



# 2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary  
**Indiana PathWays for Aging**

# Welcome

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

## Click to access different manuals

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

## Easily find information in this care provider manual using the following steps

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

View the [Medicaid glossary](#) for definitions of terms commonly used throughout the care provider manuals.



If you have questions about the information or material in this manual, or about our policies, please call **Provider Services**.



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 manual, unless your Agreement states you should use it, instead.

If there is a conflict between your Agreement, this 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 manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

## Participation Agreement

Terms and definitions as used in this 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 an 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 guide
- Any reference to “ID card” includes a physical or digital card

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

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# Chapter 1: Introduction

## Key contacts

Topic	Link	Phone number
Provider Services	<a href="https://UHCprovider.com">UHCprovider.com</a> Live chat available at <a href="https://UHCprovider.com/contactus">UHCprovider.com/contactus</a>	1-877-610-9785
Training	<a href="https://UHCprovider.com/training">UHCprovider.com/training</a>	1-877-610-9785
UnitedHealthcare Provider Portal	<a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In using your One Healthcare ID or go to <a href="https://UHCprovider.com/portal">UHCprovider.com/portal</a> New users: <a href="https://UHCprovider.com/access">UHCprovider.com/access</a>	1-877-610-9785
CommunityCare Provider Portal training	<a href="#">UnitedHealthcare CommunityCare Provider Portal user guide</a>	
One Healthcare ID support (formally known as Optum support)	Chat with a live advocate 8 a.m.–8 p.m. ET from the UnitedHealthcare Provider Portal <a href="#">Contact Us</a> page.	1-855-819-5909
Resource library	<a href="https://UHCprovider.com/resourcelibrary">UHCprovider.com/resourcelibrary</a>	

UnitedHealthcare Community Plan supports the Indiana state goals of increased access, improved health outcomes and reduced costs by offering Indiana PathWays for Aging benefits to the following members:

- Individuals who are 60 years of age and older
- Individuals who are eligible for Medicaid based on age, blindness or disability
- Individuals who have limited income and resources
- Individuals who may be full-benefit dually eligible
- Individuals in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting

The state of Indiana will determine enrollment eligibility.



If you have questions about the information in this manual or about our policies, go to [UHCprovider.com](https://UHCprovider.com), or call **Provider Services** at **1-877-610-9785**.

## How to join our network

You and your service locations need to be enrolled in Indiana Medicaid before joining our network. Complete the Indiana Medicaid enrollment and credentialing forms at [in.gov/medicaid](https://in.gov/medicaid).

Learn how to join the UnitedHealthcare Community Plan care provider network at [UHCprovider.com/join](https://UHCprovider.com/join). There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

## Already in network and need to make a change?

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

# Approach to health care

## Care Model

The UnitedHealthcare care model serves to optimize the health and well-being of members with complex physical, behavioral and functional limitations that put them at risk for adverse health outcomes. We employ an integrated care model that is person-centered and facilitates collaboration between our members and their health care teams. These programs focus on improving members' active decision-making, providing strong Care and Service Coordination, and encouraging member participation in social determinants of health (SDOH) interventions personalized to their risks and conditions. All members will receive a care coordinator. Members who are nursing facility level of care (NFLOC) will receive a Care Coordinator and Service Coordinator to assist their integrated care team to provide a seamless member experience.

Care model provides a team that helps increase member engagement, offers resources to fill gaps in care, and develops personalized health goals and service planning 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. The Care Coordination program provides:

- Medical, behavioral and social care management using community resources
- An extended care team, including a Primary Medical Provider (PMP), Pharmacist, Medical and Behavioral Director, and Peer Specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance making and coordinating appointments
- 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 program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates

- Improve access to PMP and other needed services, measured by number of PMP visit rates within identified time frames
- Identify and discuss behavioral health needs, measured by 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 Care 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 coordination program, call **Member Services** at **1-800-832-4643**, TTY **711**. You may also call **Provider Services** at **1-877-610-9785**.

## Compliance

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

Atypical care providers may use their state issued Medicaid ID instead of NPI.

Contracted care providers should refer to the Indiana State Program Regulatory Requirements Appendix that is part of the Provider Agreement.

## 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. Your commitment to supporting UnitedHealthcare Community Plan's Cultural Competency Program is paramount in breaking through barriers associated with linguistic and cultural barriers.

For more information, go to [UHCprovider.com/resourcelibrary](https://www.uhc.com/providerexpress) > 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**.

- **Behavioral health providers**

Visit [providerexpress.com](https://www.providerexpress.com) to complete the required Cultural Sensitivity training through Optum Health Education.

- **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.

Indiana PathWays for Aging provides the following:

- **Language interpretation line**

We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET.

To arrange for interpreter services, 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](https://www.uhc.com).

## Online resources

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

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

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, 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](https://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 it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. The benefits of EDI are 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](https://UHCprovider.com/edi) for more information. Learn how to optimize your use of EDI at [UHCprovider.com/optimizeedi](https://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

Point of Care Assist® integrates members' UnitedHealthcare health data within the electronic medical record (EMR) to provide real-time insights of 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](https://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, regulatory and practice updates and quality programs.

### UnitedHealthcare Provider Portal

#### Chat support now available

Have a question? Access patient- and practice-specific information 24/7 within the [UnitedHealthcare Provider Portal](#). You can complete tasks online, get updates on claims, reconsiderations, appeals 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](https://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](https://uhcprovider.com/claims).

- **Prior authorization and notification**

Submit notification and prior authorization requests. For more information, go to [UHCprovider.com/priorauth](https://uhcprovider.com/priorauth).

- **Specialty pharmacy transactions**

Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to [UHCprovider.com/pharmacy](https://uhcprovider.com/pharmacy) for more information.

- **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](https://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](https://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 recoupmnt 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](mailto:directconnectsupport@optum.com) to get started with Direct Connect.

## Individual Health Record

The Individual Health Record<sup>®</sup> (IHR) is a digital tool that helps create a more complete picture of a member's health. This supports collaboration between you and other care providers during member visits. The IHR includes each member's care history, including lab results and prescribed medications.

PMPs and behavioral health providers are encouraged to review the IHR for your members before each visit or at least each quarter. Find out more at [UHCprovider.com/ihr](https://uhcprovider.com/ihr).

## Privileges

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

## Provider Services

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

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

## How to contact us

Topic	Contact
Behavioral, mental health and substance abuse	Optum <sup>®</sup> <a href="https://uhcprovider.com">providerexpress.com</a> <b>1-877-614-0484</b>



Benefits	<p><a href="https://UHCprovider.com/benefits">UHCprovider.com/benefits</a>  <b>1-877-610-9785</b>  <a href="https://in.gov/medicaid">in.gov/medicaid</a></p>	Confirm a member’s benefits and/or prior authorization.
Cardiology prior authorization	<p><a href="https://UHCprovider.com/cardiology">UHCprovider.com/cardiology</a> &gt; Sign In  <b>1-877-610-9785</b></p>	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care Model (care management/disease management)	<p><a href="mailto:in_caremanagement@uhc.com">in_caremanagement@uhc.com</a>  <b>1-877-610-9785</b></p>	Refer high-risk members (e.g. asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	<p><a href="https://myoptumhealthphysicalhealth.com">myoptumhealthphysicalhealth.com</a>  <b>1-800-873-4575</b></p>	<p>We provide members older than 21 with up to 5 office visits per calendar year with an in-network chiropractor.</p> <p>This benefit does not need prior authorization.</p>
Claims	<p><a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a>  <b>1-877-610-9785</b></p> <p>Mailing address:  <b>UnitedHealthcare Community Plan</b>            P.O. Box 5270            Kingston, NY 12402-5270</p> <p>For FedEx (use for large packages/more than 500 pages):  <b>UnitedHealthcare Community Plan</b>            1355 S 4700 West, Suite 100            Salt Lake City, UT 84104</p>	Verify a claim status or get information about proper completion or submission of claims.
Topic	Contact	Information

Topic	Contact	Information
Claim overpayments	<p>Sign in to <a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a> to access the UnitedHealthcare Provider Portal</p> <p><b>1-877-610-9785</b></p> <p>Mailing address:  <b>UnitedHealthcare Community Plan</b>            ATTN: Recovery Services            P.O. Box 740804            Atlanta, GA 30374-0800</p>	<p>Ask about claim overpayments.</p> <p>See the <b>Overpayment</b> section for requirements before sending your request.</p>
Dental services	<p><a href="https://uhcdentalproviders.com">uhcdentalproviders.com</a></p> <p><b>1-844-402-9118</b></p>	<p>Call for details about dental eligibility, benefits, authorizations, claims or other key information.</p>
Electronic Data Intake (EDI) Issues	<p><b>EDI Transaction Support Form</b></p> <p><a href="https://UHCprovider.com/edi">UHCprovider.com/edi</a></p> <p><a href="mailto:ac_edi_ops@uhc.com">ac_edi_ops@uhc.com</a></p> <p><b>1-800-210-8315</b></p>	<p>Contact EDI Support for issues or questions.</p>
Eligibility	<p><a href="https://UHCprovider.com/eligibility">UHCprovider.com/eligibility</a></p> <p><b>1-877-610-9785</b></p>	<p>Confirm member eligibility.</p>
Enterprise Voice Portal	<p><b>1-877-842-3210</b></p>	<p>The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent.</p>
Fraud, waste and abuse (payment integrity)	<p><a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a>            &gt; Integrity of Claims, Reports, and Representations to the Government</p> <p>Reporting: <a href="https://uhc.com/fraud">uhc.com/fraud</a></p> <p><b>1-800-455-4521</b> (NAVEX) or  <b>1-877-401-9430</b></p>	<p>Learn about our payment integrity policies.</p> <p>Report suspected FWA by a care provider or member by phone or online.</p>

Topic	Contact	Information
Hearing services	<p><a href="http://uhhearing.com">uhhearing.com</a>  <b>1-877-610-9785</b></p>	<p>The Indiana Health Coverage Programs (IHCP) provides coverage of hearing services for eligible members.</p> <p>UnitedHealthcare Hearing is one provider option offered through Medicaid.</p>
Laboratory services	<p><a href="http://UHCprovider.com">UHCprovider.com</a> &gt; Our Network &gt; <b>Preferred Lab Network</b></p> <p>Labcorp 1-800-833-3984            Quest Diagnostics 1-866-697-8378</p>	<p>Labcorp and/or Quest Diagnostics are network laboratories.</p>
Medicaid (Indiana Family and Social Services Administration)	<p>Indiana Office of Medicaid Policy and Planning</p> <p><a href="http://in.gov/medicaid">in.gov/medicaid</a>            1-800-403-0864</p>	<p>Contact Medicaid directly.</p>
Medical claim, reconsideration and appeal	<p><a href="http://UHCprovider.com/claims">UHCprovider.com/claims</a>  <b>1-877-610-9785</b></p> <p>Most care providers in your state must submit reconsideration requests electronically.</p> <p>For further information on reconsiderations, see the <a href="#">Reconsiderations and Appeals interactive guide</a>.</p> <p>For those care providers exempted from this requirement, requests may be submitted at one of the following addresses:</p> <p>Reconsiderations mailing address:  <b>UnitedHealthcare Community Plan</b>            P.O. Box 5240            Kingston, NY 12402-5240</p> <p>Appeals mailing address:  <b>UnitedHealthcare Community Plan Grievances and Appeals</b>            P.O. Box 31364            Salt Lake City, UT 84131-0364</p>	<p>Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.</p>
Member Services	<p><a href="http://myuhc.com">myuhc.com</a><sup>®</sup>  <b>1-800-832-4643</b>, TTY <b>711</b> for help accessing member account</p>	<p>Helps assist members with issues or concerns. Available 8 a.m.-8 p.m. ET, Monday-Friday.</p>

## Chapter 1: Introduction

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	<b>1-800-832-4643</b> (members) <b>1-877-610-9785</b> (providers) TDD <b>711</b>	Available 8 a.m.–8 p.m. ET, Monday–Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	<a href="https://nppes.cms.hhs.gov">nppes.cms.hhs.gov</a> 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	<a href="mailto:in_nm_team@uhc.com">in_nm_team@uhc.com</a>	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support team	Chat with a live advocate, available 7 a.m.–7 p.m. CT at <a href="https://UHCprovider.com/chat">UHCprovider.com/chat</a> .	Self-service functionality for medical network care providers to update or check credentialing information.
NurseLine	<b>1-877-303-2422</b> , TTY <b>711</b>	Available 24 hours a day, 7 days a week
One Healthcare ID support center	Chat with a live advocate 8 a.m.–8 p.m. ET at <a href="https://UHCprovider.com/chat">UHCprovider.com/chat</a> . <b>1-855-819-5909</b>	Contact if you have issues with your ID. Available 8 a.m.–10 p.m. ET, Monday–Friday; 7 a.m.–7 p.m. ET, Saturday; and 10 a.m.–7 p.m. ET, Sunday.
Pharmacy services	<a href="https://professionals.optumrx.com">professionals.optumrx.com</a> <b>1-877-305-8952</b>	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	<a href="https://UHCprovider.com/pharmacy">UHCprovider.com/pharmacy</a> <b>1-800-310-6826</b>	Request authorization for medications as required. Use the <a href="#">UnitedHealthcare Provider Portal</a> to access the <a href="#">PreCheck MyScript®</a> . 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.
Prior authorization requests/ advanced and admission notification	To notify us or request a medical prior authorization: <ul style="list-style-type: none"> <li>• EDI: Transactions 278 and 278N</li> <li>• <a href="https://UHCprovider.com/priorauth">UHCprovider.com/priorauth</a></li> <li>• Call Care Coordination at the number on the member’s ID card (self-service available after hours) and select “Care Notifications.” or call <b>1-877-610-9785</b></li> </ul>	Use the Prior Authorization and Notification Tool online to: <ul style="list-style-type: none"> <li>• Determine if notification or prior authorization is required.</li> <li>• Complete the notification or prior authorization process.</li> <li>• Upload medical notes or attachments.</li> <li>• Check request status</li> </ul> Information and advance notification/ prior authorization lists: <p><a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a> &gt; <a href="#">Prior Authorization and Notification</a></p>

Topic	Contact	Information
Provider Services	<a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a> <b>1-877-610-9785</b>	Available 8 a.m.–8 p.m. ET, Monday–Friday.
Reimbursement policy	<a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a> > <a href="#">Policies and Protocols</a>	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	<a href="https://UHCprovider.com/contactus">UHCprovider.com/contactus</a> Chat with a live advocate 8 a.m.–8 p.m. ET available at <a href="https://UHCprovider.com/chat">UHCprovider.com/chat</a> <b>1-866-209-9320</b> for Optum support or <b>1-866-842-3278</b> , Option 1 for web support	Call if you have issues logging in to the <a href="#">UnitedHealthcare Provider Portal</a> , you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Refer members to Quit Now Indiana for tobacco and vaping cessation services.
Transportation	Member Services <b>1-800-832-4643</b>	Call Member Services to schedule transportation or for transportation assistance.  To arrange nonemergent transportation, please call at least 3 business days in advance.
Utilization management	Provider Services <b>1-877-610-9785</b>	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 <a href="https://UHCprovider.com/protocols">UHCprovider.com/protocols</a> .  Request a copy of our UM guidelines or information about the program.
Vision services	MARCH Vision Care 1-844-486-2724 MARCH Vision Care Provider Reference Guide: <a href="https://marchvisioncare.com/providerreferenceguides.aspx">marchvisioncare.com/providerreferenceguides.aspx</a>	Contact MARCH® Vision Care’s provider relations department for information on benefits, lab order submissions and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers and federal tax identification numbers.  Attend a training session on eyeSynergy®. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
Website for Indiana Community Plan	<a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a>	Access your state-specific Community Plan information on this website.

# Frequently asked questions

### **Q: When did the UnitedHealthcare Community Plan Indiana PathWays for Aging program begin?**

A: The UnitedHealthcare Community Plan program went live on July 1, 2024.

### **Q: What are the timely filing requirements?**

A: Timely filing requirements are generally 90 days from the date of service. Out-of-network provider filing limit is 6 months from date of discharge or date of service.

### **Q: What is UnitedHealthcare Indiana PathWays for Aging time frame for processing a care provider's credentialing application?**

A: The state of Indiana requires we provisionally credential providers at 15 business days, and complete full credentialing within 30 days.

### **Q: Which member populations are included in the Indiana PathWays for Aging program?**

A: Indiana PathWays for Aging covers a variety of individuals who are not eligible for Medicare, including those who:

- Are 60 years of age or older
- Are eligible for Medicaid based on age, blindness or disability
- Have limited income and resources
- May be full-benefit dually eligible

### **Q: Do I need to enroll with the state of Indiana to become a participating care provider?**

A: If you are not an existing Medicaid provider in Indiana, you must enroll with the state of Indiana to provide services to Indiana PathWays to Aging members. Providers may enroll with the state of Indiana at [in.gov/medicaid](https://in.gov/medicaid).

### **Q: How do care providers access the state of Indiana Provider Healthcare Portal?**

A: Use the Provider Healthcare Portal, your online health care portal for eligibility access and other insurance information. The portal is an internet-based solution that offers you reliability, speed, ease of use and security.

It can help you with the following transactions:

- Completing care provider eligibility and enrollment applications
- Verifying member eligibility/identifying a member's plan, including whether the member is in the Right Choices Program
- Confirming any third-party liability (i.e., presence of other health insurance such as commercial or Medicare insurance)
- Managing your care provider profile

Reminder: You may also use the UnitedHealthcare Community Plan provider portal for Indiana PathWays for Aging transactions, such as claims, remits, prior authorization, adjustments, etc.

See Online Resources in Chapter 1 for more information.

To access the portal, go to [portal.indianamedicaid.com](https://portal.indianamedicaid.com).

