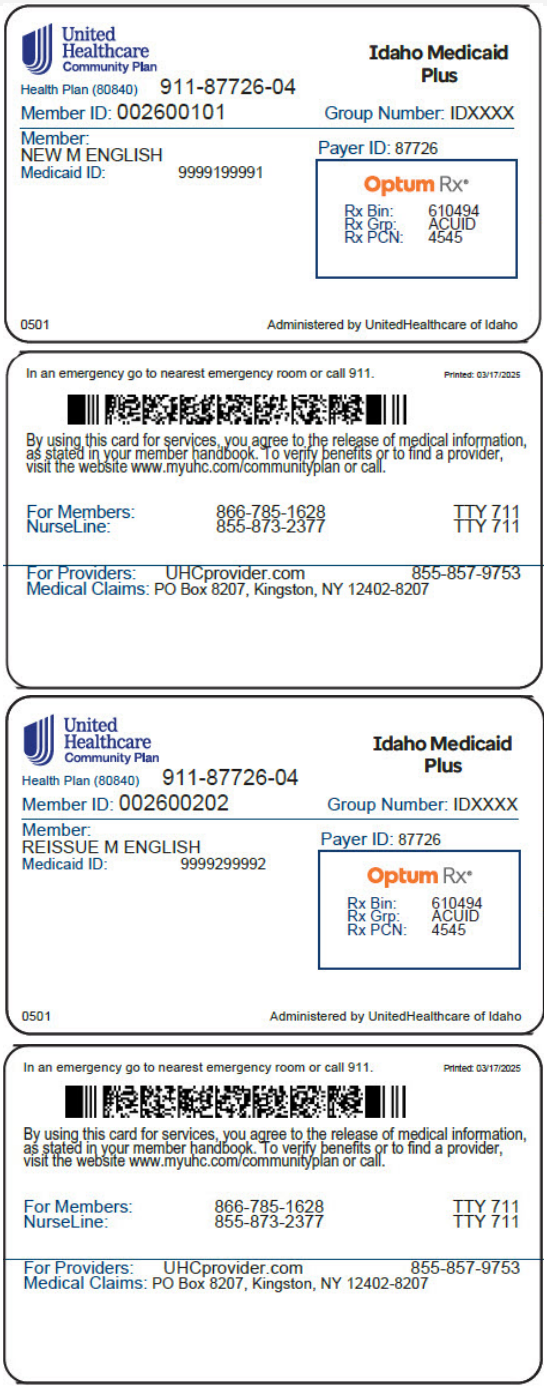
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the fraud, waste and abuse hotline at **1-844-359-7736**.

If a member does not bring their card, call **Provider Services**. Also document the call in the member's chart.

Member identification numbers

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

Sample health member ID card



Verifying member enrollment

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

- Access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Services** is available from 8 a.m.–6 p.m. MT, Monday–Friday at **1-855-857-9753**

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	UHCprovider.com/referrals	
Prior authorization	UHCprovider.com/priorauth	1-855-857-9753
Pharmacy	professionals.optumrx.com	

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

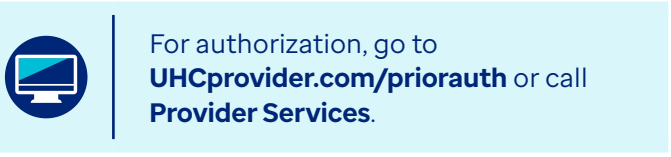
Ambulance services

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 members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Nonemergent air ambulance requires prior authorization.



Emergency ambulance transportation

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

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

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

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

Nonemergency medical transportation

If a member requires transportation for a medical appointment, they can request a ride from MTM at 1-877-503-1261. They must call at least 48 hours prior to the appointment.

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member 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

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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

- Hospital emergency department room and ancillary care provider service 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 member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed.

Members have been told to call their provider 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 members 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 member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

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

Members do not pay for these services. This applies whether the member 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**.

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.

Deliver emergency care 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/portal**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services**.

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

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

For policies and protocols, go to **UHCprovider.com/policies** > **For Community Plans**.

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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members 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

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.
  - Morning-after pill. Contact the IDHW to verify state coverage

Parenting/child birth education programs

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

Voluntary sterilization

In-network treatment with consent is covered. Before a member can get a tubal ligation or vasectomy, they first must give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent.

Out-of-network services require prior authorization.

View the IDHW regulations for more information on sterilization.

Care coordination/health education

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve members' quality of care, quality of life and health outcomes
- Help individuals understand and actively participate in the management of their condition and adhere to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with care providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition 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, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based on evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management.

The care coordinator collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Programs are based on the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

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
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover hospice at the member's home during a medical crisis. A medical crisis is when a member 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 member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver.

Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by 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.

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

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** or call **1-888-397-8129** Monday–Friday, 8 a.m.–5 p.m. MT.

