2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

North Carolina

Doc#: PMG 20241105-080420

v 71.10.2024

United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® 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.

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

Click to access different care provider manuals

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**
- **We partner with United Behavioral Health**, operating under the brand name Optum® (herein Optum) who administers behavioral health and substance use disorder (SUD) benefits
  - Behavioral health care providers and medical care providers who provide behavioral health and/or SUD services should refer to Chapter 7 of this manual for behavioral health and SUD information
  - Additional behavioral health and SUD requirements can be found in the Optum National Network Manual at **providerexpress.com**
  - The Optum National Network Manual controls when there are differences between this manual and the Optum National Network Manual

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 providers manuals.

If you have questions about information/material listed, or about our policies, please call **Provider Services** at **1-800-638-3302**.

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should utilize the Agreement, instead. If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

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

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-800-638-3302**
CommunityCare Provider Portal Training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
One Healthcare ID support (formally known as Optum support)	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
Resource Library	**UHCprovider.com/resourcelibrary**	

This care provider manual applies to services provided under your Agreement(s) with UnitedHealthcare Community Plan® and Optum. For care providers delivering behavioral health services and/or SUD services, this manual does not replace the Optum National Network Manual. Behavioral health and SUD services are described in detail in Chapter 7 of this manual, however the Optum National Network Manual provides the full scope of information needed for behavioral health and SUD care providers. This manual will direct you to the Optum National Network Manual as required.

UnitedHealthcare Community Plan® supports the North Carolina state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to eligible North Carolinians. The North Carolina Department of Health and Human Services (NCDHHS) will determine enrollment eligibility through their enrollment broker MAXIMUS.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call **Provider Services** at **1-800-638-3302**.

How to join our network

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

Already in 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**, or other changes, go to nctracks.nc.gov.

Approach to health care

Care Model

The Care Model program helps empower UnitedHealthcare Community Plan® members enrolled

in Medicaid, care providers and our community to improve care coordination and raise outcomes. Targeting UnitedHealthcare Community Plan® members with chronic complex conditions, the program addresses their needs holistically by referral to care management delivered either by medical home or internal care management team.

The program provides care management to members with complex medical, behavioral, social, pharmacy and specialty needs. The Care Model approach provides a local care management team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan® serves.

The Care Model program provides:

- Market-specific local care management involving medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Engage members, connecting them to needed resources, care and services
- Personal and multidisciplinary care plans
- 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

Care Model goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to needed services, such as behavioral health (BH) and community resources
- 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 members to manage their complex illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community and care provider networks to help ensure access to affordable care and the appropriate use of services

To refer your patient who is a UnitedHealthcare Community Plan® member to the Care Model program, call **Member Services** at **1-800-349-1855**, TTY 711 or call **Provider Services** at **1-800-638-3302**.

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 health care providers who handle business electronically.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan® has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information, go to **UHCprovider.com** > Resources > Resource Library > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

  Cultural competency information is stored within your care provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process.**

  You must also provide interpreter services in the member's primary language and for the hearing impaired for all appointments and emergency services. In addition, you must provide information about care options and alternatives as well as complaints and appeals. Deliver this information in a manner appropriate to the member's condition and ability to understand.

You must provide physical access, reasonable accommodations, and related equipment for members with physical or mental disabilities. This includes the following interpretation and translation services:

- You must provide qualified sign language interpreters if closed captioning is not the appropriate aid
- You must help ensure your staff can appropriately communicate with members who have hearing loss
- You will report to UnitedHealthcare Community Plan®, in a format and frequency we determine, whether hearing loss accommodations are needed and provided, and the type of accommodation provided

UnitedHealthcare Community Plan® provides the following:

- **Language Interpretation Line:**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call 1-877-842-3210 (TTY **711**)
- **I Speak language assistance card**

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

- **Materials for limited English-speaking members**

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

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan® uses InterQual® for medical care determinations.

For behavioral health we use American Society of Addiction Medicine (ASAM), Early Childhood Services Intensity Instrument (ECSII) for children ages 0 through 5, and the Children and Adolescents Needs and Strengths (CANS).

Mobile apps

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network care providers
- **SMART** Patient allows users to track important numbers such as blood pressure, record appointments, and record doctors' orders. It also helps them view educational videos
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan®'s care provider network and obtain travel directions to a care provider's location. The app provides users with the ability to call a care provider by tapping on the search result.

Online resources

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

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

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient — and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

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

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the

UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse.

The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

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

The benefit of using EDI is 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.

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

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

Getting started

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

Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan®, you will do business with us electronically.

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

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

Chat support now available

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

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

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

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

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

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library**
  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

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

Direct Connect

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

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

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

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

Privileges

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

Medicaid Managed Care Provider Ombudsman Program

Contact the NCDHHS Ombudsman Program to assist you with submitting a complaint about UnitedHealthcare Community Plan®.

Call the Medicaid Managed Care Provider Ombudsman Program at **1-866-304-7062** or send an email to the Medicaid Managed Care Provider Ombudsman email address Medicaid.ProviderOmbudsman@dhhs.nc.gov.

Members have a separate ombudsman program.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan®. With any questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions - please call **Provider Services** at **1-800-638-3302.**

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

How to contact us

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

Topic	Contact	Information
Behavioral, Mental Health & Substance Abuse (United Behavioral Health operating under the brand Optum)	Optum® **providerexpress.com** **1-800-888-2998** **1-877-614-0484**	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-800-638-3302**	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization (eviCore healthcare)	**UHCprovider.com/cardiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Management Referrals	Provider Services **1-800-638-3302**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing and long-term services and supports.
Chiropractor Care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	**UHCprovider.com/claims** **1-800-638-3302** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5280 Kingston, NY 12402-5280 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.
Claim Overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-800-638-3302** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 101760 Atlanta, GA 30392	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.

Topic	Contact	Information
Doctor Chat	Download the application at **uhcdoctorchat.com**	Connect to a doctor in seconds who can help address health concerns and prescribe medication
Dispatch Health	1-855-752-9254 dispatchhealth.com	Get in-home care from nurse practitioners who offer a range of services including same-day, high-acuity care • Available only in the greater Triangle area
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions
Eligibility	**UHCprovider.com/eligibility** **1-800-638-3302**	Confirm member eligibility.
Enterprise Voice Portal	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, Waste and Abuse (Payment Integrity)	**UHCprovider.com/NCcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-800-455-4521** (NAVEX) or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory Services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics 1-866-697-8378 questdiagnostics.com	Labcorp and Quest Diagnostics are nationally contracted lab care providers.
Medicaid	medicaid.gov 1-888-245-0179	Contact Medicaid directly.

Topic	Contact	Information
Medical Claims, Reconsiderations, and Appeals	**UHCprovider.com/claims** **1-800-638-3302** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations see the **Reconsiderations and Appeals interactive guide**. For those care providers exempted from this requirement, requests may be submitted at the following address: Claims and reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5280 Kingston, NY 12402-5280 Appeals mailing address: **UnitedHealthcare Community Plan** **Attn: Grievances and Appeals Unit** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** **1-800-349-1855** **1-877-542-9239** / TTY **711** for help accessing member account	Helps members with issues or concerns. Available 7 a.m.–7 p.m. CT, Monday–Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	Member Services **1-800-349-1855** Language Interpretation Line **1-877-261-6608** TDD **711**	Available 7 a.m.–6 p.m. ET, Monday-Friday.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
NC Track	NCTracksProvider@nctracks.com 1-800-688-6696	Self-service functionality to update or check credentialing information.
Network management support	Chat, with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality for medical network care providers to update or check credentialing information.

Topic	Contact	Information
Obstetrics/Pregnancy and Baby Care	Maternal and Child Care Management Pregnancy Notification form at **UHCprovider.com** > Provider Portal Healthy First Steps® Rewards **UHChealthyfirststeps.com**	For all pregnant members, complete the Pregnancy Risk Screen found at **UHCprovider.com** or on the North Carolina Medicaid website at **medicaid.ncdhhs.gov/media/8475/open.** Fax forms to the local health department (LHD) of the member's residence. If no LHD in the member's county of residence, fax risk screen to 1-844-897-2462.
One Healthcare ID Support Center	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday-Friday; 6 a.m.–6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday.
Pharmacy Services	**professionals.optumrx.com** **1-855-258-1593** (OptumRx)	OptumRx oversees and manages our network pharmacies.
PreCheck MyScript®	**UHCprovider.com** **1-866-842-3278**, option 3	Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com** > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** **OptumRx** **Prior Authorization Department** P.O. Box 25183 Santa Ana, CA 92799 **1-855-258-1593**	Request prior authorization for certain drugs prescribed to North Carolina Medicaid members.

Topic	Contact	Information
Prior Authorization Requests and Advance Admission Notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/paan** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-800-638-3302.**	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/ prior authorization lists: **UHCprovider.com/NCcommunityplan** > **Prior Authorization and Notification**
Provider Services	**UHCprovider.com/NCcommunityplan** **1-800-638-3302**	• Support is available 7a.m.–7p.m. ET, Monday-Friday, for the following topics: provider portal, claims, prior authorization or eligibility and benefits
Radiology Prior Authorization (eviCore healthcare)	**UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	**UHCprovider.com/referrals** or use Referrals on the UnitedHealthcare Provider Portal. Click Sign In at the top right corner of **UHCprovider.com**, then click Referrals. Provider Services **1-800-638-3302**	Submit new referral requests and check the status of referral submissions. UnitedHealthcare Community Plan of North Carolina does not require referrals.
Reimbursement Policy	**UHCprovider.com/NCcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Support	**UHCprovider.com/contactus** Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.