# Chapter 2: Care provider standards and policies

## Key contacts

Topic	Link	Phone number
Provider Services	<a href="https://UHCprovider.com">UHCprovider.com</a>	1-877-610-9785
General provider assistance		1-877-842-3210
Eligibility	<a href="https://UHCprovider.com/eligibility">UHCprovider.com/eligibility</a>	1-877-610-9785
Provider Directory	<a href="https://UHCprovider.com/findprovider">UHCprovider.com/findprovider</a>	1-877-610-9785

## 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 or intellectual and developmental disabilities
- 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 UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PMPs and other

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 you to:

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 plan care manager 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](https://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 health care professionals.



For the most current list of network professionals, review our Provider Directory at [UHCprovider.com/findprovider](https://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.

### Changing an existing TIN or adding a care provider

Visit [UHCprovider.com/attestation](https://UHCprovider.com/attestation) to view ways to update and verify your provider demographic data.

To add a PMP, please complete the Indiana Health Coverage Programs (IHCP) MCE Practitioner Enrollment Form located at [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > **Provider Forms and References**

### Updating your practice or facility information

You can update your practice information through the UnitedHealthcare Provider Portal on [UHCprovider.com](https://UHCprovider.com). Go to [UHCprovider.com](https://UHCprovider.com), then Sign In > My Practice Profile. Or submit your change by:

- Visiting [UHCprovider.com/attestation](https://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. For a list of urgent care centers, contact Provider Services.

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 UnitedHealthcare Community Plan's and payer's protocols, including those contained in this manual.

You may view protocols at [UHCprovider.com/protocols](https://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 the Health Insurance Portability and Accountability Act of 1996 ("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 is 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/in](https://UHCCommunityPlan.com/in).

Also reference **Chapter 12** of this manual for information on care provider claim reconsiderations, appeals and grievances.

## Appointment standards (Indiana access and availability standards)

Care providers must comply with the appointment availability standards shown in the following table.

Service type	Condition description	Time frame
Aftercare/follow-up	Aftercare appointment after hospital discharge.	Within 7 calendar days.
	Outpatient in-person follow-up appointment after inpatient behavioral health hospitalization.	Within 7 calendar days.
Consultative clinical and therapeutic services	For informal caregivers.	Within 60 business days from the time of the service order.
Durable medical equipment	Excluding hearing aids, prosthetics and family planning supplies.	Within 30 business days from the time of the service order.
	Highly specialized equipment and supplies.	Within 120 business days from the time of the service order.
Emergency	A condition with acute symptoms the severity of could cause serious impairment of body or organ functions, in whole or in part.  Includes mental health or substance use disorder (SUD) crisis.	Immediately, upon presentation.
Environmental accessibility adaptations	Includes home modifications.	Within 90 business days from the time of the service approval.
Routine care	Routine care with physical or behavioral symptoms. Examples include recurring high-grade temperature, persistent rash, nonspecific pain and fever.	Within 1 week or 5 days, whichever is earlier.
	Routine care without physical or behavioral symptoms. Includes routine physical exams.	Within 30 calendar days.
Urgent	A condition with acute symptoms the severity of could cause serious impairment of body or organ functions, in whole or in part, but do not constitute emergencies. Includes mental health or SUD crisis, high temperature, persistent vomiting or diarrhea, and symptoms which are of sudden or severe onset but do not require emergency room services.	Within 24 hours.

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.

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for:

1. Care for a non-life-threatening emergency within 6 hours.
2. Urgent care within 48 hours.
3. Initial visit for routine care within 10 business days.
4. Follow-up routine care.

## 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](https://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](https://UHCprovider.com/findprovider).
- In addition to updating UnitedHealthcare Community Plan, you are required to submit a profile update to the IHCP Provider Healthcare Portal at [portal.indianamedicaid.com](https://portal.indianamedicaid.com) within 10 business days. Profile updates must be submitted electronically using the IHCP Provider Healthcare Portal or by mail, using the appropriate paper forms.

## Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at. 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**. 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](https://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. Find the IHCP Prior Authorization Form at [in.gov/medicaid](https://in.gov/medicaid).

**Obtaining an approved prior authorization does not guarantee payment.** You must follow all applicable state and Indiana PathWays for Aging billing guidelines and verify eligibility requirements.

# Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

# Requirements for primary medical provider and specialists serving in primary medical provider role

## Primary medical provider access standards

Primary medical providers (PMPs) must arrange for service coverage 24 hours a day, 7 days a week (anytime). They must also offer members direct contact with the care provider, or the care provider's qualified clinical staff person, through a toll-free telephone number anytime. They must ensure the Indiana PathWays for Aging population is receiving accessible services equally with the provider's non-Indiana PathWays for Aging population.

They must provide "live voice" coverage after normal business hours. After-hours coverage may include an answering service or a shared-call system with other medical providers. Members must have telephone access to their provider (or appropriate designee such as a covering care provider) in English and Spanish anytime.

## Specialists include gynecologists and endocrinologists (if primarily engaged in internal medicine)

PMPs are an important partner in the delivery of care, and UnitedHealthcare Community Plan Indiana PathWays for Aging members may seek services from any participating care provider. The UnitedHealthcare Community Plan Indiana PathWays for Aging program requires members be assigned to PMPs.

We encourage members to develop a relationship with a PMP who can maintain all their medical records and provide overall medical management. The PMP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care

delivery in 4 critical areas: access, coordination, continuity and prevention.

As such, the PMP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members.

The PMP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and physician assistants (P.A.s) from any of the following practice areas including:

- Geriatricians
- Internal medicine
- Physicians
- Gynecologists
- General practitioners
- Family medicine physicians
- Endocrinologists (if primarily engaged in internal medicine)
- Physician extenders

Members may change their assigned PMP by contacting Member Services. Customer service is available 8 a.m.–8 p.m. ET, Monday–Friday.

UnitedHealthcare Community Plan may auto-assign a PMP to members who don't select a PMP during enrollment to complete the enrollment process within 30 days.

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

Members have direct access (without a referral or authorization) to women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PMP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. This includes PMP availability of 24 hours a day, 7 days a week.

During nonoffice hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PMP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services.

**Recorded messages are not acceptable.**

Consult with other appropriate care providers to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- If the member has other insurance, file first, if applicable. Then submit the Medicaid claim to us with a copy of the paid claim EOB.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members for each practice location up to 2 locations per health plan/managed care entity.
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

## Responsibilities of primary medical providers and specialists serving in primary medical provider role

**Specialists include gynecologists and endocrinologists (if primarily engaged in internal medicine)**

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment standards section of this manual
- Conduct a baseline exam during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate their medical care while they are hospitalized
- Respect members' advance directives and document in a prominent place in the medical record whether a

member has an advance directive form.

- Provide covered benefits consistently with professionally recognized standards of health care based on UnitedHealthcare Community Plan standards.
- Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments
- Transfer medical records upon request
- Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the state of Indiana Access and Availability standards for scheduling emergency, urgent care and routine visits

Appointment standards are covered in this chapter.

## Primary medical provider checklist

- Verify eligibility and benefits on the [UnitedHealthcare Provider Portal](#), or call **Provider Services**
- 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](#)
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.
- Maintain enrollment with the Indiana Health Coverage Programs.

## Rural health clinic and federally qualified health clinic

Members may choose a care provider who meets the

PMP requirements and performs PMP-type services within a rural health clinic (RHC) and federally qualified health center (FQHC) as their PMP.

### • 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

## Specialist responsibilities

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

- Contact the PMP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PMP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PMP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record, to be shared information in writing with the PMP
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the state of Indiana Access and Availability standards for scheduling routine visits. Appointment standards are covered in this chapter
- Provide anytime coverage. PMPs and specialists serving in the PMP role must be available to members by phone 24 hours a day, 7 days a week or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating care provider. UnitedHealthcare Community Plan tracks and follows up on all instances of care provider unavailability.

- Remember to maintain enrollment with the IHCP
- Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

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

## 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

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

UnitedHealthcare Community Plan participating ancillary care 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**
- 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](https://www.uhcprovider.com/priorauth)
- Identify and bill other insurance carriers when appropriate
- Maintain enrollment with Indiana Health Coverage Programs.

# Chapter 3: Care provider office procedures and member benefits

## Key contacts

Topic	Link	Phone number
Member benefits	<a href="https://in.gov/medicaid">in.gov/medicaid</a> <a href="https://UHCCommunityPlan.com/in">UHCCommunityPlan.com/in</a>	1-800-832-4643
Member handbook	<a href="https://UHCCommunityPlan.com/in">UHCCommunityPlan.com/in</a> > Plan Details > Member Resources > View Available Resources	1-800-832-4643
Provider Services	<a href="https://UHCprovider.com">UHCprovider.com</a>	1-877-610-9785
Prior authorization	<a href="https://UHCprovider.com/priorauth">UHCprovider.com/priorauth</a>	1-877-610-9785
D-SNP	<a href="https://UHCprovider.com/in">UHCprovider.com/in</a> > Medicare > <b>Indiana Dual Complete Special Needs Plan</b>	1-877-610-9785
Indiana Department of Health	<a href="https://in.gov/health">in.gov/health</a>	1-800-457-8283

## Benefits



Go to [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) or [UHCprovider.com/eligibility](https://UHCprovider.com/eligibility) for more information.

See **Appendix A** for the list of member benefits.

## Assignment to primary medical provider panel roster

Once a member is assigned a PMP, view the panel rosters electronically by signing into the UnitedHealthcare Provider Portal at [UHCprovider.com](https://UHCprovider.com).

Each month, PMP panel size is monitored by reviewing PMP to member ratio reports. When a PMP's panel approaches the maximum limit, we remove it from auto-assignment. To update the PMP panel limits, send a written request. PMPs serving in the UnitedHealthcare Indiana PathWays for Aging provider network must accept a minimum panel size of 150 members.

1. Go to [UHCprovider.com](https://UHCprovider.com).
2. Select Sign In on the top right.
3. Log in.
4. Click on Clinical & Pharmacy.
5. Click on UnitedHealthcare CommunityCare.

The CommunityCare Roster has member contact information and clinical information, to include HEDIS measures and Gaps in Care, in an Excel format with customizable field export options that can be pulled at the individual practitioner or TIN level.

You may also use **Document Library** for member contact information in a PDF at the individual practitioner level.

You may also find the Document Library quick reference guide at [UHCprovider.com](https://UHCprovider.com) > Resources the UnitedHealthcare Provider Portal Resources > Document Library > **Self-Paced User Guide**.

## Choosing a primary medical provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PMP. The assignment considers the distance to the PMP, the PMP's capacity and if the PMP is accepting new



members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PMP.

Depending on the member's age, medical condition and location, the choice of PMP may cover a variety of practice areas, such as:

- Family practice
- General practice
- Internal medicine
- Geriatrics
- Physician extenders
- Endocrinology
- Obstetrics

If the member changes the initial PMP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PMP at any other time, the change will be effective on the request date.

### Primary medical provider panel add form

The purpose of this form is to add a member to a PMP panel either at full capacity status or approved by us for a "hold" status. The PMP or office manager may complete the form if the member or the member's family member is an established patient.

Established patients must have been treated in the past 24 months from today's date. You may also use this form if you would like to begin providing primary care services to that member. Find the Community Plan of Indiana Primary Health Care Professional PCP Panel Add Request Form at [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > [Provider Forms and References](#).

### Primary medical provider member disenrollment form

A primary health care professional may request disenrollment of a member from the primary care assignment if the member demonstrates one of the reasons for request detailed in the form.

Care must be provided to the member for up to 30 calendar days following the disenrollment request submission to UnitedHealthcare, or until the change request process is completed. Your request will be reviewed and, if approved, will be completed within 10 business days.

Find the Community Plan of Indiana health care professional request form for member disenrollment at [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > [Provider Forms and References](#).

## Liability

There are no copayments or cost share for Indiana PathWays for Aging. There could be member payment liability as described in **Chapter 11**. Check the [UnitedHealthcare Provider Portal](#) for deductibles, copayments and member liability. You may also call [Provider Services](#) for more information.

## Self-referral services and coverage

Based on state and federal requirements, UnitedHealthcare Community Plan covers benefits available to members on a self-referral basis. These services do not require a physician's referral or other network authorization from us.

We may direct members to seek self-referral care from care providers contracted in our network. However, except for behavioral health and routine dental services, we cannot require the members to receive services from network care providers. UnitedHealthcare Community Plan members may self-refer to any IHCP-qualified care provider to provide the services. When members choose to receive self-referral services from care providers who do not have contractual relationships with us, UnitedHealthcare Community Plan is responsible for payment to these care providers up to the applicable benefit limits and at 100% of Indiana Medicaid fee for service (FFS) rates.

#### • **Chiropractic services**

May be provided by a licensed chiropractor, enrolled with IHCP within the scope of the chiropractic practice.

#### • **Eye care services**

Except surgical services, may be provided by any IHCP licensed care provider under D.M. or D.O. optometrist.

#### • **Podiatric services**

May be provided by any IHCP-licensed care provider under D.M., D.O. or doctor of podiatric medicine.

#### • **Psychiatric services**

May be provided by any IHCP licensed care provider under D.M. or D.O.

#### • **Behavioral health services**

Self-referral for in-network IHCP care provider. Members may self-refer within the UnitedHealthcare

Community Plan’s network for behavioral health services not provided by a psychiatrist. This includes behavioral health, substance abuse and chemical dependency services by behavioral health specialty providers.

- **Family planning services**

Requires freedom of choice of care providers and access to family planning services and supplies. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP care provider qualified to provide the family planning service(s), including care providers not in UnitedHealthcare Community Plan’s network. Members may not be restricted in choice of a family planning service if the care provider is an IHCP provider.

- **Emergency services**

Covered without the need for or the existence of a contract with the emergency care provider. Emergency services must be available 24 hours a day, 7 days a week and are subject to the “prudent layperson” standard of an emergency medical condition. ER services are reimbursed at 100% of the Indiana fee schedule for noncontracted care providers.

- **Immunizations**

Self-referral to any IHCP-enrolled care provider. Immunizations are covered regardless of where they are received.

- **Diabetes self-management services**

Available on a self-referral basis to any IHCP care provider when the member obtains the services from an IHCP care provider.

- **Routine dental services**

May be provided by any in-network licensed IHCP dental provider.

## Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

You must document all services requiring medical necessity in the member’s medical record.

A medically necessary service is a covered service required for the care or well-being of the patient and is provided based on generally accepted standards of medical or professional practice.

## Member assignment

### Assignment to UnitedHealthcare Community Plan

The state of Indiana 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. The state of Indiana 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 at [UHCCommunityPlan.com/in](https://UHCCommunityPlan.com/in). Go to Plan Details > Member Resources > View Available Resources.



UnitedHealthcare Community Plan members can go to [myuhc.com/communityplan](https://myuhc.com/communityplan) to look up a care provider.

### Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Indiana’s Medicaid program. The state of Indiana determines program eligibility. An individual who becomes eligible for the state of Indiana program either chooses or is assigned to one of the Indiana health plans.

### Member ID card

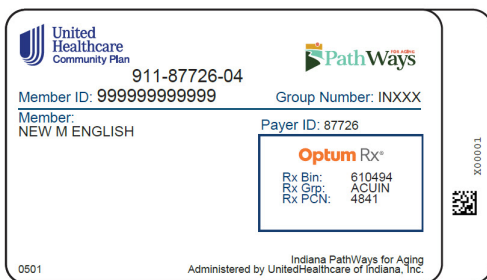
Check the member’s ID card at each visit and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver’s license, if this is your office practice.



If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to [uhc.com/fraud](https://uhc.com/fraud) to report it, or call the **Fraud, Waste and Abuse Hotline**.

The member's ID card will not include the PMP assignment. PMP assignment can be verified when checking eligibility. If you have questions about the member ID card or PMP assignment please, call Provider Services. Also document the call in the member's chart.

### Health member ID card



## Primary medical provider-initiated transfers

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

1. To transfer the member, complete the online form at [UHCprovider.com](https://UHCprovider.com), call Member Services at 1-800-832-4643, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

Mailing address:

**UnitedHealthcare Community Plan**  
**Attn: Health Services**  
P.O. Box 5240  
Kingston, NY 12402-5240

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PMP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PMP member issue, we work with the member to find another PMP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PMP) stating they have 5 business days to contact us to select a new PMP. If they do not choose a PMP, we will choose one for them. A letter will be sent to the member with the new PMP information.

## Verifying member enrollment

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

- UnitedHealthcare Provider Portal: through [UHCprovider.com/eligibility](https://UHCprovider.com/eligibility)
- **UnitedHealthcare Provider Services**: available from 8 a.m.–6 p.m. ET, Monday–Friday
- Indiana Medicaid Eligibility System (MES)

## UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to [uhc.com/medicaid/dsnp](https://uhc.com/medicaid/dsnp).

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

# Chapter 4: Medical management

## Key contacts

Topic	Link	Phone number
Prior authorization	<a href="https://UHCprovider.com/priorauth">UHCprovider.com/priorauth</a>	1-877-610-9785
Pharmacy	<a href="https://UHCprovider.com/pharmacy">UHCprovider.com/pharmacy</a>	1-877-610-9785
Dental	<a href="https://uhcdentalproviders.com">uhcdentalproviders.com</a>	1-844-402-9118

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.



For authorization, go to [UHCprovider.com/priorauth](https://UHCprovider.com/priorauth) or call **Provider Services**.

### Emergency ambulance transportation

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

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

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

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

### Nonemergent ambulance transportation

UnitedHealthcare Community Plan members may get nonemergent stretcher, ambulance and bariatric transportation services through us for covered services. Members may get transportation when they are bed-confined before, during and after transport.

### Nonemergency medical transportation

Nonemergency medical transportation (NEMT) services are arranged by LCP Transportation. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

NEMT requests are accepted between 8 a.m.–8 p.m. ET, Monday–Friday, to schedule transportation. If members have questions about their order, they may call **Member Services**. Providers may call LCP Transportation directly at 1-888-260-5339, 24 hours a day, 7 days a week.