Pharmacy

Pharmacy Preferred Drug List

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

You must prescribe Medicaid members 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 a member requires a nonpreferred medication use the online Prior Authorization and Notification tool on the United Healthcare Provider Portal or if unable to access the portal, call **1-855-857-9753.**

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**.

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.

If a member requires a nonpreferred medication use the online Prior Authorization and Notification tool on the United Healthcare Provider Portal or if unable to access the portal, call **1-855-857-9753.**

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral. Members must use the UnitedHealthcare Community Plan provider network.

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when provided by, or under the supervision of, a certified care provider or other certified licensed care provider within the scope of their practice. Care providers:

- Determine risk factors related to alcohol and other drug use disorders
- Provide interventions to enhance patient motivation to change
- Make appropriate referrals as needed

SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per care provider per calendar year.

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

Screening

With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug/substance use problems and determine how severe those problems are already. 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 members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder.

This includes coordinating with the alcohol and drug program in the county where the member 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 Evaluation and Services at cms.gov > Medicare > Payment > Fee schedules > Physician Fee Schedule > Evaluation & Management Visits > Evaluation and Management Services MLN Publication > Evaluation and Management Services-Updated 08/29/2023.

Services provided through the state of Idaho Medicaid program

The Medicaid services listed below are provided directly by IDHW:

- Medicaid dental services
- Nonemergency medical transportation
- Developmental disability services
- Intermediate care facility services

For information regarding these Medicaid-provided services, visit healthandwelfare.idaho.gov.

Sterilization

Hysterectomies

Hysterectomies cannot be reimbursed if performed for sterilization. Members 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 member should sign and date the form stating they were told before the surgery the procedure will result in permanent sterility.

Find the form on idmedicaid.com.

See “Sterilization consent form” section below for more information.

Exception: IDHW does not require informed consent if:

- As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
- 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 member's ID card.

Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. You cannot bill members if you do not submit consent forms.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures is based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members 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 member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member 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

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

Sterilization consent form

- Complete all applicable sections of the consent form before submitting it with the billing form. The IDHW cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Complete your statement section 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 member within that time frame. However, do not sign and date the form until after you perform the procedure.

Find the form on idmedicaid.com.

Have 3 copies of the consent form:

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

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

Vision

Vision services are covered by March Vision Care. Please see the March Vision Care reference guide for information such as compliance, electronic payment information, safety resources and training. You can also call 1-844-416-2724.

Waiver programs

Wavier services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS. These members are referred to the Long Term Care Division/HCBS branch to determine eligibility and availability. Refer to **Chapter 5** for additional information on HCBS.

If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid program.

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 Idaho's prior authorization page at **UHCprovider.com/IDcommunityplan** > Medicaid > 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/ member notification of denial
Non-urgent pre-service	No later than 14 calendar days after the receipt of the request with a possible extension not to exceed 14 additional calendar days if the provider requests an extension	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Not to exceed 72 hours after the receipt of the request of service	Not to exceed 72 hours after the receipt of the request of service	Not to exceed 72 hours after the receipt of the request of service
Concurrent review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member 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 member notification within 2 business days

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

When available, provide clinical information by access to electronic medical records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members 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 MCG (formerly Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings.

This includes:

- Acute and sub-acute medical
- Long-term acute care
- Acute rehabilitation
- SNFs
- Home health care
- Ambulatory facilities

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain, or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member'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 member

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and guidelines

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

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member'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 member is eligible on the date of service by using the **UnitedHealthcare Provider Portal**, contacting our **Provider Services** department, or the Idaho 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 member 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 members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member 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 IDHW. 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 member's provider refers the member to an in-network care provider for a second opinion. Care 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 member's previous provider and treating care provider, if different. The member may help 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 **1-855-857-9753**. Once the second opinion has been given, the member and the provider discuss information from both evaluations
- If follow-up care is recommended, the member meets with the provider before receiving treatment

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs
  - Long-term care services in a nursing home
  - Nursing facility services
  - Intermediate care facilities for members with mental handicap
  - Home- and community-based waiver services

  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
  - Residential inpatient hospice services
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital, such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

- Emergency or urgent facility admission – 1 business day
- Inpatient admissions; after ambulatory surgery – 1 business day
- Nonemergency admissions and/or outpatient services – at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Call **1-855-857-9753** to discuss the guidelines and utilization management.

Utilization management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network providers 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 members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Utilization management appeals

Utilization management (UM) appeals are considered medically necessary appeals. They contest 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 member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

See Appeals in **Chapter 12** for more details.

Chapter 5: Home and community-based services

Key contacts

Topic	Links	Phone number
Provider Services	**UHCprovider.com/IDcommunityplan**	**1-855-857-9753**
Training	**UHCprovider.com/training**	

Home and community-based services

HCBS are services that are provided as an alternative to long-term care institutional services in a nursing facility (NF) or to delay or prevent placement in a nursing facility.