Topic	Contact	Information
Third-Party Liability	Provider Services **1-800-638-3302**	Submit information about other member coverage not available on the Provider Portal.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/ smoking.
Transportation	ModivCare Provider Support **1-855-397-3606** Member Services **1-800-349-1855**	To arrange nonemergent transportation, please contact ModivCare 2 business days in advance. Urgent transportation such as facility discharges or appointments for new conditions can be scheduled same day. Members may call Member Services.
Utilization Management	Provider Services **1-800-638-3302**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	immunize.nc.gov American Academy of Pediatrics/ Bright Futures: healthychildren.org NC Immunization Branch: 1-919-707-5598 or 1-877-873-6247	You are strongly encouraged to participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, younger than 19 years, who might not otherwise be vaccinated because of an inability to pay. Because VFC vaccines are federally purchased, enrolled care providers cannot bill for the cost of the vaccine. However, care providers can bill for vaccine administration fees. VFC care providers must maintain adequate stock of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), as appropriate for their specific patient population. You must report all immunizations administered to the North Carolina Immunization Registry (NCIR) at immunize.nc.gov. To request access, contact the NC Immunization Branch at 1-877-873-6247.

Topic	Contact	Information
Vision Services	marchvisioncare.com 1-844-736-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from March Vision Care. Available 8 a.m.– 5 p.m. ET, Monday-Friday.
Website for North Carolina Community Plan	**UHCprovider.com/NCcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-800-638-3302**
Eligibility	**UHCprovider.com/eligibility**	**1-800-638-3302**
Referrals	**UHCprovider.com/referrals**	**1-800-638-3302**
Provider Directory	**UHCprovider.com/findprovider**	**1-800-638-3302**

General care provider responsibilities

You must comply with the terms and conditions set forth in your provider Agreement.

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider 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 affect your relationship with members as patients or with its ability to administer quality improvement, utilization management (UM) or credentialing programs. Instead, we require communication between PCPs 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:

1. Educate members, and/or their representatives 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 members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Work with the plan care manager in developing a 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 happen:

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

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

Care provider-preventable conditions

Care providers must identify provider-preventable conditions for monitoring and reporting purposes.

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 services for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

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

Transition of care

Members that change health plans

If a member joins UnitedHealthcare Community Plan® of North Carolina from another health plan, UnitedHealthcare will work with the previous health plan to get the health information, service history, service authorizations and other information about current care into our records.

- Newly enrolled members may continue to see the same care providers for ongoing treatment for up to 90 calendars day, or until the member is transferred to a network care provider, whichever comes first
- UnitedHealthcare shall assist the member in transitioning to an in-network provider at the end of the authorization period if necessary
- UnitedHealthcare shall allow pregnant members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the end/loss of pregnancy or loss of eligibility
- If a member transitions from another plan and is hospitalized at the time of the transfer, the originating health plan will be responsible for inpatient facility payment until discharge. UnitedHealthcare will participate in discharge planning and will be responsible for all services upon discharge.

Transitional period: scheduled surgery, organ transplantation or inpatient care

If surgery, organ transplantation or other inpatient care was scheduled for an member before the date of enrollment in the health plan or if the member on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period for those instances shall extend beyond the date of discharge of the individual after completion of the above circumstances and through post discharge follow-up care occurring within 90 days after the date of discharge.

Transitional period: pregnancy

If the member has entered the second trimester of pregnancy on the date of enrollment in the health plan and the provider was treating the pregnancy before the enrollment, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

Transitional period: terminal illness

If the member was determined to be terminally ill at the time of enrollment in the health plan and the provider was treating the terminal illness before the date of enrollment, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

Transferred prior authorization

In the instance when a provider does not find a transition of care (TOC) prior authorization that should have transferred from another PHP or DHHS, please follow 1 of the following processes:

1. Call case management at **1-855-873-2372**, explain situation and provide member ID, provider information and any information on previous authorizations.

2. Email case management at **nchpcm@uhc.com** a copy of the previously approved prior authorization containing member id, provider information, relevant codes and diagnosis. Unless updates are made to the provider record via an MCR in NCTracks, the updated demographic info will not transfer into the provider directory. The information must generate from NCTracks (and the PEF) as the source of truth.

Administrative terminations for inactivity

Up-to-date directories help us provide 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 taking part in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for 1 year. This is not a termination of the Agreement. Call UnitedHealthcare Community Plan® to reactivate a TIN.

Changing an existing TIN or adding a health care provider

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

Your demographic updates must be made in the NCDHHS credentialing portal, NCTracks, at nctracks.nc.gov/content/public.

Updating your practice or facility information

Your demographic updates must be made in the NCDHHS credentialing portal, NCTracks, at nctracks.nc.gov/content/public. Unless updates are made to the provider record via an MCR in NCTracks, the updated demographic information will not transfer into the provider directory. The information must generate from NCTracks (and the PEF) as the source of truth.

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

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

Updating panel limits

Participating network providers may submit a request to update their panel limit by utilizing our live advocate chat, available 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. Providers that are currently in negotiations should discuss their panel limit with the network contractor as part of the negotiation process. Additionally, any change to the accepting new patient's indicator should be updated via NCTracks as that information is ingested daily from the provider enrollment file.

After-hours care

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

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 diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 10 for more details.

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. Keep these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

You must comply with the UnitedHealthcare Community Plan® and payer's protocols, including those contained in this care provider manual. You may view protocols at **UHCprovider.com/protocols.**

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan® members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of 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. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** in this care provider manual 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 to:

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

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

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. Locate the Member handbook at **UHCCommunityPlan.com**.

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

Tobacco-free policy

- Upon the launch of Tailored Plans, the Prepaid Health Plan (PHP) shall require contracted Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles.
- A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications.
- A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve.
- EXCEPTIONS: This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

Tobacco-free policy: partial

The following partial tobacco-free policy shall be required in intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:

- Use of tobacco products is prohibited indoors when the building or home in which the care provider operates is under the care provider's control as owner or lessee
- Outdoor areas of the property under thecare provider's control as owner or lessee must:
  - Ensure access to common outdoor space(s) free from exposure to tobacco use; and
  - Prohibit staff/employees from using tobacco products anywhere on the property. c)Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a 100% tobacco-free campus policy for the safety of clients and staff.

Two new areas were added to the policy: a care provider monitoring process and additional technical assistance through Breathe Easy, North Carolina. Find additional information in the March 21, 2024 NCDHHS Bulletin.

Network adequacy standards

Our network has hospitals, physicians, advanced practice nurses, substance use disorder and behavioral health treatment providers. It also has emergent and non-emergent transportation services, safety net hospitals, and all other care provider types necessary to support capacity to make all services available. For the purposes of Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties." "Rural" is defined as a county with average population density of less than 250 people per square mile.

More information is available at ncleg.gov.

The following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Certain service types are not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

Physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.

Behavioral health providers/services, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

Prepaid Health Plan (PHP) Time and Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient Behavioral Health Services	• ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of members • Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of members • Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard
8	Location-Based Services (Behavioral Health)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members
9	Crisis Services (Behavioral Health)	≥ 1 provider of each crisis service within each PHP region	

[1] Measured on members who are female and age 14 through age 44. Certified nurse midwives may be included to satisfy obstetrics access requirements.

Prepaid Health Plan (PHP) Time and Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
10	Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP region	
11	Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	All State Plan LTSS (except nursing facilities)*	PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
13	Nursing Facilities*	PHP must have at least 1 nursing facility accepting new patients in every county.	PHP must have at least 1 nursing facility accepting new patients in every county.

Definition of Service Category for Behavioral Health Time and Distance Standards		
Reference Number	**Service Type**	**Definition**
1	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2	Location-Based Services (Behavioral Health)	• Outpatient opioid treatment program (OTP) (adult)
3	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult) • Facility-based crisis services for children and adolescents • Ambulatory withdrawal management, without extended on-site monitoring • Ambulatory withdrawal management, with extended on-site monitoring • Medically monitored inpatient withdrawal services
4	Inpatient Behavioral Health Services	**Inpatient Hospital - Adult** • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult medically managed intensive inpatient withdrawal management services beds • Acute care hospitals with adult medically managed intensive inpatient services beds **Inpatient Hospital - Adolescent/Children** • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent/child medically managed intensive inpatient services beds • Acute care hospitals with child inpatient psychiatric beds
5	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

Appointment standards -North Carolina Department of Health and Human Services Access and Availability Standards

Comply with the following appointment Department of Health and Human Services (DHHS) availability standards:

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Services: adult, members 21 years and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within 30 calendar days
1a	Specialty Preventive Care Service: pediatric, members 20 years and younger		Within 14 calendar days for members younger than 6 months old Within 30 calendar days for members 6 months and older.
2	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache	Within 24 hours
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up	Within 30 calendar days
4	After-Hours Access –Emergent and Urgent	Care requested after normal business office hours	Immediately (24 hours a day, 365 days a year)
Prenatal Care			
5	Initial Appointment – First or Second Trimester	Care provided to a member while they are pregnant to help keep member and future baby healthy, such as checkups and prenatal testing	Within 14 calendar days
5a	Initial Appointment – High-Risk Pregnancy or Third Trimester		Within 5 calendar days

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Specialty Care			
6	Urgent Care Services	Care provided for a non emergent illness or injury with acute symptoms that require immediate care; examples include sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache	Within 24 hours
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check	Within 30 calendar days
8	After-Hours Access –Emergent and Urgent Instructions	Care requested after normal business office hours	Immediately (available 24 hours a day, 365 days a year)
Behavioral Health Care			
9	Mobile Crisis Management Services	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within 2 hours
10	Urgent Care Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within 24 hours
11	Urgent Care Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within 24 hours
12	Routine Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within 14 calendar days
13	Routine Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within 48 hours
14	Emergency Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Immediately (available 24 hours a day, 365 days a year)

Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Behavioral Health Care			
15	Emergency Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Immediately (24 hours a day, 365 days a year)

Provider directory

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

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

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

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

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

Delegated care providers – submit changes to your designated submission pathway

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

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

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services**. 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**, then Sign In
  2. Select the **Prior Authorization and Notification app**
  3. View notification requirements

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare

Web Support at **1-866-842-3278**, option 3, 7 a.m.–9 p.m. ET, Monday-Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days

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

Specialists include internal medicine, pediatrics or obstetrics/gynecology

Primary care providers (PCPs) are an important partner in care delivery, and NCDHHS members may seek services from any participating care provider. The NCDHHS program requires members be assigned to PCPs. They may choose their own network PCP. If they do not, we will auto-assign them a PCP. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

When a member is enrolled in an Advanced Medical Home (AMH) Tier 3, the AMH practice will perform care management functions. These activities help support the UnitedHealthcare Community Plan® system by improving health care delivery in access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to adult members and pediatric members, makes recommendations for specialty and ancillary care, and coordinates all primary care services. For more information about AMH and Tier 3, go to medicaid.ncdhhs.gov/advanced-medical-home.