Nonemergent transportation must be requested at least 3 business days in advance.

### Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

- Emergency Room
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implantable devices)

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

Request prior authorization online or by phone:

- **Online** – [UHCprovider.com/cardiology](https://uhcprovider.com/cardiology) > Sign In
- **Phone** – **1-866-889-8054**, Monday–Friday

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk and/or the evidence-based clinical guidelines, go to [UHCprovider.com/cardiology](https://uhcprovider.com/cardiology) > Sign In > Specific cardiology programs.

### Chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse. We provide members with up to 50 units per member per calendar year with an in- or out-of-network chiropractor.

The 50 units can be a combination of office visits, spinal manipulation, or physical medicine services. Up to 5

of the 50 units can be office visits. Some chiropractic service require a prior authorization. Use the following steps to access the fee schedules online:

1. Go to [myoptumhealthphysicalhealth.com](https://myoptumhealthphysicalhealth.com).
2. Enter your provider ID & password.
3. Click “Tools & Resources.”
4. Click “Plan Summaries” or “Fee Schedules.”

For more information on chiropractic care, go to [myoptumhealthphysicalhealth.com](https://myoptumhealthphysicalhealth.com) or call **1-800-873-4575**.

### Chronic condition management

We use educational materials and newsletters to remind members to follow positive health actions such as immunizations and wellness 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 fifth-grade reading level. They are available in English as well as other languages. The materials are designed to support members as they begin to take responsibility for their health. 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. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

#### Identification

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

## Dental services

### Covered

A dental provider manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for members with the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.



Refer to the Dental Provider Manual for applicable exclusions, limitations and requirements at [uhcdentalproviders.com](https://uhcdentalproviders.com) or to find a dental care provider, go to [UHCprovider.com](https://uhcprovider.com) > Our Network > Find a Provider > **Dental Directory**.

## 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 which are:

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



See our Coverage Determination Guidelines at [UHCprovider.com/policies](https://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 PMP 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

ER services are subject to diagnosis review against Indiana's state ER autopay list. If a diagnosis billed on the claim does not appear on the emergency department autopay list, then the claim may be adjudicated nonemergent and paid at the screening fee rate.

If the claim is paid at a screening fee rate, submit the medical records for review. If you would like to submit medical records for prudent lay review, submit within 120 calendar days from day of adjudication. See **Claims reconsideration** section of this manual for more information.

If the prudent lay review determines the service was emergent, then the claim will be adjusted to reimburse at a higher emergent rate.

If the member was referred to the ER by the 24-hour NurseLine, crisis line or a PMP, the facility and professional claim will be reimbursed at 100% of the Indiana Medicaid fee schedule or specific contract rate.

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. An Indiana Medicaid provider who is out of network for UnitedHealthcare Community Plan will be paid at 100% of the Medicaid fee schedule.

### 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 PMP as soon as possible after receiving emergency care.

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 1 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 and not subject to emergency prudent review. We pay state enrolled out-of-network care providers for urgent care services at the current program rates at the time of service.

## Emergency care resulting in admissions

Prior authorization is not required for emergency services, but is required for admissions.



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/priorauth](https://UHCprovider.com/priorauth)**, EDI 278N transaction at **[UHCprovider.com/edi](https://UHCprovider.com/edi)**, or call **Provider Services**.

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

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** at **1-877-610-9785**.

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

### Care coordination/care plan

Care Coordinators are trained to understand and meet the member where they are within the stages of change in parallel to using motivational interviewing tactics. Our Care Coordinators create person centered care and service plans that have achievable and trackable goals. Our care plans are person-centered and member driven. Caregivers and providers can become part of the interdisciplinary care team and play an important role in the members health.

Our Care Coordinators collaborate with providers ensuring all member needs are being addressed. Completed care plans are available on our portal for providers to review and each care plan includes the Care and Service Coordinators contact information, including phone number and email address.

### 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 co-morbidities, 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 case manager 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

### Hearing services

Monaural and binaural hearing aids are covered (except for in-the-canal [ITC] hearing aids) for members with a unilateral pure tone average greater than 30 decibels. For more information, please visit the Indiana Hearing Services module at [in.gov/medicaid/providers/files/modules/hearing-services.pdf](https://in.gov/medicaid/providers/files/modules/hearing-services.pdf). You may also call **Provider Services** at **1-877-610-9785**.



# Home Health

Home health services are covered on a part-time and intermittent basis to Medicaid members of any age in the member's place of residence. A "place of residence" for home health services does not include a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting where payment is, or could be, made under inpatient services including room and board. Members may receive home health services in any setting where normal life activities take place. Home health services cannot be limited to members who are homebound.

Home health services include skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech language services; and renal dialysis for home-bound individuals.

Home health services are available to IHCP members of any age when the services are:

- Medically necessary
- Ordered in writing by a care provider
- Performed on a part-time and intermittent basis based on a written plan of treatment

The qualifying treating care provider must certify the medical necessity for home health services. All home health services require prior authorization, with some exceptions. An authorized representative of the home health agency submits PA requests for home health agency services, along with supporting documentation, to UnitedHealthcare. An increase in home health services, except in the case of urgent or emergency services, also requires a written request with supporting documentation of medical necessity. For some cases, providers can perform certain home health services without PA following a member's discharge from an inpatient hospital, for specific exceptions refer to [Home Health Services](#).

IHCP home health benefits include covered services performed by practitioners such as the following:

- Registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Home health aides
- Physical therapists
- Occupational therapists
- Speech-language pathologists

To learn more on Home Health Services including prior authorization requirements please review the [IHCP Provider Reference Module](#).

For more information about home health, call **Provider Services** at **1-877-610-9785**.

Members may find information regarding Home Health services by reviewing the Member Handbook or through their Care Coordinator. For more information about HCBS services refer to **Chapter 5**.

# Hospice

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

## Routine 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. In addition, members may receive routine hospice care in a nursing facility. A medical crisis is when a member requires continuous nursing care to manage symptoms.

## Continuous hospice

UnitedHealthcare Community Plan covers benefits for continuous hospice in the members home. Continuous hospice is covered when the recipient is expected to pass from illness within 6 months. Coverage is available for 2 consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.

## Respite hospice

When the member is on home hospice, they can receive respite care in an 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.

### Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month. For more information about HCBS services refer to **Chapter 5**.

## Laboratory



Labcorp and Quest are the preferred lab care provider; contact them directly.

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

For more information on our in-network labs, go to [UHCprovider.com/findprovider](https://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.

## Womens health services

Womens health services are preventive health, medical, counseling and educational services that help members manage their general health. UnitedHealthcare Community Plan members may access these services without a referral.

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

### Pregnancy/maternity

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy.

The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For OB billing, refer to the OB billing section in the [Indiana Reference Module](#).



For prior authorization maternity care, including out-of-plan and continuity of care, call **1-877-610-9785** or at [UHCprovider.com/priorauth](https://UHCprovider.com/priorauth). For information about prior authorization requirements, go to [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > **Prior Authorization and Notification**.

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

1. The member was in their second or third trimester of pregnancy when they became a UnitedHealthcare Community Plan member and
2. If they have an established relationship with a nonparticipating obstetrician.

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

A UnitedHealthcare Community Plan member does not need a referral from their PMP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

### Maternity admissions

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



Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or call **1-877-610-9785**.

### Post maternity care

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

### Hysterectomies

Hysterectomies are covered only when medically necessary and only when the member has given informed consent. The provider must inform the member both orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member or member's representative must sign a written acknowledgment of receipt of that information. Providers cannot, under any circumstances, use the Consent for Sterilization form for hysterectomy procedures.



Find the form on the Indiana Medicaid website: [in.gov/medicaid/providers/provider-references/forms](https://in.gov/medicaid/providers/provider-references/forms).

The signed acknowledgment of receipt of hysterectomy information is required in all cases, except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgment is not possible. The physician who performs the hysterectomy under these circumstances must complete one of the following certification requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed. The certification must state the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. The physician must also include a description of the nature 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.

### Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member's PMP. Members must use the UnitedHealthcare Community Plan provider network.

### Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are 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 IHCP 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, anesthesiologist or hospital.

### Sterilization informed consent

A member has only given informed consent if the IHCP Medical Assistance Consent Form for sterilization 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 IHCP 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.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure. Have 3 copies of the consent form:
  1. For the member.
  2. To submit with the Request for Payment form.
  3. For your records.



You may also find the form on the Indiana Family and Social Services Administration website: [in.gov/fssa](https://www.in.gov/fssa).

### 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 and be mentally competent at the time of consent.

Out-of-network services require prior authorization.

View the state of Indiana regulations at [in.gov](https://www.in.gov) for more information on sterilization.

### Nursing facility

Nursing facilities (NFs) provide skilled and custodial care for all enrollees including, but not limited to, the following: room and board, interdisciplinary healthcare needs and access to hospice services. NF level of care is determined based on state law and administrative rules.

UnitedHealthcare will conduct an initial screening of each member within 30 calendar days of the effective date of enrollment to identify the member's immediate physical and/or behavioral healthcare needs. Each UnitedHealthcare Care Coordinator will be assigned to a specific NF to coordinate an initial visit for introductions, discuss subsequent visits, and address any concerns or questions.

UnitedHealthcare is committed to partnering with our NF partners to ensure the best experience for our NF providers, members and families. Our Care Coordinator will review a member's NF care plan as part of coordination of care and provide input and work with the NF staff to determine the services that the member needs and the roles of who should be providing the services in the person-centered service planning process.

The Care Coordinator will be responsible for the coordination of Medicare benefits, veterans benefits, behavioral health services, and other health coverage insurers and supports in conjunction with the NF. A separate person-centered service plan does not have to be created as long as the NF care plan includes all appropriate services, goals for transitioning to the community (if desired by the member), quality of life goals, and how Medicare benefits, veterans benefits, behavioral health services, and other health coverage will be coordinated.

When a change in level of care is received, UnitedHealthcare will evaluate the member's level of service, update the comprehensive health assessment tool (CHAT) to reflect the change in status and evaluate for appropriate changes to the plan of care. The UnitedHealthcare Care Coordinator engages all members of the Intradisciplinary Care Team (IDT) to include but not limited to the UnitedHealthcare Transitions Coordinator, NF designated team members, member, members representative and other relevant parties. The UnitedHealthcare Transitions Coordinator will then take the lead to oversee and coordinate the initial and ongoing member transitions in and out of the various Indiana Medicaid programs,

UnitedHealthcare enrollment, and among care settings to confirm continuity of care during and after the transition.

The Transition Coordinator will assist members who lose nursing facility level of care or are ready for discharge from a nursing facility. UnitedHealthcare will assist the member and NF in creating a successful discharge or transfer to another residential setting. This does not apply to an individual who lose Medicaid eligibility.

### Pharmacy

#### Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its Preferred Drug List (PDL) of covered medications in accordance with Indiana's Statewide Uniform Preferred Drug List (SUPDL) for covered medications, including prescription drugs, select over-the-counter (OTC) drugs and pharmacy supplements.

This comprehensive list applies to all UnitedHealthcare Community Plan of Indiana members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

If a member requires a nonpreferred, non-formulary, or drug that requires a prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal.

In addition, you may use CoverMyMeds or Surescripts to submit a medication authorization request at [UHCprovider.com](https://UHCprovider.com) > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** > Forms and Additional Resources.

We provide you PDL updates before the changes go into effect. Change summaries are posted on [UHCprovider.com](https://UHCprovider.com).

Find the PDL and Pharmacy Prior Notification Request form at [UHCprovider.com/priorauth](https://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.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826**. We provide notification for prior authorization requests within 24 hours of request receipt.

### Specialty pharmacy medications

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

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



Specialty pharmacy medications are available through our specialty pharmacy network; see [UHCprovider.com/priorauth](https://UHCprovider.com/priorauth) for more information.

## Radiology

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

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

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)

- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

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

- Emergency Room
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- **Online** - [UHCprovider.com/radiology](https://UHCprovider.com/radiology) > Sign In
- **Phone** - **1-866-889-8054** from 9 a.m.-6 p.m. ET, Monday-Friday. Make sure the medical record is available.



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

## Right Choices Program

The Right Choices Program helps members who may have inappropriate or unnecessary use of Medicaid benefits. Dually enrolled members are excluded from the Right Choices Program and monitored through Medicare. The goal is to provide quality health care management by helping ensure the right service is delivered at the right time and place for each member. Members are identified based on their behavior patterns and utilization practices compared to their peers. The initiative is to reduce inappropriate and unnecessary use of pharmacy and other services.

The member will have a care coordination team led by their PMP and include a care/case manager, lock-in PMP, lock-in pharmacy and any other approved specialty care providers. Members can be locked in to both a PMP and pharmacy or just one, depending on their needs and goals. PMPs must make referrals to any nonlocked-in care providers. Add care providers

by logging into the IHCP provider healthcare portal, or calling **Provider Services**.

The Right Choices Program PMP can add care providers to the member's lock-in file on the IHCP Provider Healthcare Portal website at [ihcpportal.indianamedicaid.com](http://ihcpportal.indianamedicaid.com) or contact the UnitedHealthcare Right Choices Program administrator so they can be added to the member's lock-in file.

If the Right Choices Program member initiates the PMP change, a new PMP may be selected only in one or more of the following conditions:

- Access to care
- Continuity of care
- Quality of care or service

If the member is auto-assigned a PMP because of failure to respond to their initial PMP selection notification, the member is allowed to change primary lock-in care providers 1 time during tenure in the Right Choices Program.

Members are required to submit a written request to the program administrator detailing the reasons for the requested changes. If there is a change in the member's lock-in care providers, they receive a letter with the new care providers' information. The new lock-in care providers also receive letters.



To make a referral to Right Choices Program, find the referral form on [UHCprovider.com/incommunityplan](http://UHCprovider.com/incommunityplan) > **Provider Forms and References**.

Email: [in\\_rcp@uhc.com](mailto:in_rcp@uhc.com)



Please review the IHCP provider manual outlining the requirements and details about the program: [in.gov/medicaid/providers](http://in.gov/medicaid/providers) > Provider References > Provider Reference Materials > IHCP Provider Reference Modules > Right Choices Program.

## 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:

- Utilize determining 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 services?

#### 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 already are. 3 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 1 of the following places of service:

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



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

### Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The FDA-approved medications for OUD include Buprenorphine, Methadone and Naltrexone.

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

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

If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on [liveandworkwell.com](https://liveandworkwell.com).

To find a medical MAT care provider in Indiana:

1. Go to [UHCprovider.com](https://UHCprovider.com).
2. Select "Our Network," then "Find a Provider."
3. Click on "Search for Doctors, Clinics or Facilities by Plan Type."
4. Search the care provider information and select it.
5. Click on "Medical Directory."
6. Click on "Medicaid Plans."
7. Click on applicable state.
8. Select applicable plan.
9. Refine the search by selecting "Medication Assisted Treatment."



If you have questions about MAT, please call **Provider Services** at **1-877-610-9785**, and enter your TIN.

- Say "Representative," and "Representative" a second time
- Then say "Something Else" to speak to a representative

## Telehealth and telemedicine

You may use telemedicine to facilitate access to needed services in a clinically appropriate way.

For more information regarding telemedicine, please refer to **Provider Services** at **1-877-610-9785**.

## 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 PMP 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. PMPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PMP 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 reference guide at [marchvisioncare.com](http://marchvisioncare.com) for information such as compliance, electronic payment information, safety resources and training. Contact MARCH directly either through their eyeSynergy web portal or fax to refer a member. Call 1-844-486-2724 for more information.

To access eyeSynergy, log onto our website at [marchvisioncare.com](http://marchvisioncare.com) and click on the orange and blue eyeSynergy® link located at the top of the page.

**Important:** If you choose not to submit lab orders through eyeSynergy, you must fax your order to March Vision Customer Service Center at 1-855-640-6737.

### Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan of Indiana follows the medical review hierarchy requirements published in bulletin [BT2022117](#) and any subsequent bulletin(s).

## 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
- Rendering care provider and TIN/NPI
- ICD clinical modification (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable



For behavioral health and substance use disorder authorizations, please contact **Provider Services** at **1-877-610-9785**.



If you have questions, go to Indiana's prior authorization page at **[UHCprovider.com/incommunityplan](http://UHCprovider.com/incommunityplan)** > Prior Authorization and Notification.

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

Type of request	Decision TAT	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 5 working days of receipt of medical record information required but no longer than 14 calendar days of receipt of an extension request by provider	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of request receipt	Within 48 hours of request receipt , with the exception of HCBS providers HCBS providers within 24 hours of request receipt
Concurrent review	Within 48 hours of request receipt	Within 48 hours of request receipt	Within 48 hours of request receipt
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, Skilled Nursing Facilities (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 InterQual, CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes:

- Acute and sub-acute medical
- Long-term acute care
- Acute rehabilitation
- Skilled nursing facilities
- 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.

### Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at [UHCprovider.com/policies](https://UHCprovider.com/policies) > **For Community Plans.**

### Referral guidelines

We do not require a written referral. However, you must document in the member's medical record the 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.