HCBS are available for Medicaid-eligible persons age 60 and older and persons of all ages with disabilities by providing supports to complement and supplement informal supports for persons who would require care in an NF if HCBS services or other supports were not available. Find more about HCBS benefits on **UHCCommunityPlan.com/ID**.

How to join our network

To request participation in HCBS provider network, visit **UHCprovider.com/IDcommunityplan** or email UnitedHealthcare Community Plan at **hcbsprovidernetwork@uhc.com**.

Waiver services

HCBS waiver benefits are available to members who meet a specified level of care. Member benefits should be reviewed to ensure coverage of the following benefits. HCBS waiver services and definitions included are as follows:

Adult day health

Adult day health is a supervised, structured service generally furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week.

It is provided outside the home of the member in a non-institutional, community-based setting, and it encompasses health

Services, social services, recreation, supervision for safety, and assistance with activities of daily living (ADL) needed to ensure the optimal functioning of the member.

Adult day health services provided under this waiver does not include room and board payments.

On the aged and disabled (A&D) waiver, members residing in a home-based setting may only receive adult day health care services 12 hours in any 24 hour period.

Members residing in a certified family home (CFH) may only receive adult day health care services if there is an assessed unmet socialization need that cannot be provided by the CFH provider. Adult day health care services are not offered to members who reside in a residential assisted living facility (RALF).

Adult residential care

Services provided in a homelike, non-institutional setting that include residential care or assisted living facilities and CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement.

- Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that include:
  - Medication management
  - Assistance with ADLs
  - Meals, including special diets
  - Housekeeping
  - Laundry
  - Transportation
  - Opportunities for socialization
  - Recreation
  - Assistance with personal finances
- Administrative oversight must be provided for all services provided or available in this setting.
  - A written individual service plan must be negotiated between the member or their legal representative, and a facility representative.
- Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Rules Governing Certified Family Homes," that include:
  - Monitoring of medication management
  - Assistance with ADLs
  - Meals, including special diets
  - Housekeeping
  - Laundry
  - Transportation
  - Opportunities for socialization
  - Recreation
  - Assistance with personal finances
- Administrative oversight must be provided for all services provided or available in this setting.
  - A written individual service plan must be negotiated between the member or their legal representative, and a facility representative.

Attendant care

Services provided under a Medicaid HCBS waiver that involve personal and medically oriented tasks dealing with the functional needs of the member and accommodating the member's needs for long-term maintenance, supportive care, or ADL.

These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the member.

Services are based on the member's abilities and limitations, regardless of age, medical diagnosis, or other category of disability.

This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the member to perform a task.

Chore services

Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment:

- Intermittent assistance may include the following.
  - Yard maintenance
  - Minor home repair
  - Heavy housework
  - Sidewalk maintenance
  - Trash removal to assist the member to remain in the home
- Chore activities may include the following:
  - Washing windows
  - Moving heavy furniture
  - Shoveling snow to provide safe access inside and outside the home
  - Chopping wood when wood is the member's primary source of heat
  - Tacking down loose rugs and flooring
- These services are only available when neither the member, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision.
- In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service.
- Chore services are limited to the services provided in a home rented or owned by the member.

Companion services

Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult.

These are in-home services to ensure the safety and well-being of a person who cannot be left alone because of:

- Frail health
- Tendency to wander
- Inability to respond to emergency situations
- Other conditions that would require a person on-site

The service provider, who may live with the member, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other ADLs.

Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the member. However, the primary responsibility is to provide companionship and be there in case they are needed.

Consultation

Consultation services are services to a member or family member. Services are provided by a personal assistance agency (PAA) to a member or family member to increase their skills as an employer or manager of their own care.

Such services are directed at achieving the highest level of independence and self reliance possible for the member and the member's family.

Services include consulting with the member and family to gain a better understanding of the special needs of the member and the role of the caregiver.

Day habilitation

Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the member resides.

Services are normally furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in a member's plan of care.

Day habilitation services focus on enabling the member to attain or maintain their maximum functional level and are coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care.

In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Environmental accessibility adaptation

Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the member to function with greater independence in the home, or without which, the member would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include:

- The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver member
- This excludes adaptations or improvements to the home that are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, or central air conditioning.
- Unless otherwise authorized by IDHW, permanent environmental modifications are limited to a home that is the member's principal residence and is owned by the member or the member's non-paid family.
- Portable or non-stationary modifications may be made when such modifications can follow the member to their next place of residence or be returned to IDHW

Home-delivered meals

Home delivered meals are meals that are delivered to the member's home to promote adequate member nutrition. 1 to 2 meals per day may be provided to a member who:

- Rents or owns a home;
- Is alone for significant parts of the day;
- Has no caregiver for extended periods of time; and
- Is unable to prepare a meal without assistance.