The following care provider types may serve as PCPs:

- Family medicine
- General practice
- Internal medicine
- Nurse practitioner (NP)
- Obstetrics & gynecology
- Pediatrics
- Physician assistant (PA)
- Advanced practice midwife
- Psychiatry and neurology

Find information about classification at nctracks.nc.gov.

For information about becoming certified as an advanced medical home, go to files.nc.gov.

We ask members who don't select a PCP during enrollment to select 1. We may auto-assign a PCP to complete the enrollment process.

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

UnitedHealthcare Community Plan® works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage includes availability of 24 hours a day, 7 days a week. During non-office hours, access by phone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan® identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well-baby/well-child services. This includes completing and submitting the North Carolina Pregnancy Risk Screening Form on **UHCprovider.com**.
- Coordinate each member's overall course of care.

- Accept UnitedHealthcare Community Plan® members at your primary office location at least 20 hours a week for a 1 M.D. practice and at least 30 hours per week for a 2 or more M.D. practice. Regardless on the number of MDs in a practice, if it has attested to a tier 3 status, it must have at least 30 open office hours to see patients.
- Be available to members by phone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

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

Specialists include internal medicine, pediatrics or obstetrics/gynecology

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual
- Conduct a baseline exam during the member's first appointment
- Treat members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan® Clinical, or Pharmacy Department as appropriate
- Admit members to the hospital when necessary. Coordinate their medical and behavioral care while they are hospitalized
- Respect members' advance directives. 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 and based on our 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 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
- Complying with the North Carolina DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in Chapter 2 of this manual.

Primary 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. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan®, if required. Visit **UHCprovider.com/paan.**
- 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

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

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a RHC or FQHC as their PCP.

- **Rural Health Clinic:** 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.
- **Federally Qualified Health Center:** An FQHC is a

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

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan® members recommended by their PCP 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 PCP 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. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan® participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the North Carolina DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual
- Provide anytime coverage. UnitedHealthcare Community Plan® tracks and follows up on all instances of PCP or obstetrician unavailability

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

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone Number
Member benefits	**UHCcommunityplan.com**	**1-800-349-1855**
Member handbook	**UHCcommunityplan.com/NC** > Plan Details > Member Resources > View Available Resources	
Provider Services	**UHCprovider.com**	**1-800-638-3302**
Prior authorization - for medical requests	**UHCprovider.com/paan**	**1-800-638-3302**
Behavorial health (BH)	**public.providerexpress.com**	**1-800-638-3302**
D-SNP	**UHCprovider.com/NC** > Medicare > **Dual Complete Special Needs Plans**	**1-800-638-3302**

Member benefits

Benefit information is listed in the following chart. Click **UHCprovider.com/NC** > **Community Plan/Medicaid** > Member Information to view member benefit coverage information, or **UHCprovider.com/eligibility** for more information. Members may visit **UHCCommunityPlan.com/NC**.

Benefit type	Medicaid coverage	Comments
Inpatient Hospital Services	Yes	Swing bed hospitals, critical access hospitals, inpatient rehabilitation, specialty hospitals, acute care hospitals. This does not include phones and TVs used when in the hospital or personal comfort items used in the hospital such as a barber.
Outpatient Hospital Services	Yes	Preventive, diagnostic, therapeutic, rehabilitative or palliative services directed by a dentist are carved out to the Fee-For-Service (FFS) program
EPSDT Services (no copays)	Yes	Any medically necessary services regardless of whether it is covered under the NC Medicaid State Plan. Vaccines are covered under the VFC program. We cover the administration of the vaccine.

Benefit type	Medicaid coverage	Comments
Nursing Facility Services	Yes	Services must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician. After 90 consecutive days in the facility, a member will be disenrolled from managed care and placed into the FFS program.
Home Health Services	Yes	Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide services and medical supplies. Home health skilled nursing services are not covered on the same day as private duty nursing (PDN) services.
Physician for well-child check ups	Yes	We cover both the vaccine and the administration
Abortion Coverage	Yes	Covered with physician certification of life endangering conditions or the result of incest or rape
RHC/FQHC Services	Yes	Core service: physician services, physician assistants, nurse practitioners, nurse midwives, clinical psychologists and clinical social workers
Telemedicine	Yes	Medical and psychiatric services
Lab and X-Ray Services	Yes	Some services require authorization through EviCore
Family Planning Services	Yes	Preventing pregnancy or arranging care for pregnant members
Freestanding Birthing Centers	Yes	Allowed only for vaginal deliveries
Non-Emergent Transportation Services	Yes	Covered through ModivCare
Ambulance Services	Yes	Ground and air transport
Tobacco Cessation	Yes	Counseling and pharmacotherapy is covered
Prescription Drug Coverage	Yes	State PDL is followed – Diabetic testing and supplies are required to be covered through the pharmacy program.
Physical therapy/Occupational therapy/Speech therapy	Yes	Physical or other therapy to help members maintain their health.
Adult Immunization Services	Yes	Only vaccines approved by the Advisory Committee on Immunization Practices

Benefit type	Medicaid coverage	Comments
Podiatry Services	Yes	Excluded from services are amputation of the entire foot, administration of anesthetic other than a local and the surgical correction of clubfoot for an infant 2 years of age or younger
Vision Services	Yes	Services covered through March Vision, includes routine eye exam, the determination of refractive errors, refraction only, prescribing corrective lenses (eyeglasses and medically necessary contact lenses that cannot be managed by eyeglasses), and dispensing approved visual aids. Providers who supply eye exams and eyeglasses in their office must also supply Medicaid eye exams and FFS eyeglasses to members. Sunglasses and photo-gray lenses are not included.
Chiropractic Services	Yes	Limited to manual manipulation only
Private Duty Nursing (PDN)	Yes	PDN is a substantial, complex, and continuous skilled nursing care that is considered supplemental to the care provided to a beneficiary by the beneficiary's family, foster parents, and delegated caregivers, as applicable Private Duty Nursing services is defined by 42CFR 440.80. Private Duty Nursing services is for a beneficiary who may require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. Home Health Nursing services must not be provided concurrently with PDN Services. When a beneficiary requires Home Health medical supplies, the PDN provider shall provide and bill for those supplies. The PDN provider is also expected to handle blood draws, wound care, and other home health nursing tasks for a PDN beneficiary.
Personal Care Services (PCS)	Yes	Services include assistance with ADLs and light housekeeping duties. PCS cannot be rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS are: home health aide services and PDN or CAP.
Hospice Services	Yes	End of life care

Benefit type	Medicaid coverage	Comments
WA Durable Medical Equipment	Yes	Includes purchase, rentals, repairs, oxygen and related equipment, enteral nutrition and equipment
Prosthetics, orthotics and supplies	Yes	Supplies needed to help members take part in the community.
Home Infusion Therapy	Yes	Infusions administered by a health care professional at home
Individuals 18 or older in an institution for mental disease	Yes	Continuous treatment with acute psychiatric or substance abuse problems
Inpatient Psychiatric Services	Yes	Individuals younger than 21 years
Transplant and related services	Yes	Stem cell and solid organ transplants
Allergy Testing	Yes	Exams, testing and supplies are covered
Dietary Evaluation and Counseling	Yes	Support and treatment to reach a healthy weight. 13-week voucher for Weight Watchers
Hearing Aids	Yes	Hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity for individuals younger than 21.
Auditory Implant Parts	Yes	Replacement and repair of external components of a cochlear, auditory brainstem, and bone-anchored hearing aid device. Only device manufacturers are qualified providers.
Obstetrics and Gynecology	Yes	Hysterectomy and sterilization
Dental Services	No	Benefit is covered under the FFS program *Exception are codes D0145 and D1206 submitted by physicians for the Fluoride Varnish Program
Outpatient Behavioral Health Services	Yes	Assessment, therapy, and psychiatric services provided in outpatient setting or virtually. Peer Support services delievered by certified Peer Support Specialists.
Behavioral Health Crisis Services	Yes	Community based crisis services including mobile crisis, facility based crisis, non-hospital detox

Benefit type	Medicaid coverage	Comments
Substance Use Disorder (SUD) Treatment Services	Yes	Outpatient treatment services for SUD including: opioid treatment programs, therapy, intensive outpatient, and comprehensive outpatient treatment
Research Based Behavioral Health Treatment	Yes	Researched-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically by signing into the UnitedHealthcare Provider Portal at **UHCprovider.com**.