Prior authorization may be required for in-network and out-of-network providers. Care providers should verify authorization requirements for every member. 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 UnitedHealthcare Community Plan's Provider Services department or using the IHCP Provider Healthcare Portal at [portal.indianamedicaid.com](https://portal.indianamedicaid.com)
- 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
- Submit claims using Indiana Medicaid and UnitedHealthcare Community Plan guidelines
- Bill using revenue codes and/or procedure codes required by the IHCP and/or UnitedHealthcare Community Plan

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

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 state of Indiana. 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 PMP 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 PMP and treating care provider, if different. The member may help the PMP 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 **1-877-610-9785**.
- Once the second opinion has been given, the member and the PMP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PMP 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 network (except emergency treatment and self-referral services, excluding behavioral health and dental)
  - Visit **UHCCommunityPlan.com/in** for current member plan information including sample member ID cards, provider directories, dental plans and vision plans
  - For a list of in-network providers, see our directory at **UHCprovider.com/findprovider**
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs covered only by fee for service (FFS) Medicaid
  - Intermediate care facilities for members with intellectual and developmental disabilities
  - Additional waiver programs not included in Indiana PathWays for Aging

## Services requiring prior authorization



For a list of services that require prior authorization, go to **UHCprovider.com/incommunityplan > 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** – Must submit within 1 business day of admission
- **Inpatient admissions; after ambulatory surgery** – Must submit within 1 business day of admission
- **Nonemergency admissions and/or outpatient services (except maternity)** – Must submit at least 14 business days beforehand; if the admission is scheduled fewer than 14 business days in advance, submit the request as soon as possible prior to the scheduled admission time

## Utilization management guidelines



Call **1-877-610-9785** 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 PMPs and specialists on a fee for service (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 UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's 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	<a href="https://UHCprovider.com">UHCprovider.com</a>	1-877-610-9785
Provider advocate	<a href="#">UnitedHealthcare Community Plan of Indiana Homepage</a> > Contact us	
Training	<a href="https://UHCprovider.com/training">UHCprovider.com/training</a>	1-877-610-9785
UnitedHealthcare Provider Portal	<a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In using your One Healthcare ID or go to <a href="https://UHCprovider.com/portal">UHCprovider.com/portal</a> New users: <a href="https://UHCprovider.com/access">UHCprovider.com/access</a>	1-877-610-9785
CommunityCare Provider Portal training	<a href="#">UnitedHealthcare CommunityCare Provider Portal user guide</a>	
One Healthcare ID support	Chat with a live advocate 8 a.m.–8 p.m. ET at <a href="https://UHCprovider.com/chat">UHCprovider.com/chat</a> .	1-855-819-5909
Resource library	<a href="https://UHCprovider.com/resourcelibrary">UHCprovider.com/resourcelibrary</a>	
Fraud, waste and abuse (payment integrity)	<a href="https://uhc.com/fraud">uhc.com/fraud</a>	1-800-455-4521 (NAVEX)

UnitedHealthcare Community Plan supports the Indiana state goals of increased access, improved health outcomes and reduced costs by offering Indiana PathWays for Aging benefits to the following members:

- Individuals who are 60 years of age and older
- Individuals who are eligible for Medicaid based on age, blindness or disability
- Individuals who have limited income and resources
- Individuals who may be full-benefit dually eligible
- Individuals in a nursing facility, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting

The state of Indiana will determine enrollment eligibility.

## Home and Community-Based Services

Home and Community-Based Services (HCBS) are services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility (NF) or to delay or prevent placement in a nursing facility.

Indiana PathWays for Aging HCBS services 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.

The HCBS Waiver Provider Manual posted on the Indiana Family and Social Services Administration (FSSA) Medicaid HCBS webpage: [in.gov/fssa/da/medicaid-hcbs](https://in.gov/fssa/da/medicaid-hcbs). Find more about HCBS benefits on [UHCCommunityPlan.com/in](https://UHCCommunityPlan.com/in).

## Home and Community-Based Services certification

Participation in the HCBS provider network requires care providers to submit the following documents to confirm HCBS certification and Medicaid enrollment with the state:

- Completed Indiana Ancillary Community Support Services Demographic form sent by care provider
- Copy of HCBS Waiver Service Certification letter is recommended. This letter will be sent in by care provider
- W-9 form to be sent by care provider

## How to join our network

To request participation in HCBS provider network, visit [UHCprovider.com/INcommunityplan](https://UHCprovider.com/INcommunityplan) > [How to Join the UnitedHealthcare network](#) > Home and Community-Based Services or email [UnitedHealthcare Community Plan at \[uhcprovidernetwork@uhc.com\]\(mailto:uhcprovidernetwork@uhc.com\)](mailto:UnitedHealthcareCommunityPlan@uhc.com).

## Home and Community-Based Services 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 in the Indiana PathWays for Aging program are as follows:

### Adult day health service

Adult day services (ADS) are community-based group programs designed to help individuals who need structured, social integration through a comprehensive and nonresidential program. ADS provides the following support:

- Health
- Social
- Recreational

- Supervision
- Support services
- Personal care
- Transportation add-on

Members attend ADS on a planned basis. The 3 levels of adult day services are basic, enhanced and intensive with category 1 and category 2 as modifiers to meet the program requirements.

### Basic adult day services (level 1) – include:

- Monitoring of all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking and toileting with hands-on assistance provided as needed
- Comprehensive, therapeutic activities for those with cognitive impairment in a safe environment
- Initial health assessment conducted by a registered nurse (RN) consultant prior to beginning services at the adult day, and intermittent monitoring of health status
- Monitoring of medication or medication administration
- Minimum staff ratio: 1 staff for each 8 individuals
- RN consultant available

### Enhanced adult day services (level 2):

Level 1 service requirements must be met. Additional services include:

- Hands-on assistance with 2 or more ADLs or hands-on assistance with bathing or other personal care
- Initial health assessment conducted by RN consultant prior to beginning services as well as regular monitoring or intervention with health status
- Medication assistance
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure and intervention for participants with mild to moderate cognitive impairments in a safe environment
- Minimum staff ratio: 1 staff for each 6 individuals
- RN consultant available
- Minimum of 1 full-time licensed practical nurse (LPN) staff person with monthly RN supervision

### Intensive adult day services (level 3):

Level 1 & level 2 service requirements must be met. Additional services include:

- Hands-on assistance or monitoring with all ADLs and personal care
- 1 or more direct health intervention(s) required
- Rehabilitation and restorative services, including physical therapy, speech therapy, and occupational therapy (coordinated or available)
- Therapeutic intervention to address dynamic psychosocial needs, such as depression or family issues affecting care
- Therapeutic interventions for those with moderate to severe cognitive impairments
- Minimum staff ratio: 1 staff for each 4 individuals
- RN consultant available
- Minimum of 1 full-time LPN staff person with monthly RN supervision
- Minimum of 1 qualified full-time staff person to address participants' psychosocial needs

### Adult Family Care

Adult Family Care (AFC) is a comprehensive service in which a participant resides with an unrelated caregiver. The participant and up to 3 other participants who have physical and/or cognitive disabilities and are not members of the care provider's or primary caregiver's family, and/or reside in a home that is owned, rented or managed by the AFC provider.

This is a tiered service with 3 levels. Common activities include:

- Assistance with bathing, dressing and eating
- Home and community assistance
- Medication oversight

Participants selecting AFC service may also receive care management service, adult day service, specialized medical equipment and supplies, and healthcare coordination through the waiver.

### Assisted living facility

An assisted living facility (ALF) is a licensed facility where members can live, have access to meals and receive the services they need to be as independent as possible.

The assisted living service is a tiered service (3 levels) defined as personal care and services, home and community assistance, chore, attendant care and companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming provided in a congregate residential setting in conjunction with the provision of participant-paid room and board. This service includes 24-hour, on-site response staff to meet scheduled and unpredictable needs. The participant retains the right to assume risk.

### Attendant care

Attendant care services (ATTC) are provided to participants with nursing facility level of care needs. Attendant care services provide direct, hands-on care to participants for the functional needs with ADLs. The participant is the employer for participant-directed attendant care or appoints a representative to be the employer on their behalf.

Services include assistance with:

- Bathing
- Grooming
- Dressing
- Walking
- Toileting
- Eating
- Medication reminders
- Transportation of individuals to medical and non-medical community activities

### Caregiver Coaching

The purpose of Caregiver Coaching is to enable the stabilization and continued community tenure of a waiver participant by equipping the participant's lay caregiver(s) with the necessary skills to manage the participant's chronic medical conditions and associated behavioral health needs related to a cognitive impairment and/or dementia.

The following services are covered under Caregiver Coaching by Medicaid participating Structured Family Caregiving agencies:

- Initial consultation for assessment of the caregiver to determine initial coaching needs, and understand the caregiver's goals, values, needs and strengths



- Caregiver Coaching provided in the home of the participant, virtually or telephonically and through Health Insurance Portability and Accountability Act (HIPAA) secure communication platforms that allow for real time and asynchronous communication between caregivers and caregiver coaches and collaboration with waiver care managers

### Community transition services

Community transition services include reasonable setup expenses for participants who make the transition from an institution to their own home where the person is directly responsible for their own living expenses in the community. Community transition services will not be reimbursable on any subsequent move.

The following activities are allowed under community transition services:

- Security deposits and application fees that are required to obtain a lease on an apartment or home
- Essential (not luxury) furnishings and moving expenses required to occupy and use a community domicile, including a bed, table and chairs, assembly of flat-packed furniture when it is not included as part of the furniture purchase cost, window coverings, 1 land-line telephone, eating utensils, housekeeping supplies, food preparation items, microwave and bed or bath linens
- Setup fees or deposits for utility or service access including telephone, electricity, heating, internet and water
- Health and safety assurances, including pest eradication, allergen control that would be used in instances where the participant is allergic to certain things that need to be removed from the residence (like animal hair), or 1-time cleaning prior to occupancy

### Home modifications

Home modifications are physical adaptations to the home, as required by the member's service plan, which are necessary to help ensure the health, welfare and safety of the member. They enable the member to function with greater independence in their home.

Without these home modifications, the member would require institutionalization. Incidental structural repairs to facilitate modifications may be included in

this service. Modifications allowed under the home modifications service may include but are not limited to the following:

- Adaptive door openers and locks
- Bathroom modification
  - Removal of existing bathtub, toilet and/or sink
  - Installation of roll-in shower, grab bars, toilet and sink
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) that are necessary due to the bath modification
- Home control units - adaptive switches and buttons to operate medical equipment, communication devices, heat and air conditioning, and lights for an individual living alone or who is alone without a caregiver for a substantial portion of the day
- Kitchen modification, including, but not limited to:
  - Removal of existing cabinets and sink
  - Installation of sink and cabinet
  - Installation of replacement incidental items (such as flooring, storage space and cabinets) if necessary due to kitchen modification
- Home safety devices such as:
  - Door alarms
  - Anti-scald devices
  - Hand-held shower head
  - Grab bars for the bathroom
- Ramp including but not limited to portable (considered for rental property only) and permanent
- Single room air or portable conditioner(s)/single room air purifier(s)
- Vertical lift
- Widening of doorways, including:
  - Exterior or interior bedroom, bathroom, kitchen door or any internal doorway as needed to allow for access. Pocket doors may be requested.

### Home modification assessment

The service will be used to objectively determine the specifications for a home modification that is safe, appropriate, and feasible to ensure accurate bids and workmanship. If a care provider is available in the participants county, the participants must receive a home modification assessment with a certified waiver provider selected by the participant prior to any subsequent home modification as well as a home modification inspection upon completion of the work.

A home modification will not be reimbursed until the final inspection has been completed.

The home modification assessment will assess the home for physical adaptations to the home, including incidental structural repairs to facilitate modifications that, as indicated by the individual's service plan, are necessary to ensure the health, welfare, and safety of the individual and enable the individual to function with greater independence in the home. Without the modifications, the individual would require institutionalization.

The assessor will be responsible for writing the specifications, review of feasibility and the post-project inspection. The home modification assessment service includes the following activities:

- Evaluation of the current environment, including the identification of barriers underneath the home, electrical and plumbing, which may prevent the completion of desired modifications
- Reimbursement for nonfeasible assessments
- Drafting of specifications
- Preparation and submission of specifications
- Examination of the modification (inspection/approval)
- Contact county code enforcement

### Home and community assistance

Home and community assistance (homemaker) services provide instrumental activities of daily living (IADL) for participants in their home. The services are provided when participants are unable to meet their needs or when their informal caregiver or helper is unable to perform these needs for the participant.

Allowable services include:

- Grocery shopping
- Meal preparation
- Limited general housecleaning
- Escort services (not transportation) for medical appointments
- Running care-related errands such as picking up medication or mailing utility payments

### Integrated health care coordination

Integrated health care coordination (IHCC) is to promote improved health status and quality of life, delay/prevent deterioration of health status, manage chronic conditions in collaboration with the physicians, and integrate medical and social services.

IHCC may include the following activities:

- Development and oversight of a healthcare support plan that includes coordination of medical care and proactive care management of both chronic diseases and complex conditions such as recurring falls, depression and dementia
- Physician collaboration
- Medication review
- Transitional care from hospital or nursing facility to home/assisted living
- Advance care planning

### Community transportation

Community transportation is a nonmedical service that enables members to gain access to nonmedical community services, activities and resources specified by the service plan.

These service standards must be followed for nonmedical transportation waiver services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's personal care attendant (PCA)
- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them
- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be used

Transportation services are reimbursement as 3 types of service:

- **Non assisted transportation** - The participant does not require mechanical assistance to transfer in and out of the vehicle
- **Assisted transportation** - The participant requires mechanical assistance to transfer into and out of the vehicle

- **Adult day service transportation** – The participant requires round-trip transportation to access adult day services

### Home-delivered meals

Home-delivered meals helps prevent institutionalization through good nutrition, as the absence of proper nutrition in individuals with frail and disabling conditions presents a severe risk to health. No more than 2 meals per day are reimbursed under the waiver.

The home-delivered meals service may include but is not limited to:

- Diet and nutrition counseling provided by a registered dietitian
- Nutritional education based on needs of each participant
- Diet modification according to a physician's order, as required, meeting the individual's medical and nutritional needs

### Nutritional supplements

Nutritional supplements include liquid supplements, such as Boost or Ensure, to maintain a member's health, so they can remain in the community. Supplements must be ordered by a physician, physician assistant or nurse practitioner.

### Personal Emergency Response System

The Personal Emergency Response System (PERS) is an electronic device that enables certain participants at high risk of institutionalization to secure help in an emergency.

The participant may also wear a portable help button to allow for mobility.

The system is connected to the person's phone and programmed to signal a response center after a button is activated. The response center is staffed 24 hours a day, 7 days a week by trained professionals. The following activities are under the PERS service:

- Device installation
- Ongoing monthly maintenance of the device
- Electronic service that is usually a portal help button; however, it can also be an electronic device that

includes, but is not limited to GPS or video monitoring service. (Note: Remote monitoring will not be placed in participant bedrooms or bathrooms).

### Pest control

Pest control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans, or annoys humans, and is causing or is expected to cause more harm than is reasonable to accept.

Pests include, but are not limited to:

- Insects such as roaches, mosquitoes, bed bugs and fleas
- Insect-like organisms, such as mites and ticks
- Vertebrates, such as rats and mice

Services to control pests are services that prevent, suppress or eradicate pest infestation.

### Respite

Indiana PathWays for Aging services provide temporary or periodical relief in the place of the usual caregiver. Respite can occur in home and community-based settings.

The following activities are allowed under respite services:

- Home health aide services (RHHA)
- Skilled nursing services (RSKNU)

### Specialized medical equipment

The specialized medical equipment and supplies service includes medically prescribed items required by the member's service plan. These items assist the member in maintaining their health, welfare and safety. They also enable the member to function with greater independence in the home.

The specialized medical equipment and supplies service provides therapeutic benefits to a participant in need, because of certain medical conditions and/or illnesses. Specialized medical equipment and supplies primarily and customarily are used to serve a medical purpose and are not useful to a person in the absence of illness or injury.

All specialized medical equipment and supplies must be approved by the waiver program prior to the service being rendered. The following are allowable activities under this service:

- Lift chairs – The HCBS program will cover the chair. Medicaid state plan should be pursued first for prior approval of the lift mechanism.
- Medication dispensers
- Toileting and/or incontinence supplies that do not duplicate Medicaid state plan services
- Slip-resistant socks
- Self-help devices – including over-the-bed tables, reachers, adaptive plates, bowls, cups, drinking glasses and eating utensils
- Strollers – when needed because participant's primary mobility device does not fit into the participant's vehicle/mode of transportation, or when the participant does not require the full-time use of a mobility device, but a stroller is needed to meet the mobility needs of the participant outside of the home setting.
- Voice active smart devices
- Interpreter service – provided in circumstances where the interpreter assists the individual in communication during specified scheduled meetings for service planning (such as waiver case conferences or team meetings) and is not available to facilitate communication for other service provision.

### Structured family caregiving

In this caregiving arrangement, a member lives with a principal caregiver, who provides daily care and support to the member based on the member's daily care needs. The principal caregiver may be a nonfamily member or a family member who lives with the member in the private home of the member or the principal caregiver.

Structured family caregiving is a 3-tiered service that includes the following activities:

- Home and community assistance care services related to needed instrumental activities of daily living (IADLs)
- Attendant care services related to needed activities of daily living (ADL)
- Medication oversight (to the extent permitted under state law)

- Escorting to necessary appointments, whenever possible, such as transporting individuals to doctor appointments and community activities that are therapeutic in nature or assists with maintaining natural supports
- Caregivers not living in the home of the participant if this arrangement began prior to Feb. 1, 2020
- Unskilled respite for the family caregiver for a maximum of 15 days per calendar year (Note: Funding for this respite is included in the per diem paid to the service provider; the actual respite service may not be billed in addition to the per diem)

### Vehicle modifications

Vehicle modifications are additional adaptive equipment or structural changes to a motor vehicle that empower a member to have safe transportation in a motor vehicle.

Justification and documentation are required to demonstrate that the modification is necessary to meet the participant's identified need(s).

The following are allowable under the vehicle modification service:

- Wheelchair lifts
- Wheelchair tie-downs (if not included with lift)
- Wheelchair/scooter hoist
- Wheelchair/scooter carrier for roof or back of vehicle
- Raised roof and raised door openings
- Power transfer seat base

## Self-direction care services

### Member-directed attendant care

This program allows members receiving care, or representatives acting on their behalf, to select, schedule, train, supervise and (if necessary) terminate their own personal attendants. The member directing care, or their representative takes on all the responsibilities of being an employer except for payroll management, which is handled by the fiscal intermediary.