Homemaker services

Homemaker services consist of performing for the member, or assisting them with, or both, the following tasks:

- Laundry
- Essential errands
- Meal preparation
- Other routine housekeeping duties if there is no one else in the household capable of performing these tasks

Personal care services

Personal care services (PCS) means a range of medically-oriented care services related to a member's physical or functional requirements.

These services are provided in the member's home or personal residence, but do not include housekeeping or skilled nursing care.

Personal Emergency Response System

Personal Emergency Response System (PERS) is an electronic device that enables a waiver member to secure help in an emergency.

The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center once the "help" button is activated.

The response center is staffed by trained professionals. This service is limited to members who:

- Rent or own a home, or live with unpaid caregivers;
- Are alone for significant parts of the day;
- Have no caregiver for extended periods of time; and
- Would otherwise require extensive, routine supervision.

Residential habilitation

Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible members. These services and supports are designed to assist the members to reside successfully in their own homes, with their families, or in CFHs.

The services and supports that may be furnished consist of the following:

- Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities
- Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations
- Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures
- Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the member to their community
- Socialization training associated with participation in community activities includes assisting the member to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the member to continue to participate in such activities on an on-going basis
  - Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature
- Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community
- Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs
- Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on their own behalf

  - Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver member's condition and needs, household tasks essential to health care at home to include:
    - General cleaning of the home
    - Laundry
    - Meal planning and preparation
    - Shopping
    - Correspondence

Respite

Respite care includes short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or member is responsible for selecting, training, and directing the provider.

While receiving respite care services, the waiver member cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments.

Respite care services may be provided in the member's residence, a CFH, a RALF, or an adult day health facility.

Skilled nursing

Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act.

Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a home health visit.

Specialized medical equipment

Specialized medical equipment and supplies include:

- Devices, controls, or appliances that enable a member to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live
- Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and DME and non-DME not available under the Medicaid state plan
- Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid state plan and exclude those Items that are not of direct medical or remedial benefit to the member

Supported employment

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability.

Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work.

- Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the File of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA.
- Federal fund participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer of waiver members to encourage or subsidize the employer's participation in a supported employment program
  - Payments that are passed through to beneficiaries of a supported employment program
  - Payments for vocational training that is not directly related to a waiver member's supported employment program

Transition services

Transition services include goods and services that enable a member residing in a nursing facility, hospital, institution for mental diseases (IMD), or intermediate care facility (ICF) to transition to a community-based setting.

A member is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of 45 Medicaid-reimbursed days.

Authorization/notice of action for home and community-based services

The authorization process begins when a care coordinator or service coordinator assesses the member's needs and then the service coordinator works with the member as well as their family and care providers to create a plan of care and services that specifies supports their ongoing needs. The service coordinator then arranges for the services by contacting the care providers and entering an authorization/notice of action into our system.

Sometimes a plan of care may need to be adjusted to accommodate a change in the member's condition. A change in condition means a significant change in a member's health, informal support or functional status that will not normally resolve itself without further intervention. It requires review and revision to the current person-centered care plan. At that time, a service may be added, changed or deleted from the plan of care. The member can initiate this by calling care management at **1-866-785-1628.**

Before providing services, please make sure the services you provide are authorized. Confirm the authorization includes the correct billing codes with modifiers and units. Please also verify the member's eligibility on the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility** or by calling **1-855-857-9753**.

Reimbursement process

- Care providers should submit claims for payment after the service is provided
- HCBS waiver services are billed as professional claims, using the CMS-1500 paper claim form
- Care providers must use valid ICD-10 coding
- All elements of the clean claim requirements must be followed when submitting claims
- Please continue to bill for HCBS/LTSS services using the Healthcare Common Procedure Coding System (HCPCS) codes, modifiers, and units used

Electronic payments

UnitedHealthcare prefers providers to transition from paper checks to electronic payments. Paper checks will be sent for providers who do not enroll in electronic payments. Providers can also opt to receive a Virtual Card payment instead of paper check.

As part of those efforts, we encourage electronic payment signup, specifically Automated Clearing House (ACH)/direct deposit through **Optum Pay™**. Paper checks or virtual card payments will be utilized in lieu of electronic payments.

Compliance with critical incident and adverse event reporting

Every care provider must follow the critical incident and adverse event reporting and related requirements listed in your long-term services and supports contract.

HCBS care providers are required to submit an incident report for any reportable incident within 24 hours of the time of the incident or becoming aware of it. However, if an initial report involves a member death or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within 24 hours of first knowledge of the incident.

Report and submit critical incidents and adverse events and death. Report to the Idaho Commission on Aging, Adult Protective Services at idaho.getcare.com/consumer/adult_protective_services_report.php and the appropriate law enforcement agency.

Care providers must report other types of critical incidents directly to the appropriate state entity, in accordance with Idaho law.