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

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

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

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

Auto-assigning an advanced medical home/primary care provider

When a member doesn't choose an advanced medical home/primary care provider (AMH/PCP) during enrollment with us, we auto-assign them within 24 hours of the effective date. We base these assignments on the following items in this order:

1. Prior AMH/PCP.
2. Member claims history.
3. Family member's AMH/PCP assignment.
4. Family member's claims history.
5. Geographic proximity.
6. Special medical needs.
7. Language/cultural preference.

Changing a primary care provider

Members may change their assigned PCP with cause at any time. The Department defines cause as the care provider not appropriately doing the following:

- Providing primary care services
- Arranging inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary
- Arranging for consultation appointments
- Coordinating and interpreting any consultation findings with an emphasis on continuity of medical care

- Arranging for services with qualified licensed or certified care providers
- Coordinating the member's overall medical care, such as periodic immunizations and diagnosis and treatment of any illness or injury

Cause also includes:

- The member disagreeing with the treatment plan.
- The member and care provider cannot communicate due to a language barrier
- The care provider cannot reasonably accommodate the member's special needs
- The care provider's practice changes, such as:
  - The care provider moves to a location that isn't convenient for the member
  - There is a significant change in the hours the care provider is available, and the member can't reasonably make appointments during the new hours
  - The care provider no longer has hospital access
- The member and care provider agree that a change is in the member's best interest
- The care provider leaves the network

Members may change their assigned PCP twice per year without cause. They can make the request once within the first 30 days from receipt of notification of their AMH assignment. Then they can request a change again in the next year. To do so, they must call Member Services. The change is effective on the first day of the following month.

Deductibles/copayments

Members are charged copayments as follows.

North Carolina Medicaid Cost Sharing		
Income Level	**Service**	**Copay**
All Medicaid beneficiaries	Physicians	$4/visit
	Outpatient services	$4/visit
	Podiatrists	$4/visit
	Generic and Brand Prescriptions	$4/script
	Chiropractic	$4/visit
	Optical Services/ Supplies	$4/visit
	Optometrists	$4/visit
	Non-emergency ER visit	$4/visit

Medicaid cost-sharing exclusions

There are NO Medicaid copays for the following people or services:

- Members under age 21
- Services related to pregnancy, childbirth and postpartum care - including prenatal care
- Members receiving hospice care
- Federally recognized tribal members or members receiving services through Indian Health Service (IHS)
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- Children in foster care
- People living in an institution who are receiving coverage for cost of care
- Behavioral health services
- Intellectual/developmental disability (I/DD) services
- Members enrolled in NC Innovations and NC TBI waiver programs

- Members enrolled in Community Alternatives Programs for Children (CAP/C) and Disabled Adults (CAP/DA)
- Members enrolled in long-term support services (LTSS)
- Family planning services
- Services covered by Medicare and Medicaid

A provider cannot refuse to provide services if a beneficiary cannot pay a copay at the time of service. If beneficiaries have any questions about Medicaid copays, they should call the NC Medicaid Contact Center 1-888-245-0179 or their Member Services line.

Medically necessary service

UnitedHealthcare Community Plan® only pays for medically necessary services.

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

North Carolina DHHS 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®. North Carolina DHHS makes disenrollment decisions, not UnitedHealthcare Community Plan®. Disenrollment usually takes effect at month's end, but at times 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/NC**. Go to UnitedHealthcare Community Plan®, then Member Information > Member handbook.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from Fee for Service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily. Get eligibility information by calling **Provider Services**.

Unborn enrollment changes

Encourage your members to notify the North Carolina DHHS when they know they are expecting. DHHS notifies us daily of an unborn when North Carolina Medicaid learns a member is expecting. UnitedHealthcare Community Plan® or you may use the online change report through the North Carolina website to report the baby's birth. With that information, DHHS verifies the birth through the mother. UnitedHealthcare Community Plan®'s and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify DHHS when the baby is born.

Members may call the Medicaid Contact Center at 1-888-245-0179.

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

Primary care provider selection

Although unborn children cannot be enrolled with us until birth, ask members to select and contact a PCP for their baby prior to delivery. This helps avoid the delays and confusion that can occur with deferred PCP selections.

UnitedHealthcare Community Plan® Members can go to **UHCprovider.com/findprovider** to look up a care provider.

Member eligibility

UnitedHealthcare Community Plan® serves members enrolled with North Carolina DHHS, North Carolina's Medicaid program. The DHHS determines program eligibility. An individual who becomes eligible for the North Carolina DHHS program either chooses or is assigned to 1 of the North Carolina DHHS-contracted health plans.

Member ID card

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

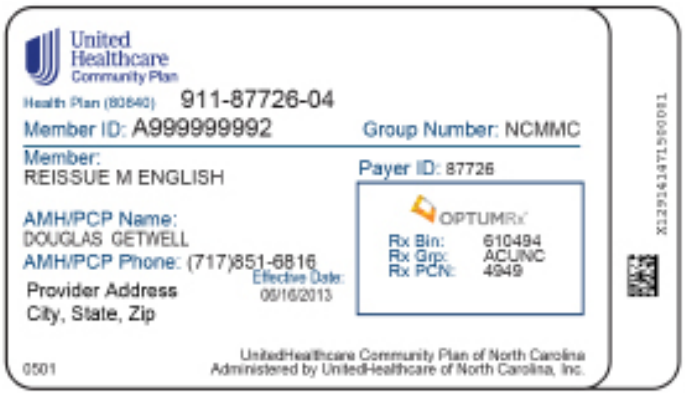
If a fraud, waste and abuse event arises from a care provider or a member, go to **uhc.com/fraud**. Or you may call the Fraud, waste, and abuse hotline.

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

Member identification numbers

Each member receives a North Carolina DHHS Medicaid member identification number. Use this number to communicate with UnitedHealthcare Community Plan® about a specific subscriber/member.

Sample health member ID card



Primary care provider - initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan® member if they can't start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

- To transfer the member, call the Member Services number on the back of the member's card, or mail with the specific events documentation. Documentation includes the dates 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
  3803 N Elm St
  Greensboro, NC 27455

- 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 PCP-member relationship.
- If the member and UnitedHealthcare Community Plan® cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
- If UnitedHealthcare Community Plan® cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose 1 for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- Access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7 a.m.–5 p.m. CT, Monday–Friday

Services not covered by UnitedHealthcare Community Plan

NCDHHS has defined services that will be carved out of Medicaid Managed Care and should continue to be billed through NCTracks. These are:

- Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
- Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
- Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
- Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program
- Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the contract
- Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

The following services are not included in our program:

- Any care covered by Medicaid but not through managed care
  - Fabrication of eyeglasses, eyeglass lenses, and ophthalmic frames

    Note: Obtain Medicaid FFS eyeglasses through the traditional NCDHHS process and bill UnitedHealthcare Community Plan®/March Vision for dispensing fees after you give the FFS eyeglasses to the member
  - Long-term care services in a nursing home
  - Intermediate care facilities for members with mental handicap
  - Home- and community-based waiver services
  - Dental services, except for emergency services. Prior authorization may be required
  - Residential inpatient hospice services

Care providers obtain Medicaid FFS eyeglasses through the traditional NCDHHS process and bill March Vision for the dispensing fees, after the FFS eyeglasses are dispensed to the member.

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**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For state-specific information, go to **UHCprovider.com/NC** > Medicare > **North Carolina Dual Complete Special Needs**.

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com/referrals	1-800-638-3302
Prior Authorization	UHCprovider.com/paan	1-800-638-3302
Pharmacy	professionals.optumrx.com	1-855-258-1593
Healthy First Steps	uhchealthyfirststeps.com	1-800-599-5985

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 needed
- The pickup point is inaccessible by land

Non-emergent air ambulance requires prior authorization.

For authorization, go to **UHCprovider.com/paan** 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 non-emergency 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.

Non-emergent ambulance transportation

UnitedHealthcare Community Plan® members may get non-emergent stretcher/ambulance transportation services (NEAT) through ModivCare for covered services. Members may get non-emergent ambulance transportation when they are bed-confined before, during and after transport.

To arrange member transportation for non-emergency ambulance trips, such as when a member is discharged from the hospital, call ModivCare at **1-855-397-3606.** Our discharge call agents will help ensure the trip meets UnitedHealthcare Community Plan® guidelines. ModivCare will coordinate the trip with a contracted transportation provider.

Non-emergency medical transportation

UnitedHealthcare Community Plan® members may get non-emergent medical transportation (NEMT) services through ModivCare for covered services. Covered transportation includes public transportation, taxis, van, wheelchair vans, mini-bus, mountain area transports, or other transportation systems and non-emergency ambulance transportation.

For non-urgent appointments, members must call **Member Services** at **1-800-349-1855** TTY **711** for transportation at least 2 days before their appointment.

We also have a mileage reimbursement program for qualifying members. It includes enrollment forms and trip logs so that pre-approved friends or family members can drive members to appointments and be reimbursed for the mileage. We use audits and controls to avoid fraud, waste, or abuse.

Value-added non-emergent transportation services include round-trip transportation for employment-related transportation for adult Temporary Assistance for Needy Families (TANF) members. This means members may get up to 3 round trips or 6 1-way ground trips per calendar year and up to 100 miles 1-way for in-state job interviews, certifications and licensure, job and career training, backup transportation to jobs and other employment-related activities.

Members must call **Member Services** at **1-800-349-1855** TTY **711** to request non-emergent transportation at least 2 business days in advance.