### Electronic visit verification system

Electronic visit verification system (EVV) is a system that electronically captures details of home visits and services provided by caregivers while helping ensure members receive the support they required, and the rendered services are billed accurately. Indiana PathWays for Aging will require EVV for the following care provider types:

- Personal Care Service providers: Home and community assistance (homemaker) and attendant care
- Home Health Service providers: Home Health (PT, OT, ST, Evals)

Services excluded from EVV include:

- Caregiver Coaching and Behavior Management
- Integrated Healthcare Coordination
- Participant Directed Attendant Care (self-direction)

#### Benefits of an electronic visit verification system

It captures individual caregiver’s activity (i.e., check-in, check-out and services performed), which reduces the likelihood for error or fraud. It increases efficiency because reporting is automated, and claims submission is cleaner. It improves quality of care by making workers’ activities transparent and measurable.

#### Do you have to use electronic visit verification system?

All Medicaid-enrolled service care providers who provide in-home assistance through a personal care provider or skilled/certified care are required to use EVV to track the time in the member’s home. If you do not use EVV, claims will be denied.

### 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 call care management at **1-855-409-7073**.

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](https://UHCprovider.com/eligibility) or by calling **1-888-350-5608**.

#### Billing instructions, codes and rates

FSSA certified providers may begin providing services once they receive a notice of action (NOA) authorizing the provisions of services to a particular member.

A complete list of Indiana’s billing codes and rates can be located on the IHCP Fee Schedules at [indianamedicaid.com](https://indianamedicaid.com).

The IHCP Fee Schedule is updated each Tuesday. Changes may include rates, limits and code updates.

For the most current fee schedule, please refer to the current Professional Fee Schedule link listed within the IHCP Fee schedule site.

#### 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 for Indiana
- For more information on waiver liability, review the **Member Payment Liability** section in **Chapter 11**

### 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 48 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 FSSA's Division of Disability and Rehabilitative Services/Division of Aging Incident Reporting System (also known as IFUR) at [ddrsprovider.fssa.in.gov/ifur](https://ddrsprovider.fssa.in.gov/ifur).

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

### You are required to:

- Submit an incident report for any reportable HCBS critical incident within 48 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 48 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 48 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 48 hours or sooner of "first knowledge" of the incident

**How:**

UnitedHealthcare requires its network providers to submit reports regarding HCBS critical incidents via FSSA's DDRS/DA Incident Reporting System (also known as IFUR) at [ddrsprovider.fssa.in.gov/ifur](https://ddrsprovider.fssa.in.gov/ifur).

Also notify the member's Service Coordinator of all HCBS critical incidents within 48 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 [in\\_providerservices@uhc.com](mailto:in_providerservices@uhc.com)

If you don't know who your provider advocate is, email the same dedicated mailbox at [in\\_providerservices@uhc.com](mailto:in_providerservices@uhc.com) and a care provider advocate will get back to you.

## 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—so are all care providers who conduct business electronically.

### Unique identifier

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

## Legacy Provider Identifier

We encourage all HCBS providers who have both an NPI and Legacy Provider Identifier (LPI) to bill using only the LPI. HCBS providers who choose to bill with an NPI must ensure that a taxonomy code is included on the claim.

### Provider enrollment:

- Successful IHCP enrollment results in a Medicaid Provider ID/Legacy Provider ID (LPI)
- All IHCP providers bill with NPI except for Provider Type 32 (waiver)

### Key for data match:

- Taxonomy
- Service location zip code +4

### HCBS provider claim tip:

- Bill with the IHCP Provider ID/LPI (rather than NPI)

## Member ID card for billing

The member ID card has the UnitedHealthcare Community Plan member ID. The member ID is the same as the members Medicaid ID. UnitedHealthcare Community Plan prefers you bill with the Medicaid ID.

## Clean claims and submission requirements

Complete a CMS-1500 form whether you submit an electronic (via EDI or portal) 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

## 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.

- 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) guidelines for CMS-1500 forms

### Electronic data interchange

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

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



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

## Electronic data interchange companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within implementation guides (IG) adopted by HIPAA.

The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices
- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires
- Provide general information and specific details pertinent to each transaction.

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



The companion documents are located on **UHCprovider.com/edi > EDI Companion Guides**.

### Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment



reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, go to [UHCprovider.com/edi](https://UHCprovider.com/edi) > **EDI Clearinghouse Options**.

## e-Business support

Call Provider Services at **1-877-610-9785** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

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

## 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

### 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 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 submit 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.

### UnitedHealthcare Provider Portal

Go to [UHCprovider.com](https://UHCprovider.com) and sign in to view your claims transactions.

### Submitting a claim reconsideration

- A claim reconsideration request is the quickest way to address your concerns regarding claim payments
- Preferred method for submitting a claim reconsideration: the UnitedHealthcare Provider Portal at [UHCprovider.com/claims](https://UHCprovider.com/claims)
- Call **Provider Services** at **1-877-610-9785** or use the telephone number on the back of the member's ID card

Submit claim reconsideration form by mailing to:

#### UnitedHealthcare Community Plan

P.O. Box 5270  
Kingston, NY 12402-5270

- Access the Single Paper Claim Reconsideration Request Form at [UHCprovider.com/claims](https://UHCprovider.com/claims) > Documents and forms
- **3-step process for Indiana:**
  1. Claim reconsideration.
  2. Informal dispute.
  3. Formal appeal.

## Balance billing

Balance billing is not allowed.

Federal and state regulations prohibit you from charging any member, or a family member, for any amount not paid for covered services following a reimbursement determination by the IHCP.

As a condition of your participation in the IHCP, you must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If you disagree with the Medicaid determination of payment, your right of recourse is limited to an adjustment request, administrative review and appeal.

### Billable noncovered services

If the member chooses to receive the service without an approved notice of action, a provider must use a waiver to establish member responsibility for payment, and the waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment
- A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services
- The waiver must specify the date the services are provided and the services that fall under the waiver's application.

### Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

For more information, go to [UHCprovider.com/resourcelibrary](https://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.

Indiana PathWays for Aging Community Plan provides the following:

- **Language interpretation line**

- We provide oral interpreter services Monday-Friday from 8 a.m. – 8 p.m. ET
- To arrange for interpreter services, please call **1-877-842-3210 TTY 711**

- **I Speak language assistance card**

This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.

- **Materials for limited English-speaking 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](https://uhc.com) > **Language Assistance**.

### Informal disputes and appeals

If you are not satisfied with the outcome of a claim reconsideration, you can submit an informal dispute.

If the outcome of the informal dispute is not favorable, a formal appeal can be submitted.

To submit either an informal dispute or formal appeal, follow the process outlined in **Chapter 12**.

### Surveys and care provider satisfaction

UnitedHealthcare Community Plan facilitates surveys the following:

- Members
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Plan, HCBS and Nursing Home National
- Core Indicators Survey – Aging and Disabilities
- Informal caregivers
- Care provider surveys

We incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for improvement.

### Frequently asked questions

#### Q: When did the UnitedHealthcare Community Plan Indiana PathWays for Aging program begin?

A: The UnitedHealthcare Community Plan program went live on July 1, 2024.

#### Q: What are the timely filing requirements?

A: Timely filing requirements are generally 90 days from the date of service. Out-of-network provider filing limit is 6 months from date of discharge or date of service.

#### Q: What is UnitedHealthcare Indiana PathWays for Aging time frame for processing a HCBS care provider’s network participation request?

A: For HCBS providers, all network participation requests will be processed within 30 days.

#### Q: Which member populations are included in the Indiana PathWays for Aging program?

A: Indiana PathWays for Aging covers a variety of individuals who are not eligible for Medicare, including those who:

- Are 60 years of age or older
- Are eligible for Medicaid based on age, blindness or disability
- Have limited income and resources
- May be full-benefit dually eligible

#### Q: Do I need to enroll with the state of Indiana to become a participating care provider?

A: If you are not an existing Medicaid provider in Indiana, you must enroll with the state of Indiana to provide services to Indiana PathWays to Aging members. Providers may enroll with the state of Indiana at [in.gov/medicaid](https://in.gov/medicaid).

#### Q: How do care providers access the Provider Healthcare Portal?

Use the **UnitedHealthcare Provider Portal**, your online health care portal for eligibility access and other insurance information. The portal is an internet-based solution that offers you reliability, speed, ease of use and security.

#### It can help you with the following transactions:

- Completing care provider eligibility and enrollment applications
- Verifying member eligibility/identifying a member’s plan, including whether the member is in the Right Choices Program
- Confirming any third-party liability (i.e., presence of other health insurance such as commercial or Medicare insurance)
- Managing your care provider profile

**Reminder:** You may also use the UnitedHealthcare Community Plan web portal for Indiana PathWays for Aging transactions, such as claims, remits, prior authorization, adjustments, etc.

See **Online resources** in **Chapter 1** for more information. To access the portal, go to [portal.indianamedicaid.com](https://portal.indianamedicaid.com).

## Chapter 6: Enhanced services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **1-877-610-9785** unless otherwise noted. You may also chat with a live advocate on the UnitedHealthcare Provider Portal at **UHCprovider.com** from 8 a.m.– 8 p.m. ET. We will respond and facilitate a referral through the member's assigned care coordinator.

### Alternative healing pain relief

Through our Member Support Program, we offer \$250 annual reimbursement to members for pain management alternatives such as herbal remedies, vitamins, minerals, acupuncture or therapeutic massage. This can be paired with our fitness program to improve health outcomes.

### Animatronic pets

Our members with Alzheimer's and related dementia diagnoses may qualify for participation in our Joy for All companion pet program. This program offers an animatronic pet, which has been shown to improve well-being, sense of purpose and quality of life for individuals affected by dementia.

### Assistive devices

When a member requires an assistive device, the care coordinator can work with the member to obtain these products. These devices include a magnifying tool to enhance vision or a talking scale to support weight management goals. When the item is not covered under the Indiana Medicaid fee schedule, the care coordinator will access our Member Support Fund to get the member what is needed to help them improve, maintain or thrive in their preferred setting.

### DivvyDose

Optum Rx offers a multi-dose packaging solution for members who can benefit from medication synchronization and polypharmacy management. The packaging may contain both prescription and over-the-counter (OTC) medications in a personalized and pre-sorted roll of medications delivered to the member through the mail every 4 weeks. As part of our support, we work to identify opportunities to conduct comprehensive medication reviews, evaluate polypharmacy risk, and work with members to better understand and manage their medications.

### FarmboxRx

Members with nutritional care plan goals associated with the control of diabetes and/or congestive heart failure are eligible for referral into the FarmboxRx program. A Farmbox filled with fresh fruits and vegetables and nutrition education is delivered to members in 3-month periods. The program is renewable through the member's assigned care coordinator based on need.

### Fitness programs

Our One Pass program includes many fitness centers across Indiana, including YMCA and Planet Fitness. Members may also access many online fitness sites, such as Yoga Works and Les Mills Studio. D-SNP members with UnitedHealthcare coverage have access to the same benefit, called Renew Active.

### HERO Council

We host monthly member and informal caregiver meetings through our Health, Empowerment, Resources, and Opportunities (HERO) Council. These meetings will be in-person and virtual, with a focus on listening to our members and their supports. The goal is to use feedback that changes how managed care programs interact and engage throughout the health care system. Members will receive SDOH-based incentives as they participate. Key stakeholders such as community- and faith-based organizations are also invited to participate during HERO Council events.

### 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](https://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.

### Legal assistance

Members in need of legal support may request help with:

- Power of Attorney
- Advance directive form
- Removing a criminal record that makes getting work or housing a challenge

## Member portal

[Member.uhc.com/communityplan](https://member.uhc.com/communityplan) offers immediate access to the member's ID card, claims, health record, medication list and health record. It also helps members learn how to access tools and articles on health and well-being, as well as their benefits and enhanced services. Our core member portal content is available in 11 languages, including Spanish and Burmese.

## Member rewards

Members can earn rewards for engaging with the health plan and care providers. They may get incentives for activities such as:

- Completing a health needs screening and comprehensive health assessment
- Engaging with a transition coordinator
- Scheduling timely follow-up visits following a hospital-to-home transition due to inpatient stay
- Completing a smoking cessation program

[UHCCommunityPlan.com/in](https://UHCCommunityPlan.com/in) lists all applicable member incentives. Incentives are subject to change.

## Mobile app

The UnitedHealthcare smartphone app enables members to:

- Complete their health needs screening
- Review health benefits
- Access claims information
- Locate in-network care providers
- Access details about programs and services

## Mom's Meals

For members who qualify and are scheduled for, or experience an inpatient stay, we offer 2 meals per day for 14 days post-discharge. This nutritional support is crucial during the recuperation stage and has proven to reduce readmission rates by up to 55%.

## NurseLine

NurseLine is available at any time at no cost to our members. 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 PMP. Our nurses also help educate members about staying healthy. Call **1-877-303-2422**, TTY **711** to reach a nurse

## Pharmacy

Members can earn rewards by having immunization consults at pharmacies. This helps them complete a targeted medication review, an adherence consultation that may help resolve potential and existing barriers to care. From there, members are encouraged to talk to their doctor to address any immunization gaps and obtain a prescription for the vaccine, if necessary.

## Postbook

A Postbook creates deeper relationships with a relative or friend. Members choose a Postbook pal and share post cards based on ideas in the journal. We include postage and supplies.

## Respite support

If members receive unpaid caregiver support from a friend or family member, we offer a special program to support them. We provide gift cards to help them enjoy their free time. Our care coordinators arrange for member care while the informal caregiver takes a break.

## Self Care by AbleTo

Self Care by AbleTo® is an application that contains tools and resources to help with self-management of symptoms of stress and worry. It is free to members and their domestic family members.

To access Self Care, members visit [ableto.com/begin](https://ableto.com/begin) to create an account. The AbleTo app can be downloaded on the Apple App Store or Google Play Store using the same information used when creating the account.

## Smartphone

UnitedHealthcare offers free smartphones with unlimited talk, text and data. This offer is limited to 1 per household. All our web-based programs and services are loaded onto this phone. We also load popular apps like Facebook and WhatsApp Messaging. Members may apply at [mybenefitphone.com](https://mybenefitphone.com).

## Teledental service

Through Dial Care we offer a dentist who can consult with a member on the phone or by video chat.

### Tobacco cessation

This enhanced tobacco cessation program combines cognitive behavioral therapy and motivational interviewing. It offers:

- Instant rewards
- Biofeedback
- Social supports
- Remote patient monitoring
- Clinical support

#### Indiana tobacco cessation

Quit Now Indiana 1-800-QUIT-NOW (1-800-784-8669) is a free phone-based counseling service that helps Indiana tobacco users quit. Funded by the Indiana Tobacco Prevention and Cessation Agency, Quit Now Indiana offers experienced professional Quit Coaches® trained in cognitive behavioral therapy.

Quitline staff are skilled in working with people who use all forms of tobacco products, including smokeless tobacco, pipes, cigars, and e-cigarettes.

Refer patients and employees for help with quitting tobacco. Learn more at [quitnowindiana.com](http://quitnowindiana.com).

### UHC Doctor Chat — virtual visits

Through Doctor Chat, members can virtually access a board-certified and Indiana licensed physician within 60 seconds, 24/7 via secure chat and/or video. Doctor Chat can address urgent/acute, chronic, preventive, women's, and behavioral health conditions. A board-certified physician assesses the severity of the enrollee'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 ER. This program highlights our commitment to expand and deliver access to care. Application is available in English and Spanish. They also have Globo support via telephone, who offers 253 language translation services.

See Frequently Asked Questions at [uhcdoctorchat.com](http://uhcdoctorchat.com).

### UHC Healthier Lives

Visit [uhchealthierlives.com](http://uhchealthierlives.com) to find community-based resources that address social needs. This site can be

used by members and is available in more than 60 languages.

### Virtual community center

This unique website offers live classes for adults who are older, led by adults who are also older. Join millions of others learning something new every day. Members access this site through [member.uhc.com/communityplan](http://member.uhc.com/communityplan) or by calling Member Services. Live classes include:

- Online banking tips
- Email scams and how to recognize them
- Arts, crafts and hobbies
- Recipes and cooking tips
- Health and well-being sessions like meditation, chair yoga and mindfulness

### Vision

Through our enhanced vision benefits, members will receive 1 free eye exam every 12 months with an allowance to cover the cost of frames and lenses or contact lenses.

### Government assistance programs

UnitedHealthcare offers member assistance with enrolling in the following government assistance programs.

#### Supplemental Nutritional Assistance Program

Supplemental Nutritional Assistance Program (SNAP) provides food assistance to low- and no-income people and families living in the United States. In Indiana, the FSSA is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Visit [in.gov/fssa/dfr/snap-food-assistance](http://in.gov/fssa/dfr/snap-food-assistance) for details, including eligibility and application requirements.

#### Affordable Connectivity Program

This federal program offers monthly discounts on internet service as well as 1-time support toward the purchase of a tablet, laptop or desktop computer. For more information, members may visit or apply by visiting [fcc.gov/acp](http://fcc.gov/acp).

# Chapter 7: Mental health and substance use

## Key contacts

Topic	Link	Phone number
Optum Behavioral Health - clinical	<a href="https://providerexpress.com">providerexpress.com</a>	<b>1-800-888-2998</b> for clinical questions
Optum Provider Services - network	<a href="https://providerexpress.com">providerexpress.com</a>	<b>1-800-614-0484</b> for network, claims or contract questions
Indiana Community Plan prior authorization	<a href="https://UHCprovider.com/incommunityplan">UHCprovider.com/incommunityplan</a>	<b>1-877-610-9785</b>

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

The Optum Behavioral Health National Network Manual is located on [providerexpress.com](https://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.

The IHCP reimburses care providers for outpatient behavioral health services. This includes group, family and individual psychotherapy.