You are required to:

- Submit an incident report for any reportable HCBS critical incident within 24 hours of the time of the incident or becoming aware of the incident (whichever is sooner)
- Also notify the member's Service Coordinator of all HCBS critical incidents within 24 hours of the time of the incident or becoming aware of the incident (whichever is sooner)

Care provider expectations involving critical incidents

Care providers shall:

- Cooperate and follow up with UnitedHealthcare staff on all reported critical incidents
- Collaborate and cooperate with investigations of critical incidents regarding any necessary follow up to ensure member has no unmet needs
- Protect the health and welfare of all members and collaborate as well as cooperate in addressing any quality of care or quality of service investigation

When and how to submit a critical incident

When:

- Report any identified critical incidents within 24 hours
- If an initial report involves a member death, or an allegation or suspicion of abuse, neglect or exploitation, the report must be submitted within 24 hours or sooner of "first knowledge" of the incident

How:

UnitedHealthcare requires its network providers to submit reports regarding HCBS critical incidents via Idaho Commission on Aging, Adult Protective Services at idaho.getcare.com/consumer/adult_protective_services_report.php.

Also notify the member's Service Coordinator of all HCBS critical incidents within 24 hours of the time of the incident or becoming aware of the incident (whichever is sooner).

Any of the following people may report critical incidents:

- Care provider
- Care provider staff
- Case manager
- Member representative
- UnitedHealthcare employee

Critical incident type are categorized as:

- Home and community-based services (HCBS) critical incidents
- Abuse, Neglect and Exploitation (ANE) critical incidents
- All other critical incidents, such as:
  - Physical threats to staff, patients or others
  - Suicide threats or death of a member from nonnatural cause, including suicide, homicide or other unexpected cause for death
  - Serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the member requires medical treatment beyond basic first aid
  - Natural disaster such as fire, serious flooding or incidents causing displacement in which the member is harmed or in danger of being harmed due to displacement
  - Exposure to hazardous material (including blood-borne pathogens)
  - Medication error (requiring medical intervention)
  - Person missing from scheduled care
  - Unexplained deaths
  - Witnessed or un-witnessed falls requiring ER treatment or hospitalization
  - Member-to-member, other residents-to-member, staff-to-member or other encounters or assaults that have adverse consequences requiring ER treatment or hospital admission

Home and community-based services provider advocate roles and responsibilities

Home and community-based services provider advocate overview

Care providers will be assigned a dedicated HCBS Provider Advocate whose name and contact information will be available on the web site.

The assigned HCBS Provider Advocate is an important resource when you have questions. They are your single point of contact across all lines of business and medical benefit plans to help make your interactions with us easier and more efficient.

The assigned provider advocate:

- Serves as primary contact for provider with UnitedHealthcare Community Plan
- Keeps providers advised on new and amended programs and processes
- Specializes in issue resolution
- Answers a dedicated mailbox

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com/IDcommunityplan**	**1-855-857-9753**
Value-added services	**UHCCommunityPlan.com/ID** > View plan details	

We offer the following services to our UnitedHealthcare Community Plan members. if you have questions or need to refer a member, call UnitedHealthcare **Provider Services** at **1-855-857-9753** unless otherwise noted.

Chronic condition management

We use educational materials and newsletters to remind members to get their immunizations, check-ups and screenings. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a 5th grade reading level. They are available in English as well as other languages. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma, congestive heart failure, diabetes, chronic obstructive pulmonary disease and coronary artery disease receive more intense health coaching.

Identification

The health plan uses claims, data (e.g., hospital admissions, ER visits, pharmacy claims) to identify members with gaps in care and/or chronic conditions.

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 member. The program requires prior authorization and documentation stating they have severe asthma. The member's service coordinator will decide eligibility.

Just Plain Clear Glossary

The Just Plain Clear® Glossary contains thousands of health care terms defined in plain, clear language to help you make informed decisions. Visit justplainclear.com to use this free and helpful tool. This resource is currently available in English, Spanish, Burmese, Chinese and Portuguese. Share this resource with your patients, regardless of their assigned health plan

Mindfulness: Be here now

We deliver this program to social worker and community partners. It focuses on caregiver well-being. The program provides mindfulness techniques to reduce burnout, raise performance and improve quality of care.

Mobile apps

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

- **Health4Me®** – enables users to review health benefits, access claims information and locate in-network care providers.
- **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 members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their provider. Our nurses also help educate members about staying healthy. Call **1-855-873-2377** to reach a nurse.

On My Way

On My Way™ (OMW) is an online program that helps young adults who are either transitioning from foster care or from their parents'/ guardians' home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

Quit For Life

The Quit For Life® program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members 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% member satisfaction.

Substance use disorder recovery coaching

Our substance use disorder (SUD) recovery coach works with members 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 members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

UHC Doctor Chat-virtual visits

Members have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for nonemergent care. A board-certified emergency medicine physician assesses the severity of the member's situation, provides treatment (including prescriptions) and recommends additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to expand and deliver access to care.