Nursing facility trips are only covered if the member is a new admit. If they are a current member (i.e., returning from the emergency department or a doctor's appointment), the facility is responsible to arrange and cover transportation.

Current nursing home residents are exempt from NEMT/NEAT because it is the facilities responsibility. All NEAT trips should be requested through Modivcare as outlined in the NEMT policy and all claims for NEAT trips should be submitted to Modivcare.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

- **Online – 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** > Specific cardiology programs.

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to help ensure care coordination services are provided to members. 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 the quality of care, quality of life and health outcomes of members
- Help members understand and take part in their care and stick to treatment plans, including medications and self-monitoring
- Lower unnecessary hospital admissions and ER visits
- Promote care coordination by working with care providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed diseases
- Support member empowerment and informed decision making

- Effectively manage their conditions, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, to members that address topics that help members manage their condition. The case manager works with the member to identify educational opportunities and monitors the member's progress toward managing the targeted condition.

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

Care management programs

We support the North Carolina philosophy of local care management delivered by a multidisciplinary care team for all members who need this help. Using a data-based approach, we identify members with the following needs for our programs:

- Long-term services and supports (LTSS)
- Special health care needs, including high-risk pregnant women and at-risk children
- High unmet resource needs related to social determinants of health
- Unusual utilization patterns
- Complex co-morbidities

Individual care providers and community organizations may refer members to any of the following care management programs. Members may also self-refer.

Advanced medical homes

The advanced medical home (AMH) model consists of care provider practices that offer primary care services as well as other sub-specialty services. AMH practices that are ready to take on the responsibility of care management are designated as Tier 3 practices. These practices may develop their own care management capabilities in-house. Or they may decide to partner with clinically integrated networks (CIN) to share responsibility for these functions. For AMH practices not yet ready to perform care management for members independently, we are responsible for care management for the members within those practices. All care management members will receive screening, assessment, individualized care planning, follow-up and transitional care assistance.

Long-term services and supports

The LTSS model has medical and non-medical programs that help members with chronic illnesses or disabilities maintain their health and remain in the home environment. We provide local care management for the vulnerable members who use LTSS and prioritize their engagement and outreach. We conduct comprehensive needs and health risk assessments for these LTSS members to help ensure gaps in care are addressed through patient-centered care plans. Transitional care is also part of the program.

Care management for at-risk children

We work closely with local health departments (LHDs) that provide specialized care management services for at-risk children. We identify at-risk children and these members are referred to LHDs for further care management.

Pregnancy Management Program and Case Management for High-Risk Pregnancy

The Pregnancy Management Program (PMP) and Case Management for High-Risk Pregnancy (CMHRP) are specialized maternity programs that help members who are:

- Pregnant
- Experiencing an uncomplicated pregnancy
- Dealing with other medical, behavioral and social risks

They help improve birth outcomes and lower neonatal intensive care unit (NICU) admissions by managing prenatal and post-partum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Pregnant Medicaid beneficiaries may also be referred to LHDs for care management when they have a high risk of a poor birth outcome. The care management model has education, support, linkages to other services. It also helps manage high-risk behavior and responds to social determinants of health that may

affect birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care through the end of the post-partum period.

See the Maternity section of this chapter for more care management programs available to pregnant members.

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

DME may be covered when all the following criteria are met:

1. Provides therapeutic benefit because of certain medical conditions and/or illnesses and
2. Prescribed by a licensed care provider

DME is not covered when it:

- Is used primarily for convenience or upgrades beyond what is necessary to meet the member's legitimate medical needs. Examples include decorative items, unique materials (e.g., magnesium wheelchairs wheels, lights, extra batteries);
- Does not provide a therapeutic benefit to a member
- Has not been prescribed by a licensed care provider
- Primarily serves as a comfort or convenience item. Trays, back packs, and wheelchair racing equipment are examples of non-covered or convenience items
- Is used in a facility expected to provide such items to the member
- Enhances the environmental setting (e.g., air conditioners, humidifiers, air filters, portable Jacuzzi pumps, or chair lifts)

For more information, visit medicaid.ncdhhs.gov.

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

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan® covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

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

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

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed.

Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

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

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

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

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

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

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-800-638-3302.**

Emergency care resulting in admissions

Prior authorization is not required for emergency services.Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan® about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-800-638-3302**.

UnitedHealthcare Community Plan® makes UM determinations based on appropriateness of care and benefit coverage 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** at **1-800-638-3302.**

The criteria are available in writing upon request or by calling **Provider Services** at **1-800-638-3302.**

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

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

Facility admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided before 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

Family planning

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

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

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

View the DHHS Regulations for more information on Family Planning Services.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not
  - Morning-after pill. Contact the state of North Carolina to verify state coverage.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHHS Regulations for more information on sterilization.

Hearing services

Hearing aids

Hearing aids are covered for children younger than 21. Coverage includes the fitting, follow-up care, batteries, accessories (ear molds, care kits, FM systems), and repairs.

Cochlear and auditory brain stem implants

Cochlear and auditory implants are covered for children and adults. Coverage includes parts, accessories, batteries and repairs.

Implantable bone anchored and soft band hearing aids

Implantable bone anchored hearing aids and soft band bone conduction hearing aids are covered. Age criteria may vary. Coverage includes parts, accessories, batteries and repairs.

Note: Only the device manufacturers are enrolled providers for auditory implant parts.

For more information about auditory implant external parts, see the DHHS regulations at ncdhhs.gov.

Prior approval and regulations

Some hearing devices and services may require prior approval. Visit **UHCprovider.com/priorauth** to see current prior authorization requirements.

Hospice

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

Home hospice

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

Respite hospice

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

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.

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

Laboratory

Labcorp and Quest Diagnostics are nationally contracted lab providers. Contact Labcorp or Quest Diagnostics 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 a PCP, other care providers or dentist in 1 of these laboratories do not require prior authorization except as noted on our prior authorization list.

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

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

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

Maternity/pregnancy/ well-child care

Pregnancy notification form

Notify UnitedHealthcare Community Plan® immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Maternal and Child Health program. This helps ensure appropriate follow-up and coordination by maternal and child health team. Pregnancy notification forms can be found at **UHCprovider.com** within the Provider Portal. In addition, see the pregnancy risk screening form section below for details on submitting the required pregnancy risk screening form. If you have questions regarding case management, call the county local public health office.

Healthy First Steps (HFS)-Maternal care model

The maternity program strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it

- Give multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs
- Program staff act as a liaison between members, care providers, and UnitedHealthcare Community Plan® for care coordination

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days regardless of whether the antepartum care was provided prior to a member enrolling in the UnitedHealthcare Community Plan®.

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 prior authorization maternity care, including out-of-plan and continuity of care, call Provider Services or go to or go to **UHCprovider.com/paan**. For more information about prior authorization requirements, go to **UHCprovider.com/NCcommunityplan > 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 woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan® member, and
2. If she has an established relationship with a non-participating obstetrician.

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

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

Local Health Department – Care Management For High-Risk Pregnancy

Local Health Departments (LHDs) provide Care Management For High-Risk Pregnancy (CMHRP) to pregnant Medicaid beneficiaries identified as high risk of a poor birth outcome. The care management model involves education, support, links to other services, high risk behavior management and response to social determinants of health that may affect birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care and services through the end of the post-partum period.

Referrals to Care Management For High-Risk Pregnancy

- Complete the NC Pregnancy Risk Screen for each Medicaid member at the first prenatal visit and with any change in risk during subsequent prenatal visits. Fax the pregnancy risk screen to the LHD where the member resides. If there is not a CMHRP program in the member's county, fax the form to 1-844-897-2462.
- Work with the LHD case manager on care plan/ treatment plan development
- Help ensure a post-partum visit occurs within 56 days of delivery

Pregnancy risk screening form

NC Pregnancy Risk Screening form must be completed at the first prenatal visit with recommendations to complete additional screenings at 28 and 36 weeks gestation. Complete the North Carolina Pregnancy Risk Screening Form found here and fax it to the LHD

in county where the member resides. If there is not a CMHRP program in the member's county, fax the form to 1-844-897-2462.

Continuation of care

UnitedHealthcare Community Plan® allows pregnant members to get services from their behavioral health care provider, without prior authorization, until:

- The birth of the child
- The cessation of pregnancy
- Loss of eligibility

Maternity admissions

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

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

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

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

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires notification and will be subject to medical necessity review. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

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

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

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

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

Post maternity care

UnitedHealthcare Community Plan® covers post-discharge care to the mother and her newborn. A home visit for postnatal assessment and follow-up care must be a one-to-one, face-to-face visit conducted in the client's home. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. Providers are encouraged to render services as close to delivery as possible. Prior authorization is required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital is responsible for telling the county of all deliveries, including UnitedHealthcare Community Plan® members. The hospital provides required birth data during admission.

Bright Futures Assessment

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

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

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

Settings for Bright Futures implementation include:

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

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

Home care and all prior authorization services

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

Women, Infants and Children program

Women, Infants and Children (WIC) is the special supplemental nutrition program for women, infants, and children funded by the United States Department of Agriculture. County health departments, community and RHC, and community action agencies provide WIC services. Help ensure all pregnant women and children younger than 5 years of age are referred to WIC. For more information or to find the WIC Program in your county, go to ncdhhs.gov/ncwic.

Hysterectomies

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

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

Find the form on the North Carolina Medicaid Division of Health Benefits medicaid.ncdhhs.gov.