Behavioral health care providers are required to enroll with Indiana Medicaid as billing or rendering providers. These providers include:

- Community behavioral health centers
- Outpatient behavioral health clinics
- Psychiatrists
- Health service care provider in psychology
- Psychologist
- Licensed Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)

- Licensed clinical addiction counselor (LCAC)
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing, from an accredited school of nursing

These care providers can be enrolled in Indiana Medicaid if they have an National Provider Identifier (NPI) and a valid professional license. They receive direct reimbursement for their services at the applicable current Indiana Medicaid Fee Schedule rate. They can be employed by an outpatient mental health facility, clinic, physician or HSPP enrolled in the IHCP.

The following care providers can supervise the member's treatment plan and certify the diagnosis for outpatient behavioral health or SUD services:

- Psychiatrist or physician
- Health service provider in psychology (HSPP)
- LCSW
- LMFT
- LMHC
- LCAC
- APN

Licensed psychologists and licensed independent school psychologists still require that an eligible practitioner supervise the member's treatment plan and certify the diagnosis. These practitioners can bill for services if they meet Indiana Medicaid's enrollment requirements and are enrolled as providers.

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



To request an NPI number, go to [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers) > Provider Enrollment > Become a Provider or check the Indiana Provider Enrollment Application Process.



Credentialing information is available at [providerexpress.com](https://www.providerexpress.com) > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

If you have questions about network participation, credentialing, or your provider record, please go to [providerexpress.com](https://www.providerexpress.com) > **Contact Us**.

### 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 PMPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in 1 place.

[liveandworkwell.com](https://www.liveandworkwell.com), accessed through a link on [myuhc.com](https://www.myuhc.com), includes mental health and well-being information plus articles on health conditions, addictions and coping. It also provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.



For member resources regarding mental health and substance use issues, go to [providerexpress.com](https://www.providerexpress.com) > Clinical Resources Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency.

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention and mobile crisis)
- Inpatient psychiatric hospital (acute and sub-acute, including SUD)

- Outpatient assessment and treatment
  - Partial hospitalization
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Electroconvulsive therapy
  - Telehealth
- Rehabilitation services
- Low and high-intensity SUD residential
- Long-term institutional care
- HCBS waivers

### Excluded services

- Psychiatric treatment in a state hospital
- Intermediate care facilities for individuals with intellectual disabilities
- Traumatic Brain Injury Waiver
- Community Integration and Habilitation Waiver
- Family Supports Waiver

UnitedHealthcare Community Plan will provide care coordination services for transition and discharge planning.

These excluded benefits are available under traditional Medicaid.

### Residential Substance use disorder services

The health plan covers short-term low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other substance use disorder (SUD) in settings of all sizes, including facilities that qualify as institutes of mental disease.

Prior authorization is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society for Addiction Medicine (ASAM) Patient Placement Criteria:

- ASAM Level 3.1 - Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 - Clinically Managed High-Intensity Residential Services



When residential services are determined medically necessary for a member, we approve a minimum of 14 days for residential treatment, unless the facility requests fewer than 14 days.

If a facility determines a member requires more time than the initial 14 days, the facility should submit an update request showing the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

For more information about ASAM, go to [asam.org](https://asam.org).

Only state-certified SUD residential facilities may provide this service.

### 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, partial hospitalization or residential treatment.

Help ensure prior authorizations are in place before rendering nonemergent services. Get prior authorization by going to [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan), calling **1-877-610-9785**.

### Notifications

You must notify us within 5 calendar days of the member's visit, and submit information about the treatment plan, member diagnosis, medications and other pertinent information.

### Collaboration with other care providers

#### Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This should include:

- Summary of treatment
- Primary and secondary diagnosis
- Assessment findings
- Medication
- Psychotherapy

Please talk to your patients about the benefits of sharing their condition.

Go to [UHCprovider.com](https://UHCprovider.com) then login to the UnitedHealthcare Provider Portal to find the member's PMP, who is the coordinator, or other participating care providers.

No form is required to participate in coordination of care.

### Release of information

The Authorization for Release of Information (ROI) form gives you access to the UnitedHealthcare Community Plan medical portal system and allows the treating care providers to share physical, social and behavioral health information about that member.

Find the ROI at [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > Provider Forms and References.

Ask the member to complete the form during the appointment. Member should complete 1 form per care provider. The member may decline to complete the form.

### 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.

**Website:** [providerexpress.com](https://providerexpress.com)

Update your care provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call **Provider Services** at **1-877-610-9785**.

### Claims

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

When you submit a CMS-1500 claim form, include the billing group NPI in 33a. Bill the supervising practitioner NPI in block 24J. The supervising practitioner provides the service or oversees the mid-level practitioner providing the member's service.

### Monitoring audits

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

### Addressing the opioid epidemic

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

#### Brief summary of framework

- **Prevention**  
Prevent 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 UnitedHealthcare Provider Portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice

guidelines, free SUDs/ODU assessments and screening resources, and other important state-specific resources.



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

#### Prescribing opioids

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization and if they have prescription limits.

#### Pharmacy lock-In

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances).

When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Indiana handles pharmacy lock-ins through the Right Choices Program. For more information, see the Right Choices Program in **Chapter 4**.

### Expanding medication assisted treatment access and capacity

Evidence-based medication-assisted treatment (MAT) treatment 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 member MAT network.

Only state-certified opioid treatment programs (OTP) may prescribe and provide methadone. To find a behavioral health MAT care provider in Indiana:

1. Go to [UHCprovider.com](https://uhcprovider.com).
2. Select “Our Network,” then “Find a Provider.”
3. Select under “Specialty Directory and Tools” the option of Optum Behavioral Health, employee assistance program (EAP), Work life & Mental Health Services.
4. Click on “Search for a Behavioral Health Provider.”
5. Enter “(city)” and “(state)” for options.
6. If needed, refine the search by selecting “Medication Assisted Treatment.”

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.



To find medical MAT care providers, see the MAT section in **Chapter 4**.

current or potential member, or contracting care provider when requested

- Providing a reason for denial of reimbursement or payment benefits to members
- Providing out-of-network medical and surgical benefits for mental health or SUDs
- Coordinating transition of care for members going from a higher to a lower level of care
- Coordinating transition of care to approved lower level of care for patients who are, due to lack of medical necessity, denied a higher level of care

## Mental Health Parity and Addiction Equality Act

By providing behavioral health benefits, you must comply with the Mental Health Parity and Addiction Equality Act (MHPAEA). This includes, but is not limited to:

- Ensuring medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques applied to medical and surgical benefits
- Ensuring compliance with MHPAEA for any benefits you offer Indiana PathWays for Aging members beyond those specified in Indiana’s Medicaid state plan
- Making criteria and guidelines available to any

# Chapter 8: Member rights and responsibilities

## Key contacts

Topic	Link	Phone number
Member Services	<a href="https://uhc.com/communityplan/indiana">uhc.com/communityplan/indiana</a> > <a href="#">Indiana PathWays for Aging</a>	1-800-832-4643
Member handbook	<a href="https://uhc.com/communityplan/indiana">uhc.com/communityplan/indiana</a> > <a href="#">Indiana PathWays for Aging</a> > Member handbook	1-800-832-4643

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

### Amendment of Protected Health Information

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must 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, you or we will provide 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 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 located at [uhc.com/communityplan/indiana](https://uhc.com/communityplan/indiana) > [Indiana PathWays for Aging](#) > Member handbook.

#### Native American access to care

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

#### Indiana PathWays for Aging member rights

Members have the **right** to:

- Be treated with dignity and respect when getting health services
- Be given information on medical benefits and plan information
- Be given privacy for medical records
- Be given easy-to-understand explanations of medical problems and treatment choices
- Stay involved in decisions about treatment choices
- Get care 24 hours a day, seven days a week
- Get prompt answers to complaints or appeals
- Appeal decisions made about health care received
- Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA) – This means that persons with disabilities or physical problems can get into medical buildings and use important services.
- Get a second opinion from a different doctor
- Request and receive a copy of medical records and request that they be changed or corrected
- Say no to treatment or therapy – If no, the health care provider or health plan must talk to member about what could happen, and a note must be in the member’s medical record about the treatment refusal.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, per federal regulations – This means a doctor cannot make a member do something they do

not want to do. The doctor cannot retaliate against the member for something that they may have done.

- Be free from any restrictions on freedom of choice among network providers
  - Receive information on available treatment options and alternatives, presented in a way that is right for the member’s condition and that can be understood
- Members receiving HCBS also have the **right** to:
- Have and review their service plan and care plan
  - Request a fair hearing if they are:
    - not given the choice of home and community-based waiver services that allow the member to live in the setting of their choice (for example, a private home instead of a long-term care facility)
    - denied the services or providers that they choose, or whose services were denied, suspended, reduced, or terminated

#### Member responsibilities

According to the state of Indiana, members have the **right** to:

- Tell care providers about their medical conditions to the best of their ability
- Call their personal doctor (PMP) for all their medical care
- Keep all their appointments; if they cannot keep an appointment, call to cancel or reschedule as soon as they can
- Tell their doctor if they do not understand what they are told about their condition, care or what they need to do
- Call your doctor if they are not sure they are having a true emergency
- Follow the rules of their care provider’s office

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 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	<p>Office policies and procedures exist for:</p> <ul style="list-style-type: none"> <li>• Privacy of the member medical record</li> <li>• Initial and periodic training of office staff about medical record privacy</li> <li>• Release of information</li> <li>• Record retention</li> <li>• Availability of medical record if housed in a different office location</li> <li>• Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern</li> <li>• Coordination of care between medical and behavioral health care providers</li> </ul>
Record organization and documentation	<ul style="list-style-type: none"> <li>• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 24 hours.</li> <li>• Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records.</li> <li>• Release only to entities as designated consistent with federal requirements</li> <li>• Keep in a secure area accessible only to authorized personnel</li> </ul>
Procedural elements	<p><b>Medical records are readable*</b></p> <ul style="list-style-type: none"> <li>• Sign and date all entries</li> <li>• Member name/identification number is on each page of the record</li> <li>• Document language or cultural needs</li> <li>• 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</li> <li>• Procedure for monitoring and handling missed appointments is in place</li> <li>• An advance directive is 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.</li> <li>• Include a list of significant illnesses and active medical conditions</li> <li>• Include a list of prescribed and over-the-counter medications. Review it annually.*</li> <li>• Document the presence or absence of allergies or adverse reactions*</li> </ul>

\*Critical element

Topic	Contact
History	<p>An initial history (for members seen 3 or more times) and physical is performed. It should include:</p> <ul style="list-style-type: none"> <li>• <b>Medical and surgical history*</b></li> <li>• A family history that includes relevant medical history of parents and/or siblings</li> <li>• A social history that includes information about occupation, living situations, education, smoking, alcohol use and/or substance abuse use/history beginning at age 11</li> <li>• Current and history of immunizations of children, adolescents and adults</li> <li>• Screenings of/for:               <ul style="list-style-type: none"> <li>- Recommended preventive health screenings/tests</li> <li>- Depression</li> <li>- High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit</li> <li>- Medicare members for functional status assessment and pain</li> <li>- Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise, nutrition and counseling, as appropriate</li> </ul> </li> </ul>
Problem evaluation and management	<p>Documentation for each visit includes:</p> <ul style="list-style-type: none"> <li>• Appropriate vital signs (measurement of height, weight and BMI annually)               <ul style="list-style-type: none"> <li>- <b>Chief complaint*</b></li> <li>- <b>Physical assessment*</b></li> <li>- <b>Diagnosis*</b></li> <li>- <b>Treatment plan*</b></li> </ul> </li> <li>• Tracking and referral of age and gender-appropriate preventive health services consistent with preventive health guidelines</li> <li>• Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets</li> <li>• Treatment plans are consistent with evidence-based care and with findings/diagnosis:               <ul style="list-style-type: none"> <li>- Time frame for follow-up visit as appropriate</li> <li>- Appropriate use of referrals/consults, studies and tests</li> </ul> </li> <li>• X-rays, labs consultation reports are included in the medical record with evidence of care provider review</li> <li>• There is evidence of care provider follow-up of abnormal results</li> <li>• Unresolved issues from a previous visit are followed up on the subsequent visit</li> <li>• There is evidence of coordination with behavioral health care provider</li> <li>• Education, including lifestyle counseling, is documented</li> <li>• Member input and/or understanding of treatment plan and options is documented</li> <li>• Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented</li> </ul>

\*Critical element

### Member copies

A member or their representative is entitled to a copy of their medical record upon reasonable request at no charge. Medical records must be legible, signed (manually or electronically) and dated and maintained for at least 7 years as required by state and federal regulations.

## 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:

- The identity of the individual to whom service was rendered
- The identity of the care provider rendering the service
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians, optometrists and dentists only
- A detailed statement describing services rendered, including duration of services rendered
- The location at which services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of physician involvement, including signature or initials and personal patient evaluation will be required to document the acute medical needs, excluding HCBS services
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals, if applicable (e.g. pest control and home modification would not require a treatment plan)
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records



# Chapter 10: Quality management program and compliance information

## Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team. Chat with a live advocate 8 a.m.-8 p.m. ET at <a href="https://uhcprovider.com/chat">UHCprovider.com/chat</a> . Physical health: <a href="https://myoptumhealthphysicalhealth.com">myoptumhealthphysicalhealth.com</a>	
Fraud, waste and abuse (payment integrity)	<a href="https://uhc.com/fraud">uhc.com/fraud</a>	<b>1-800-455-4521</b> (NAVEX)

## What is the Quality Improvement program?

UnitedHealthcare Community Plan's 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 addresses the following quality goals:

- Developing service plans and delivering services in a manner that is person-centered, member-driven and holistic; involves caregivers; and addresses Social Determinates of Health (SDOH)
- Helping ensure continuity of care and seamless experiences for members as they transition into the Indiana PathWays for Aging program or among providers, settings or coverage types
- Assuring timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life

It also consists of:

- Identifying the scope of care and services given
- Taking appropriate action to address service delivery, provider and other quality management and improvement issues as they are identified
- Developing and implementing targeted strategies to improve health, functional or quality of life outcomes
- Addressing the unique needs of populations and subpopulations served, including a focus on equity across subpopulations
- Following procedures for a provider value-based

payment program

- Striving for improvement of member health care and services
- Using mechanisms to understand and assess members' SDOH and promote connections with social services providers to address member and informal caregiver SDOH needs
- Using the results of quality management and improvement program activities to design improvement activities to support the quality of all covered benefits under the program, including long-term services and supports as well as other benefits, with appropriate input from members, informal caregivers and providers. This includes survey data, call center data, complaint and grievance data, and input from the member and informal caregiver advisory committee.
- Developing and maintaining mechanisms, including our member and informal caregiver advisory committee, to solicit feedback and recommendations from key stakeholders, members and family members to monitor service quality and to develop strategies to improve member outcomes and quality improvement activities related to the quality of care and system performance

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 Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits, 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)

### Surveys and care provider satisfaction

UnitedHealthcare Community Plan facilitates the following surveys:

- Member satisfaction
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Plan, HCBS and Nursing Home National Core Indicators Survey – Aging and Disabilities, as applicable
- Informal caregivers
- Care provider surveys

We incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for improvement.

### 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](https://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 Indiana 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.

Criteria includes:

- IHCP MCE Enrollment Form located at [UHCprovider.com/incommunityplan](https://UHCprovider.com/incommunityplan) > **Provider Forms and References**
- Required medical or professional education and training
- Verification of post-graduate education or training and/or board certification
- Current license or certification
- DEA certificate and number, if applicable
- Medicare/Medicaid program participation eligibility
- Work history
- Professional liability insurance
- Malpractice history
- Sanction and limitation on licensure
- Hospital staff privileges
- Office site review on PMPs and OB/GYNs

### Credentialing and recredentialing process

UnitedHealthcare Community Plan's 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.

Meet the credentialing and recredentialing standards and be eligible to enroll with Indiana Medicaid. As a condition of network participation, you must be enrolled with the state as a participating care provider in the IHCP.

We credential physicians, health care providers and facilities who want to join our network and be listed in our Provider Directory. We recredential at least every 36 months. Our credentialing program helps us maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with the NCQA, CMS and Indiana state requirements. We have a thorough, written credentialing program outlined in our Credentialing Plan on [UHCprovider.com/join](https://uhcprovider.com/join).

### 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)
- N.P.-Cs (Certified Nurse Practitioners)
- P.A.s (physician assistants)
- 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
- Optum Physical Health outpatient clinic PT, OT and speech language pathology care providers. You can learn more at [myoptumhealthphysicalhealth.com](https://myoptumhealthphysicalhealth.com).

### Health facilities

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

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body

- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or another recognized accrediting agency
- Have no Medicare/Medicaid sanctions

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

Go to [UHCprovider.com/join](https://uhcprovider.com/join) to submit a participation request.



For Optum Physical Health chiropractic and outpatient clinic physical therapy, occupational therapy and speech language pathology care providers credentialing, call **1-800-873-4575** or visit [myoptumhealthphysicalhealth.com](https://myoptumhealthphysicalhealth.com).

## 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.

Credentialing applications will be completely processed within 30 calendar days of receipt of a complete application by our National Credentialing Committee (NCC). Upon failing to issue a credentialing determination within 15 business days after receipt of a completed clean credentialing application, the care provider shall be considered provisionally credentialed. To be considered provisionally credentialed, a care provider must meet the standards and guidelines established by the National Committee for Quality Assurance (NCQA). Care providers will be notified in writing of their credentialing 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](http://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 and 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 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 7 a.m.-7 p.m. CT at [UHCprovider.com/chat](http://UHCprovider.com/chat).

A UnitedHealthcare representative will be in touch with you within 2 business days from when we receive your request.

### 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 at [UHCCommunityPlan.com/in](http://UHCCommunityPlan.com/in) 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—so are all care providers who conduct business electronically.

## Transactions and code sets

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

## Unique identifier

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

## National Provider Identifier

The 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.