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 program (WIC) to help with nutritional needs for low-income families. For more information about WIC, go to healthandwelfare.idaho.gov.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-877-614-0484**

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members 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 Optum Behavioral Health National Network Manual is located on **providerexpress.com**.

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

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

To participate in the Idaho Medicaid program, go to the IDHW provider enrollment site.

How to join our network: Credentialing information is available at **public.providerexpress.com/content/ope-provexpr/us/en/our-network.html.**

Covered services

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

For member resources, go to **providerexpress.com**, click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility (PRTF) and residential treatment services for mental health and substance use disorders
- Outpatient treatment including therapy and medication management
  - Partial hospitalization for mental health and substance use disorders
  - Social detoxification
  - Day treatment
  - Intensive outpatient for mental health and substance use disorders
- Rehabilitation services

The primary insurance is Medicare. IMPlus is the secondary insurance and will cover most eligible Medicaid services. Please contact the number on the back of the members card for questions.

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online using the Eligibility and Benefits tool on the **UnitedHealthcare Provider Portal** > Sign In.

Authorizations

Members 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 program; day treatment; partial or inpatient psychiatric hospital. Help ensure prior authorizations are in place before rendering nonemergent services. Request prior authorization using the Prior Authorization and Notification tool on the portal or by calling **1-855-857-9753**.

Collaboration with other care providers

Coordination of care

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

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

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

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.

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**
- **liveandworkwell.com**

Addressing the opioid epidemic

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

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 data infrastructure and analytics**
  Identify needs early and measure progress

Increasing education and awareness of opioids

You must be up to date on the cutting-edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on the 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 substance use disorders/OUD assessments and screening resources, and other important state-specific resource.

Access these resources at **UHCprovider.com/pharmacy.**

Click "Opioid Programs and Resources-Community Plan" to find a list of tools and education.

Expanding medication assisted treatment access and capacity

Evidence-based medication assisted treatment (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 MAT network.

The member's Medicare plan is the primary payer for many services including MAT. Please review the primary payer's provider directory to locate a MAT provider. If you need additional assistance locating a MAT provider, please follow the steps below.

To find a behavioral health MAT care provider in Idaho:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Behavioral Health Directory."
3. Click on "Medicaid plans."
4. Select "Idaho."
5. Click on the applicable plan name.
6. In the search field, type "Medication Assisted Treatment" and click "Search."

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.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/ID**	**1-866-785-1628**
Member handbook	**UHCCommunityPlan.com/ID** > Community Plan > Member benefits	

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

Privacy regulations

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

Access to Protected Health Information

Members may access their medical records or billing Protected Health Information (PHI) 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 members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member 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 member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members 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 members or pursuant to member'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

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members 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

Members 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 member states disclosure could endanger them.

Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member right and responsibilities

The following information is in the member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com/ID** > Community Plan > Member benefits

Native American access to care

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

Members rights

Members have the right to:

- Exercise their rights and not be adversely affected by the way they are treated by their health plan, providers, and the state
- Request information on advance directives
- Be treated with respect, dignity and privacy
- 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 form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- 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 in a manner they understand, comprehend 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 member 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

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member 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 member rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary member 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 member 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 member 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 24 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 • Member 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 member'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 members 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 members 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 • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented

***Critical element**

Member copies

A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and TB records required for lifetime)

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% 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 members 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 member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member 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 provider to indicate review
- Consultation and abnormal studies, including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK and PHQ-9)

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	**UHCprovider.com/join**	
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736** (FWA hotline)

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 members 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 member health care and services
- Monitoring and enhance patient safety
- Tracking member 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

We require your cooperation and compliance to:

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

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

Survey results are reported to our QI 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 Idaho 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 members.

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, masters prepared therapists)

Excluded from this process are:

- Practitioners who practice only in an inpatient setting
- Hospitalists employed only by the facility

Health facilities

Facility care providers such as hospitals, home health agencies, skilled nursing facilities (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 at caqh.org. Go to **UHCprovider.com/join** to submit a participation request.

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

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

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.

All care providers are notified of credentialing decisions within 30 calendar days of the Credentialing Committee's decision or as required by state law, though we are generally able to notify care providers within 14 days of the Credentialing Committee's decision.

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 at caqh.org. 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 QI database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application; please connect with a live advocate via chat. It is available 6 a.m.-6 p.m. MT at **UHCprovider.com/contactus**.

Confidentiality

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

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

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

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

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

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the member handbook located on **UHCCommunityPlan.com/ID** > Community Plan > Member benefits and **Chapter 12** of this manual.

Health Insurance Portability and Accountability Act 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 – as are all care providers who conduct business electronically.