See “Sterilization consent form” section on next page for more information. Exception: North Carolina DHHS does not require informed consent if:

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

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

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member's PCP. Members must use our care 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 State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

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

Sterilization informed consent

A member has only given informed consent if the NCDHHS 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

Use the consent form for sterilization:

- **Complete all applicable sections of the form** before submitting it with the billing form. The North Carolina Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Complete your statement section after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on the North Carolina Medicaid Division of Health Benefits website at medicaid.ncdhhs.gov.

Have 3 copies of the consent form:

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

Neonatal intensive care unit case management

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

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

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

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-855-202-0992** to reach a nurse.

Pharmacy

Pharmacy Preferred Drug List

The North Carolina Division of Health Benefits (DHB) determines and maintains its Preferred Drug List (PDL). This list applies to all UnitedHealthcare Community Plan® of North Carolina members. The PDL is not a complete formulary or listing of every outpatient drug or drug class that Medicaid covers. Prescribers are encouraged to write prescriptions for preferred products; however, prescribers are not restricted to PDL drugs only. For drugs not on the PDL, North Carolina law states that the DHB may not cover a brand-name drug if an equally effective generic drug is available and is less costly unless prior authorization is followed. The same applies to UnitedHealthcare Community Plan® of North Carolina members.

If a member's condition requires a non-preferred medication, call Pharmacy Provider Services at **1-855-258-1593,** or use the Prior Authorization and Notification tool on the Provider Portal. Or mail your form to:

OptumRx
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799

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

Pharmacy prior authorization

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

To request pharmacy prior authorization, call the Pharmacy Service Line at **1-855-258-1593** Optum RX. 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. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

Pharmacy claims processing

1. Refer to the **OptumRx Pharmacy Provider Manual** and payer specification documents for complete claims submission requirements and guidelines, including NCPDP format.

2. Pharmacies must submit a 340B pharmacy claim by submitting the actual acquisition cost (AAC) and submitting the Cost Basis (423-DN) field (value 08) and the Submission Clarification Code (420-DK) field (value 20). Claims may be rejected if the claim is submitted without Cost Basis value 08 (423-DN).

Personal care services and home health

UnitedHealthcare Community Plan® of North Carolina may cover:

- PCS
- Home health care, including therapy, private duty nursing (PDN), skilled nursing and DME for eligible members in the home or community living settings
- PCS and home health fall under HCBSu

For information for HCBS providers, please reference our Introduction to HCBS and Long-Term Services and Support (LTSS) guide at **UHCprovider.com/NCcommunityplan** > **Education and Training**.

PCS services require prior authorization. For information on this prior authorization process, view the North Carolina Community Plan Personal Care Services (PCS) Prior Authorization Provider Training at **UHCprovider.com/NCcommunityplan** > **Education and Training**.

Quit for Life

The Quit For Life® Program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. There are also additional supports within this program for individuals with co-occurring behavioral health conditions.

Using a mix of medication support, phone-based coaching, and web-based learning tools, the Quit For Life Program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% member satisfaction. Quit for Life is for members 18 years and older.

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.

- Certain computed tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA) and positron emission tomography (PET) scans
- Nuclear medicine and nuclear cardiology procedures.

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- **Online** – **UHCprovider.com/radiology** > Sign In

Phone – **1-866-889-8054** from 8 a.m.–5 p.m. CT, 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** > Specific Radiology Programs.

Screening, brief interventions, and referral to treatment services

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

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

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 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 s 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 of the following are met:

- The billing and servicing providers are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per 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 DHHS Evaluation and Services at cms.gov > Medicare > Payment > Fee schedules > Physician Fee Schedule > Evaluation & Management Visits > Evaluation and Management Services MLN Publication > Evaluation and Management Services-Updated 08/29/2023.

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**.

To find a medical MAT care provider in North Carolina:

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

If you have questions about MAT, please call **1-877-842-3210**, enter your TIN then say "Representative," and "Representative" a second time, then "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. We cover services provided through telemedicine in an amount, duration and scope no less than what is available to beneficiaries under the Medicaid FFS program.

We consider for reimbursement telehealth services CMS recognizes. We also consider those appended with modifiers GT or GQ as well as services the AMA recognizes included in Appendix P of CPT and appended with modifier 95. We require 1 of these modifiers to be reported when performing a service through telehealth to indicate the type of technology used and to identify the service as telehealth.

UnitedHealthcare Community Plan® reimburses for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

For more information, such as eligible sites and practitioners, please see the UnitedHealthcare Community Plan® Telehealth and Telemedicine Policy on **UHCprovider.com/policies** > For Community Plans > **Telehealth/Virtual Health Policy, Professional**.

Tuberculosis screening and treatment; direct observation therapy

Guidelines for Tuberculosis (TB) and direct observation therapy (DOT) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all 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 LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

Vision services are covered by March Vision Care. Please see the Reference Guide at marchvisioncare.com for information such as compliance, electronic payment information, safety resources and training or call 1-844-736-2724.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering health care professional name and TIN/NPI
- Rendering health care professional and TIN/NPI
- ICD clinical modification (CM.
- Anticipated dates of service
- Type of service (primary and secondary) procedure codes 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 UnitedHealthcare Behavioral Health.

If you have questions, please use the Provider Portal or go to your state's prior authorization page at **UHCprovider.com/NCcommunityplan > Prior Authorization and Notification Resources.**

The following table lists medical management notification requests and the amounts of time required for a decision.

Type of Request	Decision TAT
Non-urgent Pre-service	As quickly as the member's condition requires but no longer than 14 calendar days of request receipt
Urgent/Expedited Pre-service	Within 72 hours of request receipt
Concurrent Review	Within 24 hours or next business day following
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information

Concurrent review guidelines

UnitedHealthcare Community Plan® requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities. We perform a record review 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 an admission to inpatient level of care and a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

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

Your cooperation is required with all UnitedHealthcare Community Plan® requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our 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 (formerly MCG), CMS, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those needed to:

- Prevent, diagnose, treat 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 a condition from getting worse
- 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. No other equally effective, more conservative or substantially less costly treatment is available to the member.

Experimental treatments are not medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

Project Extensions for Community Healthcare Outcomes

Project Extensions for Community Healthcare Outcomes (ECHO®) increases specialty treatment access in rural and underserved geographical areas. It provides front-line clinicians with knowledge and support to manage members with complex conditions. Complex conditions include cardiology, chronic lung disease, pathology, endocrinology, hepatitis C, psychiatry and addictions. By connecting clinicians with medical center specialist teams in weekly virtual clinics or teleECHO™ clinics, rural area PCPs, nurses and other clinicians learn to provide specialty care in their own communities. We provide a stipend to North Carolina care providers who participate in Project ECHO trainings.

Referral guidelines

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

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

- Continuity of care issues
- Necessary services not available in our 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 on **UHCprovider.com**, contacting our Provider Services department, or the North Carolina Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan® has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan® will not reimburse:

- Services UnitedHealthcare Community Plan® decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the dates of service

Second opinion benefit

If a 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 NCDHHS. 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 PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan® will arrange for a consultation with a non-participating provider. The participating provider should call UnitedHealthcare Community Plan® at **1-800-638-3302**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services requiring prior authorization

For a list of services that require prior authorization, the Prior Authorization and Notification section at **UHCprovider.com/NCcommunityplan**.

Seek prior authorization within the following time frames

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

Utilization management guidelines

Call **1-800-638-3302** to discuss the guidelines and 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 PCPs and specialists on a FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan® network on a 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. See Appeals in **Chapter 12** for more details.

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

Key contacts

Topic	Link	Phone Number
EPSDT	medicaid.ncdhhs.gov	1-888-245-0179
Vaccines for Children	immunize.nc.gov/family/nc_immnz_program.htm	

Medicaid offers children and youth younger than age 21 a comprehensive benefit for preventive health care and medical treatment. UnitedHealthcare Community Plan® care providers offer or arrange for the full range of preventive and treatment services available within the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. We offer preventive (wellness) services without copays or other charges on a periodic schedule established by the state of North Carolina.

Early periodic screening services include physical exams, up-to-date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices. When treatment is medically necessary to correct or improve health problems, you must provide the treatment directly or arrange a referral, even when a Medicaid-covered service is not available under the state Medicaid plan.

Our pediatric primary care goal is to improve the health of Medicaid members from birth to age 21 by increasing participation in comprehensive early periodic screening (wellness) visits. When conducting early periodic screenings, you must adhere to best practice guidelines published by the American Academy of Pediatrics (AAP) in their Bright Futures publication.

For complete details about diagnoses codes as well as full and partial screening, exam, and immunization requirements, go to the EPSDT schedule.

To find more information about the periodicity schedule, go to:

NCDHHS Wellness Visits, and Diagnostic and Treatment Services
medicaid.ncdhhs.gov

Medicaid Benefit for Children and Adolescents Younger Than Age 21
medicaid.ncdhhs.gov

NCDHHS EPSDT State Instructions (Policy)
files.nc.gov

Health Check Early Prevention Screening Program Guide
nctracks.nc.gov

Bright Futures Periodicity Schedule (Form)
aap.org

Coding for Pediatric Preventive Care (Bright Futures)
aap.org

Development disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These include intellectual disabilities, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment. The Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months through adulthood.

Referral – If you think supportive services would benefit the member, refer the member to DDS for approval and assignment of a regional center case manager. That person schedules an intake assessment. The Regional Center Interdisciplinary Team then determines eligibility. While the regional center (RC) does not

provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the life of a member with a developmental disability.