With the exception of atypical providers, atypical providers may use their state issued Medicaid ID instead of NPI.

## 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 HIPAA regulations at [cms.gov](https://www.cms.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.

UnitedHealthcare Community Plan's special investigations unit (SIU) is an important part of the compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and 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** or go to **uhc.com/fraud**.

Please refer to the **Fraud, waste and abuse** section of this 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 Indiana 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 state of Indiana.

### 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 Indiana 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 Indiana program standards.

You must cooperate with the state or any of its authorized representatives, the state of Indiana, 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 PMP 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	<a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a>	1-877-610-9785
National Plan and Provider Enumeration System (NPPES)	<a href="https://nppes.cms.hhs.gov">nppes.cms.hhs.gov</a>	1-800-465-3203
EDI	<a href="https://UHCprovider.com/edi">UHCprovider.com/edi</a>	1-800-210-8315

## Our claims process



For claims, billing and payment questions, go to [UHCprovider.com/claims](https://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](https://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.

## National Provider Identifier

HIPAA requires you have a unique NPI, with the exception of atypical care providers. Atypical care providers may use their state issued Medicaid ID instead of NPI. The NPI identifies you in all

standard transactions.

If you have not applied for a NPI, contact [National Plan and Provider Enumeration System \(NPPES\)](#). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-877-610-9785**.

Your clean claims must include your NPI (or Medicaid ID for atypical care providers) 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. Refer to the IHCP Fee Schedule for procedure code or revenue code coverage at [in.gov/medicaid](https://in.gov/medicaid).

## 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 UnitedHealthcare Community Plan member ID card has the member ID which is the same as the member's Medicaid ID that is used for billing.

### 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 information in all required fields

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



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](https://UHCprovider.com/guides). You can also visit [UHCprovider.com/en/policies-protocols.html](https://UHCprovider.com/en/policies-protocols.html). 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 **EDI Claims**.

### Electronic data interchange companion documents

UnitedHealthcare Community Plan's 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

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

The companion documents are located on [UHCprovider.com/edi](https://UHCprovider.com/edi) > **EDI Companion Guides**.

### Clearinghouse and status reports

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

For clearinghouse options, go to [UHCprovider.com/edi](https://UHCprovider.com/edi) > **EDI Clearinghouse Options**.

### e-Business support

Call **Provider Services** at **1-877-610-9785** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

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

For further information about EDI online, go to [UHCprovider.com/resourcelibrary](https://UHCprovider.com/resourcelibrary) to find **Electronic Data Interchange** menu.

### Electronic payment solution: Optum Pay

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. You can sign up for automated clearing house (ACH)/ direct deposit or to receive a Virtual Card. Both of these options allow you to get paid quickly and securely.

### Why choose automated clearing house/ 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

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](https://UHCprovider.com/resourcelibrary) to find the **EDI** section.

Visit the [National Uniform Claim Committee](https://www.nucm.com) website to learn how to complete the CMS-1500 form. In addition, visit the [Indiana Health Coverage Programs Claims Submission and Processing Module](#).

### 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

In addition, visit the [Indiana Health Coverage Programs Claims Submission and Processing Module](#).

### 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](https://www.uhcprovider.com) > Resources > Plans, Policies, Protocols and Guides > 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. Only report the most extensive service.

- **With/without services**

Don't report combinations where 1 code includes and the other excludes certain services

- **Medical practice standards**

Services part of a larger procedure are bundled

- **Laboratory panels**

Don't report individual components of panels or multichannel tests separately

## Clinical laboratory improvements amendments

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

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

For more information about the CLIA number, contact the CMS CLIA Central Office at:

Indiana Department of Public Health  
Division of Acute Care Services  
2 N Meridian Street, Room 4A  
Indianapolis, IN 46204

**Phone:** 1-317-233-7502

**Fax:** 1-317-233-7157

**Email:** [indianaclia@isdh.in.gov](mailto:indianaclia@isdh.in.gov) or go to [cms.gov](https://www.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 state of Indiana 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](https://www.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 **1-877-610-9785**. 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](https://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 5270  
Kingston, NY 12402-5270

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 submit 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

## Member payment liability

All liability balances are the members responsibility.

### Waiver liability

Waiver liability is similar to a monthly deductible that applies only to services from a Home and Community-Based Services (HCBS) provider. Waiver liability will not roll over month to month and will not change in the middle of a month.

A liability summary notice will be sent to the member and their authorized representative at the start of each month. The notice will detail the services and amounts applied to the waiver liability for claims processed in the previous month. The member is not required to pay the provider until the expense has been included in the waiver liability summary notice.

Waiver liability information can be found on the Provider Portal within the deductible section of the members benefits.

State plan benefits such as primary medical provider (PMP) visits and inpatient or outpatient services are not subject to the patient liability.

### Patient liability

Patient liability applies to members who reside in a nursing facility (NF) greater than 30 consecutive days. Patient liability is like a monthly deductible that will be deducted from the nursing facility claims payment.

Patient liability will not roll over month to month and will not change in the middle of a month. If a member transfers between facilities during a billing period, the patient liability is applied to the first claim received and paid as first in, first out (FIFO). Therefore, the facilities involved in the transfer must coordinate any liability deductions. Patient liability information can be found on the Provider Portal within the deductible section of the members benefits.

State plan benefits such as primary medical provider (PMP) visits and inpatient or outpatient services are not subject to the patient liability.

### Transfer of property penalty period

Eligible Indiana PathWays for Aging members or applicants who are in a nursing home or on an HCBS waiver, may be penalized if they inappropriately transferred assets without adequate consideration to qualify for Medicaid.

The Division of Family Resources (DFR) determines the penalty period. The transfer of property penalty period will always start on the first day of a month but can end on any day of a month. During a penalty period, long term nursing facility stays (over 30 days) and HCBS are not payable by Medicaid.

The member's state plan benefits such as hospitalization and PMP visits are payable during this time period. Transfer of property information can be found on the Provider Portal within the deductible section of the members benefits.

## Balance billing

Balance billing is not allowed.

Federal and state regulations prohibit you from charging any member, or a family member, for any amount not paid for covered services following a reimbursement determination by the IHCP.

As a condition of your participation in the IHCP, you must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If you disagree with the Medicaid determination of payment, your right of recourse

is limited to an adjustment request, administrative review and appeal.

## Billable noncovered services

In cases where prior authorization is denied, or a member elects a noncovered service that does not require prior authorization, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider.

### For cases where prior authorization is denied:

- The provider must establish that authorization has been requested and denied prior to rendering the service
- The provider has an opportunity to request review of the authorization decision. For more information, see **Utilization management appeals** in **Chapter 4**.
- If the authorization appeal is denied, the provider must inform the member that the service requires authorization, and that authorization has been denied. Out-of-network providers must explain to the member that covered services may be available without cost in-network if authorization is provided.
- The provider must inform the member of their right to appeal if the member disagrees with the decision
- The provider must inform the member of member responsibility for payment if the member chooses to receive the services without authorization
- The provider has the right to appeal any denial of payment for denial of authorization

### For all cases:

- If the member chooses to receive the service providers must use a waiver to establish member responsibility for payment, and the waiver must meet the following requirements:
  - The waiver is signed only after the member receives the appropriate notification
  - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
  - A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services
  - The waiver must specify the date the services are provided and the services that fall under the waiver's application

## Charging for missed appointments

You may not charge IHCP members for missed appointments. This is based on the reasoning that a missed appointment is not a distinct reimbursable service, but part of your overall cost of doing business. Furthermore, the Medicaid rate covers the cost of doing business, and you may not impose separate charges on members.



If you don't know who your provider advocate is, email [in\\_pr\\_team@uhc.com](mailto:in_pr_team@uhc.com) and a care provider advocate will get back to you.

## 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: Claims reconsiderations and informal disputes

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](https://UHCprovider.com/claims). Please use our online options or phone number.

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

Appeals and grievances standard definitions and process requirements								
Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim reconsideration  (step 1 of dispute)	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	Most care providers in your state must submit reconsideration requests electronically.  For further information on reconsiderations see the <a href="#">Reconsideration and Appeals Interactive Guide</a>  For those care providers exempted from this requirement, requests may be submitted at the following address:  <b>UnitedHealthcare Community Plan</b> P.O. Box 5240 Kingston, NY 12402-5240	<a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a>	<b>1-877-610-9785</b>	Use Claims on the Provider Portal. <a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In on top right.	Must receive within 60 calendar days from denial paid date	30 business days
Care provider claim informal dispute	The first step to dispute how a claim was paid or to submit a corrected claim. If you disagree with the outcome of the reconsideration, move to a formal appeal process.	Care provider	<b>UnitedHealthcare Community Plan</b> P.O. Box 5240 Kingston, NY 12402-5240  Use Claims on the <a href="#">Unitedhealthcare Provider Portal</a>		<b>1-877-610-9785</b>	Use Claims on the <a href="#">Unitedhealthcare Provider Portal</a> on <a href="#">UnitedHealthcare Provider Portal</a> . <a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In on top right.	Must receive within 60 calendar days from denial paid date	30 calendar days
Care provider claim formal appeal  (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider	Most care providers in your state must submit reconsideration requests electronically.  For further information on appeals see the <a href="#">Reconsideration and Appeals Interactive Guide</a>  For those care providers exempted from this requirement, requests may be submitted at the following address:  <b>UnitedHealthcare Community Plan</b> P.O. Box 31364 Salt Lake City, UT 84131-0364		<b>1-877-610-9785</b>	Use Claims on the <a href="#">Unitedhealthcare Provider Portal</a> <a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In on top right.	60 calendar days	45 calendar days
Member appeal	A request to change an adverse benefit determination that we made.	<ul style="list-style-type: none"> <li>Member</li> <li>Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent</li> </ul>	<b>UnitedHealthcare Community Plan</b> P.O. Box 31364 Salt Lake City, UT 84131-0364	<a href="#">AOR Consent Form</a> on this site for member appeals	<b>1-800-832-4643</b> , TTY <b>711</b>	Use Prior Authorization on the <a href="#">Unitedhealthcare Provider Portal</a> <a href="https://UHCprovider.com">UHCprovider.com</a> , then Sign In on top right.	60 calendar days from date of denial	Urgent appeals: We will resolve within 48 hours  Standard appeals acknowledgment letter sent within 3 business days  Resolution of standard appeal within 30 calendar days
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	<ul style="list-style-type: none"> <li>Member</li> <li>Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent</li> </ul>	<b>UnitedHealthcare Community Plan</b> P.O. Box 31364 Salt Lake City, UT 84131-0364		<b>1-800-832-4643</b> , TTY <b>711</b>	<a href="#">Submit a Pre-Service Appeal and or Grievance for a Medicaid Member</a>	At any time	Urgent grievances: We will resolve within 48 hours  Standard grievance acknowledgment letter sent within 3 business days  Resolution of standard grievance within 30 calendar days

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

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

## Denial

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

- **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

## Claim reconsideration

### What is it?

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

### When to use it:

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.

### Emergency services:

- Medical records for prudent lay review

### 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

### 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 5270  
Kingston, NY 12402-5270

## Claim informal dispute (step 1 of dispute)

### What is it?

A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. However, if you are not satisfied with the outcome of the reconsideration an informal dispute can be submitted. Please submit additional supporting information.

### When to use:

An informal dispute is a one-time request that should include new information. Submit an informal

dispute when you think a reconsideration has not been properly processed.

### For emergency services:

- Medical records for prudent lay review.

### 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

### For adverse benefit determinations:

A adverse benefit determination is a request that is denied as the service has already been received or there is termination of benefits.

- In your request, please include additional clinical information and explanation regarding why the benefit should be extended or reinstated.

### 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 **1-877-610-9785** 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.
- **Mail:** Submit the Claim Reconsideration Request Form to:

**UnitedHealthcare Community Plan**  
P.O. Box 5270  
Kingston, NY 12402-5270

Available at [UHCprovider.com/claims](https://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 **1-877-610-9785** 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
- **Mail reconsiderations** – 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 the time specified in your contract. 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 **1-877-610-9785**.

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](https://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 the **Dispute** section in this chapter.

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

### Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	\$115.03	\$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/24	\$77.29	\$27.29	Contract states \$50, 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
55555555	05/05/24	14A000000005	06/15/24	\$332.63	\$332.63	Member terminated

## Former provider appeal (step 2 of dispute)

### What is it?

An appeal is a review of a reconsideration claim. It is a 1-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 claims:** Use Claims Management or Claims on the UnitedHealthcare Provider Portal. Click Sign In on the top right corner of [UHCprovider.com](https://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: Appeals and Grievances Unit  
 P.O. Box 31364  
 Salt Lake City, UT 84131-0364

### Questions about your appeal or need a status update?

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

Provider appeals are resolved within 45 calendar days from the day we receive it. If you disagree with our appeal decision, you have the right to arbitration.

## Care provider submits on behalf of member grievances and appeals definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

## Care provider submits 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, with a member's written consent, may act on behalf of the member by submitting a grievance at any time.

### Where to send:

You or the member may call, mail or submit the information electronically anytime to:

Mailing address:

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

**Phone: 1-800-832-4643 (TTY 711)**

As the care provider, you may also submit electronically on [UHCprovider.com](https://www.uhcprovider.com) and submit a pre-service appeal and or grievance for a Medicaid member.

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

## Care provider submits appeal on behalf of member

### What is it?

An appeal is a formal way to share dissatisfaction with an adverse 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, mail or submit the information electronically within 60 calendar days from the date of the adverse benefit determination.

Mail: Send the appeal to:

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

**Phone: 1-800-832-4643 (TTY 711)**

As the provider, you may also submit electronically on [UHCprovider.com](https://www.uhcprovider.com). Navigate to Prior Authorization to submit an appeal on a member's behalf.

You must sign an Authorization of Representation form on [UHCprovider.com/claims](https://www.uhcprovider.com/claims). If needed, an appeals representative will provide you with this form.

### How to use:

Whenever we deny a service, appeal rights will be sent to the member and provider. 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 of a previously authorized service(s) within 10 days of the initial termination, suspension, or reduction to continue 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.

We resolve a standard appeal 30 calendar days from the day we receive it. We resolve an expedited appeal 48 hours from when we receive it.

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

1. Member requests we 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—Claim Appeal.

A copy of the form is online at [providerforms.uhc.com](https://providerforms.uhc.com).

## Care provider submits state fair hearing on behalf of member

### What is it?

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

### When to use:

You, with a member's written consent, or a member have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

They must exhaust the health plan's appeal process before requesting a state fair hearing.

### How to use:

The UnitedHealthcare Community Plan member or member's representative may ask for a state fair hearing by writing a letter to:

Office of Administrative Law Proceedings  
Attn: FSSA Hearings  
100 N. Senate Avenue, Room N802  
Indianapolis, IN 46204

Phone: 1-317-234-3488 or 1-866-259-3573 (toll free)

Fax: 1-317-232-4412

Email: [fssa.appeals@oalp.in.gov](mailto:fssa.appeals@oalp.in.gov)

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

## Care provider submits external review on behalf of

## member

An alternative to a state fair hearing is an external review by an independent review organization (IRO). The rules for a state fair hearing also apply to an external review.

You, with a member's written consent, or a member can share why they think Indiana Medicaid services should not have been denied, reduced or terminated. The member must complete the first-level appeal before asking for an external review.

Members have up to 120 calendar days from the receipt of the first-level appeal decision letter to ask for an external review.

The IRO will make their decision within 72 hours for an expedited review, or 15 business days for a standard reviews. Whatever the decision is from the IRO, we will comply. If a member does not agree with the IRO's decision, they may ask for a state fair hearing. The UnitedHealthcare Community Plan member or member's representative may ask for an external review by writing a letter to:

**UnitedHealthcare Community Plan**  
**Attn: Indiana Grievance and Appeal Manager**  
P.O. Box 31364  
Salt Lake City, UT 84131-0364

or

**UnitedHealthcare Community Plan**  
**Attn: Indiana Grievance and Appeal Manager**  
7440 Woodland Drive  
Indianapolis, IN 46278

## 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.





Call the toll-free **Fraud, waste and abuse hotline** to report questionable incidents involving plan members or care providers, or **uhc.com/fraud** to learn more or to report and track a concern.

### Fraud, waste and abuse

UnitedHealthcare Community Plan’s 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/incommunityplan >** 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

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

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

#### What you need to do for exclusion checks

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

# Chapter 13: Care provider communications and outreach

## Key contacts

Topic	Link	Phone number
Provider education	<a href="https://UHCprovider.com/INcommunityplan">UHCprovider.com/INcommunityplan</a> > Training and Education	1-877-610-9785
News and bulletins	<a href="https://UHCprovider.com/INcommunityplan">UHCprovider.com/INcommunityplan</a> > Bulletins and Newsletters	1-877-610-9785
Provider manuals	<a href="https://UHCprovider.com/guides">UHCprovider.com/guides</a> > Community Plan Care Provider Manuals	1-877-610-9785

## Communication with care providers

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

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

- **Chat support available**  
Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**. Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**  
This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **Indiana health plans**  
**UHCprovider.com/in** is the fastest way to review all the health plans UnitedHealthcare offers in

Indiana. To review information for another state, use the drop-down menu at **UHCprovider.com** > Resources > **Health Plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.

- **Policies and protocols**  
**UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > **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 (Twitter)
- **UHCprovider.com/incommunityplan**  
The UnitedHealthcare Community Plan of Indiana page has state-specific resources, guidance and rules
- **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](https://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](https://UHCprovider.com/networknews). It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
  - This includes the communication formerly known as the Network Bulletin. Receive personalized Network News emails twice a month by subscribing at [UHCprovider.com/subscribe](https://UHCprovider.com/subscribe).
  - You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

## Care provider education and training

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

View the training resources at [UHCprovider.com/training](https://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 PMPs and specialist offices. All in-network care providers have an assigned provider advocate account manager. Our advocates are available to deliver face-to-face or virtual support depending on the provider preference. We do this to create program awareness, 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/incommunityplan](https://UHCprovider.com/incommunityplan) > Contact Us.

## Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. You can request a hard copy of this manual by contacting **Provider Services** at **1-877-610-9785**.

## State websites and forms

Find the following forms on the state's website at [in.gov/fssa](https://in.gov/fssa):

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form

# Glossary

## Abuse (by care provider)

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

## Abuse (of member)

Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault

## Acute inpatient care

Care provided to members sufficiently ill or disabled requiring:

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

## Advance directive

Legal papers that list a member's wishes about their end-of-life health care

## Adverse benefit determination

- For a resident of a rural area, the denial of a member's request to exercise their right, to obtain services outside the network
- The denial, in whole or in part, of payment for a service
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities
- The denial or limited authorization of a requested service, including determinations based on the type of level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit

- The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals
- The failure to provide services in a timely manner, as defined by the state
- The reduction, suspension, or termination of a previously authorized service

## Ambulatory care

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

## Ambulatory surgical facility

- A facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries
- Members can leave the facility the same day surgery or delivery occurs

## Americans with Disabilities Act

Americans with Disabilities Act (ADA) Public Law 101-336. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

## American Indian or Alaska Native enrollee

American Indian or Alaska Native (AI/AN) is an individual eligible for services from an Indian health care provider

## Ancillary care provider services

Extra health services, like laboratory work and physical therapy, which a member gets in the hospital

## Appeal

A member request that their health insurer or plan to review an adverse benefit determination

## Area Agencies on Aging

Not-for-profit agencies around the state that provide case management, information, and referrals to various services for persons who are aging or developmentally disabled

## Authorization

- Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered
- Used interchangeably with “preauthorization” or “prior authorization”

## Billed Charges

Charges you bill for rendering services to a UnitedHealthcare Community Plan member

## Capitation

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

## Care provider group

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

## Care Coordinator/Case Manager

The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member’s representative and the member’s provider

## Centers for Medicare & Medicaid Services

**CMS** – a federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs

## Children’s Health Insurance Program

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

## Clean claim

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

## Contracted health professionals

- Primary care providers, specialists, medical facilities, allied health professionals and ancillary care service providers under contract with UnitedHealthcare Community Plan
- These care providers deliver specific covered services to members

- They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures

## Coordination of benefits

**COB** – a process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute

## Covered services

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

## Credentialing

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

## Current procedural terminology (CPT®) codes

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

## Delivery system

- The mechanism by which health care is delivered to a member
- Examples include hospitals, care provider offices and home health care

## Disallow amount

Medical charges for which the network care provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member.

Examples are:

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

## Discharge planning

- Screening eligible candidates for continuing care following treatment in an acute care facility
- It involves care planning, scheduling, arranging and steps that move a member from 1 level of care to another

## Disenrollment

The discontinuance of a member's eligibility to receive covered services from a contractor

## Dispute

- **Care provider claim reconsideration** – step 1 when a care provider disagrees with the payment of a service, supply or procedure
- **Care provider appeal** – step 2 when a care provider disagrees with the payment of a service, supply or procedure

## Dual Eligible Member

A member who is eligible for both Medicare and Medicaid. There are 2 types of Dual Eligible Members:

- A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and
- A Non QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible). Eligible member – Person certified by the State as eligible for medical assistance.

## Durable medical equipment

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

## Electronic data interchange

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

## Electronic funds transfer

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

## Electronic medical record

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

## Eligible care providers

Person, organization, or institution approved by the State as eligible for participation in Medicaid

## Eligibility determination

Deciding whether an applicant meets the requirements for federal or state eligibility

## Emergency care

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

## Encounter

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

## Enrollee

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

## Enrollment

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

## Evidence-based care

An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care

## Expedited appeal

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

## Family and Social Services Administration

Indiana Family and Social Services Administration (FSSA) is a health care and social service funding agency with 8 care divisions established by Indiana to consolidate and better integrate the delivery of human services by state government. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs; includes the Office of Medicaid Policy and Planning, the Division of Aging, the Division of Family Resources, the Division of Mental Health and Addiction, and the Division of Disability & Rehabilitative Services.

## Fee-for-service

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

## Fraud

The knowing and willful executing, or attempt to execute, a scheme or deceit to defraud a health care insurance or benefit program, or to obtain by fraudulent means any benefit or payment from the program.

## Grievance

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

## Home and Community-Based Services

- Home and Community-Based Services (HCBS) that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility

- An HCBS listing and definitions of services can be found in the HCBS Waiver Provider Manual posted on the FSSA Medicaid HCBS webpage [in.gov/fssa/da/medicaid-hcbs](https://www.in.gov/fssa/da/medicaid-hcbs)

## Healthcare Effectiveness Data and Information Set

**HEDIS**<sup>®</sup> – a rating system developed by NCQA that helps health insurance companies, employers and consumers learn about the value of their health plan(s) and how it compares to other plans

## Health Insurance Portability and Accountability Act

**HIPPA** – a federal law that provides data privacy protection and security provisions for safeguarding health information

## Home health care (home health services)

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

## Home Health Services

Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care [42 CFR 440.70]

## Indian or American Indian

Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. Indian Health Service (IHS) is the federal agency charged with administering the health programs for federally recognized American Indians

## Indiana PathWays for Aging

- Indiana's health care program for Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid based on age, blindness, or disability

- Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term services and supports LTSS in a home or community-based setting health risk assessment(s) to ensure that the care of members is adequately coordinated and appropriately managed

## Individualized Care Plan

A plan of care, with contractually defined minimum components, developed for each member based on the results of the member's initial screening

## In-network care provider

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

## Long-Term Services and Supports

Long-Term Services and Supports (LTSS) services and support individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2]

## Managed care

An arrangement whereby a single care provider or organization oversees the overall care of a patient to ensure cost-efficient quality health care to its members. Managed care helps individuals who are elderly or living with disabilities by providing them with ongoing monitoring and care coordination to assess their needs, identify and treat health conditions, and ultimately close gaps in care

## Managed Care Entity

Managed Care Entity (MCE) is an organization contracted with the state of Indiana for this contract that meets all applicable requirements of Medicaid managed care organizations under Sections 1903(m) and 932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, and IC 12-15 as may be amended

## Medicare Advantage Special Needs Plan

A Medicare Advantage Special Needs Plan (MASNP) that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees and provides Part D benefits under 42 CFR Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population [42 CFR §§422.2 and 422.4(a)(1)(iv)]

## Medicaid

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

## Medical emergency

An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect 1 of the following to result:

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

## Medically necessary

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

## Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement



## National Provider Identifier

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

## Out-of-area care

Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory

## Preventive health care

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

## Primary medical provider/primary care provider

**PMP/PCP** – a physician, including an M.D. or D.O., nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services

## Prior authorization (notification)

The process where care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy

## Quality management (QM)

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

## Rural health clinic

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

## Service area

The geographic area served by UnitedHealthcare Community Plan, designated, and approved by the state of Indiana

## Service Coordinator

Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are determined NFLOC and receiving LTSS, to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS care providers as well as other community partners to provide a combination of services and supports that best meet the needs and goals of the member and caregiver

## Specialist

- A care provider licensed as a Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.) in the state of Indiana and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions
- A physician extender is a care provider who has special training in a specific area of health care

## State fair hearing

An administrative hearing requested if the member does not agree with a notice of appeal resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department

## Third-party liability

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

## Timely filing

When UnitedHealthcare Community Plan puts a time limit on submitting claims

## Title XIX

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

### **UnitedHealthcare Community Plan**

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

### **Utilization management (UM)**

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

# Appendix A

## Indiana state benefits

Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Adult Mental Health and Habilitation (AMHH)	No	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: <ul style="list-style-type: none"> <li>• Adult day services;</li> <li>• HCB habilitation;</li> <li>• Respite</li> <li>• Therapy and behavioral support services;</li> <li>• Addiction counseling;</li> <li>• Peer support services;</li> <li>• Supported community engagement services;</li> <li>• Care coordination; and</li> <li>• Medication training and support.</li> </ul>
Behavioral and Primary Healthcare Coordination (BPHC)	No	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services. Limited to 48 units per 6 months.
Care Conferences	Yes	Coverage of procedure code 99211 with the SC modifier for Indiana PathWays for Aging care conferences, payment of \$40 reimbursement to the provider.
Chiropractors*	Yes (self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to 5 office visits and 50 therapeutic physical medicine treatments per member per year.

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\*\*Prior approval always required

Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Dental Services	Yes	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to 1 set per recipient every 3 years, 1 set per recipient every 12 months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to 1 per lifetime, per recipient, per provider, with an annual limit of 2 per recipient. A periodic or limited oral evaluation is limited to 1 every 6 months, per recipient. Topical fluoride is not covered for recipients 21 years of age or older. Prophylaxis is limited to one unit every 12 months for non-institutionalized recipients over age 21. Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed.
Diabetes Self-Management Training Services*	Yes	Limited to 16 units per member per year. Additional units may be prior authorized.
Emergency Services	Yes (self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services	Yes (self-referral)	Coverage for the initial vision care examination will be limited to 1 examination every 2 years for a recipient 21 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of 1 pair every 5 years for members 21 years and older.
Family Planning Services and Supplies	Yes (self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs)	Yes	Coverage is available for medically necessary services provided by licensed health care practitioners.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Food Supplements, Nutritional Supplements, and Infant Formulas**	Yes	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient*	Yes	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services Outpatient*	Yes	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health services**	Yes	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech language services; and renal dialysis for home-bound individuals.
Hospice Care**	Yes (including hospice in an institutional setting)	Hospice is available under Medicaid if the recipient is expected to die from illness within 6 months. Coverage is available for 2 consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.
Immunizations	Yes (self-referral)	Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.
Laboratory and Radiology Services	Yes	Services must be ordered by a physician or other practitioner authorized to do so under state law.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Legend Drugs	Yes	<p>Medicaid covers legend drugs if the drug is:</p> <ul style="list-style-type: none"> <li>• Approved by the United States Food and Drug Administration</li> <li>• Not designated by CMS as less than effective or identical, related, or similar to less than effective drug</li> <li>• Not specifically excluded from coverage by Indiana Medicaid</li> </ul> <p>The following drugs are carved out of the Indiana PathWays for Aging program (full rating period):</p> <ul style="list-style-type: none"> <li>• Hepatitis C drugs (GPI 125350 or 123599)</li> <li>• Hemophilia Agents (GPI 8510)</li> <li>• Spinal Muscular Atrophy Treatments (GPI 7470)</li> <li>• Muscular Dystrophy Treatments (GPI 7460)</li> <li>• CAR-T Therapies (GPI 21651010 and 21651075)</li> <li>• Durable Genetic Therapy (GPI 8637)</li> <li>• Cystic Fibrosis Agents (GPI 453020 and 453099)</li> <li>• Sickle Cell Agents (GPI 828050 and 828070)</li> <li>• FDA approved SARS Coronavirus Vaccines and Administration</li> </ul>
Long Term Acute Care Hospitalization	Yes	Long term acute care services are covered. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)**	Yes	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.
Mental health/ Behavioral health services- Inpatient** (State Psychiatric Hospital)	No	Indiana PathWays for Aging members are disenrolled when admitted to a state psychiatric hospital.
Mental health/ Behavioral health services- Inpatient**	Yes	Covered.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Mental health/ Behavioral health services- Outpatient	Yes (except MRO services)	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for services that exceed 20 units, per recipient, per provider, per rolling 12 months.
Medicaid Rehabilitation Option (MRO) -Community Mental Health Centers	No	<p>Services provided by community mental health centers (CMHCs). Service packages are assigned based on level of need, as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be prior authorized when determined medically necessary. Services include:</p> <ul style="list-style-type: none"> <li>• Adult intensive rehabilitation services (AIRS) addition counseling;</li> <li>• Addiction counseling;</li> <li>• Behavioral health counseling and therapy;</li> <li>• Behavioral health level of need redetermination;</li> <li>• MRO case management;</li> <li>• CAIRS;</li> <li>• Medication training and support;</li> <li>• Psychiatric assessment and intervention; and</li> <li>• Skills training and development.</li> </ul>
Non-legend Drugs	Yes	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available from the <a href="#">IHCP website</a> .
Nurse-midwife Services	Yes	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners	Yes	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Nursing Facility Services** (Long-term)	Yes	<p>Requires pre-admission screening for level of care determination. Indiana PathWays for Aging coverage includes:</p> <ul style="list-style-type: none"> <li>• Room and board</li> <li>• Nursing care</li> <li>• Medical and nonmedical supplies and equipment</li> <li>• Durable medical equipment</li> <li>• Medically necessary and reasonable therapy services</li> <li>• Transportation to vocational/habilitation service programs</li> </ul>

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Nursing Facility Services (Short-term)	Yes	Services for members in a nursing facility setting on a short-term basis, i.e., for fewer than 30 calendar days.
Occupational Therapy**	Yes	<p>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility’s established per diem rate or for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in thirty 30 calendar days without prior authorization.</p> <p>Evaluations and reevaluations are limited to 3 hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than 2 years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.</p>
Organ Transplants	Yes	<p>Coverage is in accordance with prevailing standards of medical care. UnitedHealthcare Community Plan shall not pay for organ transplants unless UnitedHealthcare Community Plan follows the written standards included in the state plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to members. For additional information, please see the following documents:</p> <ul style="list-style-type: none"> <li>• <a href="https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf">https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf</a></li> <li>• <a href="https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf">https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf</a></li> </ul> <p>Prior authorization is required.</p>
Orthodontics**	Yes	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Out-of-state Medical Services**	Yes	<p>Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; hospice services, subject to the conditions in 405 IAC 5-34-3; and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in state services.</p> <p>Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Recipients may obtain services in Chicago, Illinois if the recipient’s physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient’s family, the service is not available in the immediate area, the recipient’s physician complies with all of the criteria set forth in accordance with the state plan and 42 CFR 456.3. Prior authorization will not be approved for the following out of state services: nursing facilities or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.</p>
Physician Assistant	Yes	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified Physician Assistant within the scope of the applicable license and certification.
Physicians’ Surgical and Medical Services*	Yes	Covers reasonable services provided by a M.D., D.O., N.P., P.A. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per calendar year per member per provider without prior authorization. New patient office visits are limited to 1 per recipient, per provider within the last 3 years.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Physical Therapy**	Yes	<p>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation.</p>
Podiatrists	Yes (self-referral)	<p>Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than 6 routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the 6 month period prior to the rendering of routine foot care services. Prior authorization is required for inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.</p>
Rehabilitative Unit Services - Inpatient**	Yes	<p>The following criteria shall demonstrate the inability to function independently with demonstrated impairment:</p> <ul style="list-style-type: none"> <li>• Cognitive function</li> <li>• Communication</li> <li>• Continence</li> <li>• Mobility</li> <li>• Pain management</li> <li>• Perceptual motor function</li> <li>• Self-care activities.</li> </ul>

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Residential Substance Use Disorder (SUD) Services	Yes	<p>Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria:</p> <ul style="list-style-type: none"> <li>• ASAM Level 3.1 - Clinically Managed Low-Intensity Residential Services</li> <li>• ASAM Level 3.5 - Clinically Managed High-Intensity Residential Services</li> </ul>
Respiratory Therapy*	Yes	<p>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within 30 calendar days (up to 30 units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization.</p> <p>Evaluations and reevaluations are limited to 3 hours of service per evaluation.</p>
Rural Health Clinics	Yes	<p>Coverage is available for services provided by a physician, physician assistant, nurse practitioner, a clinical psychologist, or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Home health services by a RHC to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.</p>

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\*\*Prior approval always required

Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Smoking Cessation and Tobacco Dependence Treatment Services	Yes	<p>Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment.</p> <p>Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself.</p> <p>The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling.</p> <p>The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the-counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment.</p> <p>Providers must perform tobacco dependence counseling for a minimum of 30 minutes (2 units) and a maximum of 150 minutes (10 units) within the course of treatment.</p> <p>IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.</p>

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
Speech, Hearing and Language Disorders*	Yes	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within 30 calendar days (up to 30 units) following discharge from a hospital when ordered by physician prior to discharge or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of 30 units in 30 calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 units in 30 calendar days without prior authorization. Evaluations and reevaluations are limited to 3 hours of service per evaluation.
Transportation - Emergency*	Yes	Coverage has no limit or prior authorization requirement for emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation - Non-emergency medical	Yes	Non-emergency medical travel is available when another alternative is not available.
Urgent Care Services	Yes (self-referral)	Urgent care services are covered provided that they are medically necessary. Urgent care is needed for non-life threatening emergencies that cannot wait for a normal scheduled office visit.

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Service	Reimbursed by UnitedHealthcare?	Limitations and coverage
<b>HCBS Services for those with HCBS LOC determination</b>		
Included HCBS 1915(c) LTSS Waiver Services	*Yes, but only for those eligible	<p>Please reference the most current version of the Indiana Health Care Provider manual for the most update covered services and their respective service definitions for those eligible for HCBS LTSS in the 1915(c) Managed Care Medicaid Waiver. Current list below:</p> <ul style="list-style-type: none"> <li>• Adult Day Service</li> <li>• Attendant Care</li> <li>• Caregiver Coaching</li> <li>• Home and Community Assistance</li> <li>• Respite</li> <li>• Community Home Share Assisted Living</li> <li>• Community Transition</li> <li>• Home Delivered Meals</li> <li>• Home Modification Assessment</li> <li>• Home Modifications</li> <li>• Integrated Health Care Coordination</li> <li>• Nutritional Supplements</li> <li>• Participant Directed Attendant Care</li> <li>• Personal Emergency Response System</li> <li>• Pest Control</li> <li>• Specialized Medical Equipment And Supplies</li> <li>• Structured Family Caregiving</li> <li>• Transportation</li> <li>• Vehicle Modifications</li> </ul>

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