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' 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 HIPPA regulations on cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, 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:

1. Oversight of the Ethics and Integrity program.
2. Development and implementation of ethical standards and business conduct policies.
3. Creating awareness of the standards and policies by educating employees.
4. Assessing compliance by monitoring and auditing.
5. Responding to allegations of violations.
6. Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
7. 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 members. This department oversees coordination of anti-fraud activities. To report questionable incidents involving members or care providers, call our fraud, waste and abuse line at 1-844-359-7736, go to **uhc.com/fraud** or refer to the **Fraud, waste and abuse section** of this care provider manual for additional details.

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 Idaho 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 IDHW.

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 members. Records must be kept for at least 10 years from the close of the Idaho 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 OptumHealth®) 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 members 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 program standards.

You must cooperate with the state or any of its authorized representatives, the IDHW, CMS, the Office of Inspector General (OIG), 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 quality of care (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 members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set clinical site standards for all 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 member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

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

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-855-857-9753**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-800-210-8315**

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 member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

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

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services** at **1-855-857-9753**. 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 member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or noncovered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

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

Modifier codes

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

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

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

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 member
- 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.

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

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

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

Electronic Data Interchange companion documents

The UnitedHealthcare Community Plan Electronic Data Interchange (EDI) 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 at **UHCprovider.com/edi** > **EDI transaction and code sets**.

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 **1-855-857-9753** 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**.

For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find Electronic Data Interchange menu.

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 automated clearinghouse/ 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/resourcelibrary**.

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

Capitated services

Capitation is a payment arrangement for care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an independent practice association (IPA). In a few instances, however, the capitated care provider may be an ancillary care provider or hospital.

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

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

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

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

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

Form reminders

- Note the attending care provider name and identifiers for the member'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 a member's treatment when a third party causes the injury or illness
- **COB**
  We coordinate benefits based on the member'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.

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.

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 1-208-334-0528 or go to cms.gov.

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The IDHW covers medically necessary, nonexperimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

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

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 code, unit/basis of measurement qualified and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

You can ask about claims through **Provider Services** and the **UnitedHealthcare Provider Portal.**

Provider Services

Call **1-855-857-9753**. Have the following information ready before you call:

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

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

UnitedHealthcare Provider Portal

Go to **UHCprovider.com** and sign in to view your claims transactions.

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 5240
Kingston, NY 12402-5240

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

For paper claims

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

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

Timely filing

Timely filing issues may occur if members 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 member 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 member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims.

They must be accompanied by an acceptance report.

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

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

If we reject a claim and don't receive corrections within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

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

Balance billing

Do not balance bill members 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 member for noncovered services if the member 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, connect with us 24/7 via chat at **UHCprovider.com/contactus**.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. 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 complaints

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 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 **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

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

Appeals and complaints standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and 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 correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270	**UHCprovider.com/claims**	**1-855-857-9753**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Re-submit corrected claims within 12 months from service date. If UnitedHealthcare Community Plan recoups the claim and the provider is over the regular filing limit for corrected claims, the care provider has 90 days from the date of recoupment to submit a corrected claim.	30 business days
Care provider claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with	Care provider	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 address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-855-857-9753**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com**, then click Claims.	Must receive within 365 calendar days of the claim processing date.	12 months from date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission
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 address: **UnitedHealthcare Community Plan** Attn: Complaint and Appeals Department P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-855-857-9753**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com**, then click Claims.	12 months from date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.	15 business days Standard appeal acknowledgment letter sent within 5 business days.

Appeals and complaints standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and 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 complaint	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-855-857-9753**	To access the portal, go to **UHCprovider.com**. Use the coverage and payments tab and select Idaho on the UnitedHealthcare Provider Portal. Click View plans under Community Plan (Medicaid). Select Provider forms and references to access the secure form, then click Idaho Provider Complaint Form.	Complaints can be filed any time.	Standard complaint: 30 calendar days Standard complaint acknowledgment letter sent within 5 business days.
Care provider appeal on behalf of member	A request to change an adverse benefit determination that we made	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** Attn: Appeals and Grievances Department P.O. Box 31364 Salt Lake City, UT 84131-0364	**providerforms.uhc.com/ProviderAppealsandGrievance.html** • AOR Consent Form on this site for member appeals	**1-866-785-1628** TTY **711**	Use Prior Authorization on the UnitedHealthcare Provider Portal. **UHCprovider.com**, then Sign In on top right.	Standard and urgent appeals: 60 calendar days	Expedited appeals: we will respond within 72 hours Standard appeals: 30 calendar days Standard appeal acknowledgment letter sent within 5 business days
Care provider grievance on behalf of member	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** Attn: Appeals and Grievances Department P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-866-785-1628** TTY **711**	**UHCprovider.com/IDcommunityplan**	Grievance can be filed at any time.	Standard grievances: 30 calendar days Standard grievance acknowledgment letter sent within 5 business days

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements. UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts than described in the standard process.