Continuity of Care – The RC determines the most appropriate setting for eligible home- and community-based services (HCBS). They work with the PCP and health plan coordinator to coordinate services. The care coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not available, we continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

Early and Periodic Screening, Diagnostic, and Treatment/ prevention criteria

If a service is not covered under the North Carolina Medicaid state plan, it can be covered for recipients younger than age 21 if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met. When a Medicaid-covered beneficiary younger than age 21 requires a medically necessary service not listed in the state plan, the beneficiary, or their legally responsible representative, should contact their health plan by calling the number on their health plan member ID card so this service can be appropriately delivered and coordinated.

The EPSDT service is covered only if it meets all the following criteria:

1. Within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in clinical policies or service definitions.
2. Medically necessary to correct or ameliorate a defect, physical or mental illness, or a health problem diagnosed by the member's physician, therapist, or other licensed practitioner.
3. Medical in nature.
4. Safe and effective.
5. Generally recognized as an accepted method of medical practice or treatment.
6. Not experimental/investigational.

Services are covered if they are provided by a North Carolina Medicaid-enrolled care provider for the specific service type. This may include an out-of-state care provider who is willing to enroll if an in-state care provider is not available.

For any member younger than age 21, the EPSDT federal regulations are applied and medical necessity decisions are made on a case-by-case basis, depending on the member's individual situation (physical, behavioral, psychosocial, environmental). Each service request that does not meet approval criteria will be evaluated for the EPSDT population.

Comprehensive well-child exams

UnitedHealthcare Community Plan® requires you and other appropriate child health care providers to comply with all EPSDT services and screens based on the AAP/ Bright Futures periodicity schedule. This includes:

- **Routine physical examinations.** Use as recommended and updated by the AAP Guidelines for Health Supervision III and described in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. This includes:
  - Screening for developmental delay at each visit through the fifth year
  - Screening for autistic spectrum disorders
  - Complete, unclothed physical examination
  - All appropriate immunizations based on the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
  - Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations. Health education and anticipatory guidance for both the child and caregiver.
- **Comprehensive health and developmental history.** The assessment helps determine whether a child's developmental progress falls within a normal range of achievement based on age and cultural background. Screening for developmental assessment is done at each EPSDT visit. Refer children to the Early Intervention Program as appropriate.
- **Appropriate immunizations.** The EPSDT program requires all Medicaid child and adolescent members receive all immunizations, based on the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. Find the ACIP guidelines at cdc.gov.

Full screening

Perform a full screen. Include:

- Comprehensive health and developmental history that assesses for physical and mental health, and substance use disorders
- Comprehensive, unclothed physical examination
- Appropriate immunizations, according to the pediatric vaccines schedule established by the Advisory Committee on Immunization Practices
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for the child and caregiver

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

For a complete listing of support and services available through the Infant-Toddler Program (ITP), go to beearly.nc.gov.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded services. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Interperiodic screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part in school athletics. This also applies for other school physicals when required as conditions for educational purposes.

Preventive screenings

Preventive screenings may include anemia testing, lead toxicity, cholesterol levels, hearing, vision, and other diagnostic testing. Provide tuberculin skin testing as appropriate to age and risk.

Early hearing detection and intervention program

As part of the state Title V Maternal and Child Health Services Program, you must complete the following hearing screenings:

- Hearing screening by 1 month of age
- Diagnostic evaluation by 3 months of age
- Intervention by 6 months of age

Find more information at ncdhhs.gov.

Newborn screening program

State law (GS 130A-125) requires a filter paper blood spot sample be submitted to the North Carolina State Laboratory of Public Health for each infant born in North Carolina. Help ensure all newborns complete this testing. Find more information at slph.ncpublichealth.com.

North Carolina Childhood Lead Poisoning Prevention Program

Screen all children and pregnant women for lead exposure. The Childhood Lead Poisoning Prevention Program (CLPPP) provides a Lead and Pregnancy Risk Assessment Questionnaire. It also offers a Childhood Lead Poisoning Prevention Checklist to helps ensure compliance with required screening and testing. Find more information at ehs.ncpublichealth.com.

Sexual Assault Findings Examination and Child Abuse Resource Education Examinations

Medicaid covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) Examinations. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through North Carolina Medicaid on a fee-for-service basis. Information on SAFE-CARE examinations is on medicaid.ncdhhs.gov. Call North Carolina Medicaid for more information.

Case management for at-risk children ages 0-5 years

Medicaid offers targeted care management services for at-risk children (CMARC) birth to 5 years old. The program coordinates services between health care providers, community programs and family support programs.

Referral Criteria – CMARC will accept referrals for children with the following needs:

- Special health care
- Exposed to severe stress, including:
  - Extreme poverty along with ongoing family chaos
  - Recurrent physical or emotional abuse
  - Chronic neglect
  - Severe and enduring maternal depression
  - Persistent parental substance use
  - Repeated exposure to community or familyviolence
  - In NICU needing help going back to community/ medical home care

Referral – Refer members eligible for CMARC services to the appropriate LHD.

Continuity of Care – UnitedHealthcare Community Plan® will coordinate the member's health care with the LHD/CMARC and their member's PCP. This helps determine the medical necessity of recommended diagnostic and treatment services recommended and coverage.

Vaccines for Children program

You are strongly encouraged to participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, younger than 19 years, who might not otherwise be vaccinated because of an inability to pay. The Centers for Disease Control and Prevention purchases vaccines at a discounted rate and distributes them to grantees, who in turn, distributes them to VFC enrolled public and private health care providers. The North Carolina Immunization Branch in the Division of Public Health is the state's VFC awardee.

Because VFC vaccines are federally purchased, enrolled care providers cannot bill for the cost of the vaccine. However, you may bill for vaccine administration fees. VFC care providers must maintain adequate stock of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), as appropriate for their specific patient population. Non-VFC enrolled care providers choosing to use private stock to vaccinate Medicaid-covered children will not be reimbursed for the cost of the vaccine. For more information visit immunize.nc.gov, or contact the NC Immunization Branch at 1-919-707-5598 to begin the VFC enrollment process.

You must report all immunizations administered to the North Carolina Immunization Registry (NCIR) at immunize.nc.gov.

To request access, contact the NC Immunization Branch at 1-877-873-6247.

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	**1-800-638-3302**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value Add Services (to view plan details)	**UHCcommunityplan.com/NC**	**1-800-638-3302**

In addition to covered benefits, UnitedHealthcare Community Plan® offers additional benefits to eligible members. If you have questions or need to refer a member, call **Provider Services** at **1-800-638-3302** unless otherwise noted. The member may also check eligibility by contacting **Member Services** at **1-800-349-1855** TTY **711.**

Acute home-delivered meals

Eligible members will have access to 14 prepared home-delivered meals after discharge from an acute inpatient hospital stay back into the community setting.

Alternative healing benefit

We provide a $100 annual reimbursement for alternative healing for purchases and services. This includes herbal medications and remedies, therapeutic massage, acupuncture, vitamins, and minerals. As with use for any over-the-counter medications, members should check with their care providers before use.

Assistance for asthmatics

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

Hypoallergenic bedding is limited to individuals with asthma in case management. The member's care manager will determine eligibility for a hypoallergenic mattress cover and pillowcase.

Breast pumps

Medicaid members not participating in the WIC program may receive manual, electronic or hospital-grade breast pumps. Members must be at least 36 weeks pregnant.

GED exam voucher

Eligible members receive a GED exam voucher ($160 value), preparation materials and testing support.

Babyscripts

Babyscripts® provides extra support and rewards to keep mom and baby healthy. Babyscripts is an application-based tool that provides education, resources, updates and reminders related to prenatal, postpartum and early infant care. Additionally, members can receive rewards for completing prenatal and postpartum appointments.

Babyscripts is available to pregnant UnitedHealthcare Community Plan® members.

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

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

How You Can Help

1. Identify UnitedHealthcare Community Plan® members during prenatal visits.
2. Share the information with the member to talk about the program.
3. Encourage the member to enroll at Healthy First Steps Rewards.

Healthy Weight and Your Child

Healthy Weight and Your Child is a childhood obesity program that helps create a healthier environment and behaviors in the home. Through a group intervention model, the child and caregiver learn healthy eating and exercise habits. Healthy Weight and Your Child is for members ages 6-17. Call Provider Services for more information.

My HealthLine (cellphone program)

My HealthLine, our free cellphone program, helps us more closely connect with our members. This is particularly important for high-risk members who need support for their overall health, wellness and access to care. Members can quickly and easily reach us to discuss health-related concerns or to locate a PCP. Our care managers make outbound calls to coordinate care and follow up on important activities to improve a member's health.

This Federal Lifeline program provides the cellphones. Our members who meet federal eligibility requirements receive 350 voice minutes per month and unlimited texting, plus a pre-programmed member services number that does not count against the minutes. They are also automatically enrolled in the Connect4health texting program.

On My Way

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

UnitedHealthcare Doctor Chat—virtual visits

Members will have access to UnitedHealthcare Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

Youth club membership

We provide up to $75 for membership dues to the Boys and Girls Club programs and YMCA youth club programs, for qualified members younger than age 19.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	**providerexpress.com**	**1-800-888-2998**
Provider Services	**UHCprovider.com**	**1-800-638-3302**

United Behavioral Health, operating under the brand Optum, administers mental health and substance use disorder (SUD) benefits for UnitedHealthcare Community Plan® members. The Optum National Network Manual is the source of truth for current information for care providers who offer behavioral health and substance use disorder services.

The Optum National Network Manual is located on **providerexpress.com**.

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

This manual will direct you to the Optum National Network Manual for additional information, as appropriate. The Optum National Network Manual controls when there are differences between this manual and the Optum National Network Manual.

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

To request an ID number, go to the NCDHHS website at medicaid.ncdhhs.gov. Click on "Providers," then "Provider Enrollment."