Denial

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

- **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 using your One Healthcare ID.

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, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

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

Additional information

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

Errors in member demographic data – name, age, date of birth, sex or address

- Errors in care provider data
- Wrong member 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. To mail your resubmission, provide all claim information to:

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

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

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

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

For medical necessity denials
In your request, please include any additional clinical information that may not have been reviewed with your original claim.

Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the UnitedHealthcare Provider Portal. Include electronic attachments.
  You may also check your status using the **UnitedHealthcare Provider Portal**.
- **Phone:** Call **Provider Services** at **1-855-857-9753** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.

Most care providers in your state must submit claim reconsideration requests electronically.

For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, you may 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.

- **Mail:** Submit the Claim Reconsideration Request Form to:

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

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

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-855-857-9753** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member 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 member on the date of service of the claim

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

How to use:

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

- **Electronic claims:** Include the EDI acceptance report stating we received your claim

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 address:

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

- Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

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.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within 60 calendar days after it was identified. Notify UnitedHealthcare Community Plan, in writing, of the reason for the overpayment. If your payment is not received by that time, we may apply the overpayment against future claim payments based on our Agreement and applicable law.

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

If you prefer to mail a refund, send an overpayment return check or the Overpayment Refund/Notification form.

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

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

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

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

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

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract. If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See **Chapter 12, Resolving disputes** section.

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

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim
222222	02/02/24	14A000000002	03/15/24	$77.29	$27.29	Contract states $50.00, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance
555555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

Appeals (step 2 of dispute)

What is it?

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

When to use:

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

How to use:

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

- **Electronic appeals:** Use Claims Management or Claims on the UnitedHealthcare Provider Portal. Click Sign In on the top right corner of **UHCprovider.com**, then click Claims.
- You may upload attachments

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 address:

- **Mail:** Send the appeal to:

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

Questions about your appeal or need a status update?

Call **Provider Services** at **1-855-857-9753** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

Care provider complaints

What is it?

Complaints are issues or problems related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a complaint about:

- Benefits and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service

How to file:

- **Phone:** Call **Provider Services** at **1-855-857-9753**
- **Electronic**: Use Claims Management or Claims on the UnitedHealthcare Provider Portal. Click Sign In on the top right corner of UHCprovider.com, then click Complaints. You may upload attachments.

  Most care providers in your state must submit reconsideration requests electronically.

  For further information on appeals/complaints see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, requests may be submitted at the following address:

- **Mail:** Send care provider name, contact information and your complaint to:

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

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Care provider appeal on behalf of member

What is it?

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

You, with a member's written consent, or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Doesn't act within the time frame CMS or the state requires

When to use:

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

Where to send:

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

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

Phone: 1-866-785-1628 TTY **711**

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

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights.

The member 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 member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

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

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

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

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form.

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

If needed, an appeals representative will provide you with this form. Expedited appeals do not need to be in writing.

Care provider grievance on behalf of member

What is it?

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

When to use:

You may act on the member's behalf with their written consent.

Where to send:

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

Mailing address:

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

Phone: 1-866-785-1628 TTY **711**

We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

Care provider state fair hearing on behalf of member

What is it?

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

When to use:

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

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by contacting:

Medicaid Appeals
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0009

Fax: 1-208-364-1811

Email: MedicaidAppeals@dhw.idaho.gov

Additional information is available at healthandwelfare.idaho.gov/appeals-and-fair-hearings.

IDHW responds within 30 days of the state fair hearing or sooner if the member's health condition demands.

Processes related to reversal of our initial decision

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

1. As quickly as the member's health condition requires.
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

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

Fraud, waste and abuse

Call the fraud, waste and abuse hotline **(1-844-359-7736)** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

The UnitedHealthcare Community Plan anti-fraud, waste and abuse efforts focus on prevention, detection and investigation of false and abusive acts committed by you and plan members. The effort also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law.

UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its work. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

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

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

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

This policy details our commitment to compliance with the federal and 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

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month.

For more information or access to the publicly accessible, excluded-party online databases, please see the following links:

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

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
Provider education	**UHCprovider.com/resourcelibrary**
News and bulletins	**UHCprovider.com/news**
Care provider manuals	**UHCprovider.com/guides**

Communication with care providers

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

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

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 6 a.m.–6 p.m. MT, 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/IDcommunityplan**
  The UnitedHealthcare Community Plan of Idaho page has state-specific resources, guidance and rules
- **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)
- **Idaho health plans**
  UHCprovider.com/ID is the fastest way to review all of the health plans UnitedHealthcare offers in Idaho. 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.
  Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

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 provider offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness and promote compliance and problem resolution.

If you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/IDcommunityplan** > Contact Us.

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online and updates the content (at least) annually. It includes an overview of the Medicaid program, important contact information and a list of additional care provider resources.

State websites and forms

Find the following forms on the state's website at idmedicaid.com.

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