How to join our network

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

Covered services

UnitedHealthcare Community Plan® offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in 1 place.

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

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

Provider Express has resources for behavioral and medical care providers. The **Provider Express Recovery and Resiliency** page includes tools to help members addressing mental health and substance use issues. The **Behavioral Health Toolkit** includes screening tools and other resources.

Benefits include:

- Mobile crisis management
- Medically supervised or ADATC detox crisis stabilization
- Inpatient psychiatric hospital (acute)
- Outpatient assessment and treatment:
  - Medication management
  - Outpatient therapy (individual, family, or group)
  - Psychological evaluation and testing
  - Diagnostic Assessments
  - Partial hospitalization for MH
  - Substance Use Disorder Services
  - Ambulatory detoxification
  - *Ambulatory Withdrawal Management with Extended On-Site Monitoring
  - Non-hospital medical detoxification
  - *Clinically Managed Residential Withdrawal Management Services
  - Opioid Treatment Program
  - Substance Abuse Intensive Outpatient Program (SAIOP)
  - Substance Abuse Comprehensive Treatment (SACOT)
  - Research Based-Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder (ASD)
  - Electroconvulsive therapy
  - Telemental health/virtual visits

*Awaiting state finalization

The following are available in lieu of services:

- Behavioral Health Urgent Care (BHUC): An alternative to hospital ER services, this helps members with urgent behavioral health crisis needs see behavioral health professionals faster.
- Institutions for Mental Disease (IMD) for acute psychiatric care: We offer members more choices for places to receive acute mental health hospitalization, so we are covering placement in freestanding psychiatric centers.

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.

Prior authorization

Members may access all routine behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as partial hospitalization or inpatient care. Help ensure prior authorizations are in place before rendering non-emergent services. Submit prior authorization requests using the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com/paan**, or calling **1-877-614-0484**.

Collaboration with other care providers

Coordination of care

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

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

Talk to members about the benefits of sharing essential clinical information.

Substance use disorder recovery coaching

Our substance use disorder (SUD) recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery. Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral.

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**

Update your practice information, review guidelines and policies, and view the Optum National Network Manual. Or call **United Behavioral Health Provider Services** at **1-877-614-0484**.

Claims

Submit claims using the 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.

Training resources and materials

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

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

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 solutions for pregnant members and their children** Prevent neonatal abstinence syndrome and supporting birth parents in recovery
- **Enhanced data infrastructure and analytics**
  Identify needs early and measure progress

Increasing education and awareness of opioids

You must be up to date on the cutting-edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on the portal to help ensure you have the information you need, when you need it. For example, state-specific behavioral health toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resource.

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

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-Prescriber Home program

The Pharmacy-Prescriber Home program helps ensure eligible members use services appropriately. Members are identified based on N.C. Gen. Stat. § 108A-68.2 using pharmacy and medical claims data. Enrolled members must receive state-defined covered substances from 1 prescriber and 1 pharmacy

within the PHP network. A covered substance is identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics.

When a member is enrolled in the program, they are sent a written notification that certain substances will be limited. If the member would like to use different care providers, they can call Member Services. After enrollment begins, the member may request a network provider change for a good cause reason as long as both the member and the health plan agree. All enrolled members will be provided care coordination.

The member does have appeal rights that are outlined in the notification letter and the Member Handbook. Provisions allow a 1-time, 4-day emergency supply per year for medications available at a pharmacy or written by a prescriber other than 1 of the member's lock-in providers.

To refer a member to the Pharmacy- Prescriber Home program, please include member name, member ID, member demographics and an explanation for your referral.

Fax your request to 1-844-228-5276.

Email your request to **uhpcs_pharmacy_lockin@uhc.com.**

Call **Provider Services** at **1-800-638-3302.**

Expanding medication assisted treatment access and capacity

Evidence-based 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.

To find a behavioral MAT provider in North Carolina:

1. Go to **UHCprovider.com**.
2. Select "Our Network," then "Find a Provider." Click on "Locate Providers: Mental Health or Substance Abuse Services."
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & 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.

For more information, go to **providerexpress.com**.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	**UHCCommunityPlan.com/NC**	1-800-349-1855
Member handbook	**UHCCommunityPlan.com/NC** > Community Plan > Member benefits	1-800-349-1855

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

Privacy regulations

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

Access to protected health information

Members may access their medical records or billing 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 Personal Health Information

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

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 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 rights and responsibilities

The following information is in the Member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com**.

Native American access to care

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

Member rights and responsibilities

Your rights

As a member of UnitedHealthcare Community Plan® of North Carolina, you have a right to:

- Receive information about the organization, its services, its practitioners and providers
- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told what services are available to you
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan® of North Carolina
- Be told by your PCP what your options are when getting services so you or your guardian can make an informed choice
- Be told by your PCP what health issues you may have, what can be done for you and what will likely be the result, in a way you understand regardless of cost or coverage. This includes additional languages.
- Get a second opinion about your care
- Give your approval of any treatment
- Give your approval of any plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record and talk about it with your PCP
- Ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract or with your approval
- Make suggestions about our member rights and responsibilities policies
- Use the UnitedHealthcare Community Plan® of North Carolina complaint process to settle complaints. You can also contact the NC Medicaid Ombudsman anytime you feel you were not fairly treated.
- Use the state fair hearing (SFH) system
- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment
- Receive considerate and respectful care in a clean and safe environment, free from any form of restraint or seclusion used as means of coercion, discipline, convenience or retaliation

Your responsibilities

As a member of UnitedHealthcare Community Plan® of North Carolina, you agree to:

- Work with your PCP to protect and improve your health
- Participate with practitioners in making decisions about your health care
- Find out how your health plan coverage works
- Listen to your PCP's advice and ask questions if you do not understand your rights or plan of treatment and be able to participate in developing health goals
- Call or go back to your PCP if you do not get better or ask for a second opinion
- Treat health care staff with the respect
- Tell us if you have problems with any health care staff by calling Member Services at 1-800-349-1855 TTY **711**
- Tell your PCP and Member Services Advocate or Care Manager about your health and changes in your health
- Keep your appointments. If you must cancel, call as soon as you can
- Use the emergency department only for emergencies
- Call your PCP when you need medical care, even if it is after hours

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:

- Supply information (to the extent possible) to UnitedHealthcare Community Plan® and to you that is needed for you to provide care
- Follow care to which they have agreed
- 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 accurate, timely and complete medical records, in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. – Release only to entities as designated consistent with federal requirements – Keep in a secure area accessible only to authorized personnel
Procedural Elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

Topic	Contact
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) – **Chief complaint*** – **Physical assessment*** – **Diagnosis*** – **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to help ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis – Timeframe for follow-up visit as appropriate – Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

***Critical element**

Member copies

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

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or notate member does not want 1
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

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

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	NCDHHS: nctracks.nc.gov Medical: Network management support team Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Chiropractic: **myoptumhealthphysicalhealth.com**	**1-800-688-6696**
Fraud, Waste and Abuse (Payment Integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

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

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of providers that meets adequacy standards
- Striving for improvement of member health care and services through performance improvement procedures
- Monitoring and enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

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

Cooperation with quality-improvement activities

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

- Providing requested timely medical records
- Cooperating with quality-of-care incedent investigations. For example, responding to questions and/or completing quality-improvement action plans
- Taking part in quality audits, such as site visits and medical record standards reviews. You must also take 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 do so during site visits, by email or secure email.
- Completing appointment access and availability surveys
- Allowing the plan to use your performance data
- Offering Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Care provider satisfaction

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

- Annual care provider satisfaction surveys
- Regular visits

- Town hall meetings

Our main concern with the survey is objectivity. That's why we engage independent market research firm Escalent to analyze and report findings.

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

Clinical practice guidelines

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

Credentialing standards

To join the UnitedHealthcare Community Plan® network, you must register and enroll with the Department as a North Carolina Medicaid care provider. This includes provider disclosure, screening and enrollment requirements.

The Provider Enrollment Online Application is a user-friendly online application that gathers all the information needed to enroll you or your organization as a licensed Medicaid provider in North Carolina.

Credentialing and recredentialing process

Per these credentialing standards, you must go through the Department's credentialing and recredentialing process before you may treat our members.

We accept care provider credentialing and verified information from NCDHHS or a designated NCDHHS vendor. We will not request more credentialing information from you without NCDHHS's written prior approval. We are not prohibited from collecting other information from you necessary for contracting processes.

NCDHHS is in the transition period of establishing a centralized credentialing process, including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the NCQA, to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency. Until the CVO model is in place, NCTracks should be used as the credentialing source.

It is the provider's obligation to complete reenrollment/recredentialing before contract renewal and in accordance with the following:

1. At least every 5 years during the provider credentialing transition period.
2. At least every 3 years during the provider credentialing under full implementation period, except as otherwise permitted by the Department

In addition, we will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File.

Care providers subject to credentialing and recredentialing

NCDHHS evaluates the following practitioners:

- M.D. (Doctors of Medicine)
- D.O. (Doctors of Osteopathy)
- D.D.S. (Doctors of Dental Surgery)
- D.M.D. (Doctors of Dental Medicine)
- D.P.M. (Doctors of Podiatric Surgery)
- D.C. (Doctors of Chiropractic)
- C.N.M. (Certified Nurse Midwives)
- C.R.N.P. (Certified Nurse Practitioners)
- P.N.P (Psychiatric Nurse Practitioner)
- P.A. (Physician Assistants)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Organizational providers (e.g., hospitals, home health agencies, SNFs, ambulatory surgery centers, long-term services and supports providers) are also subject to applicable requirements.

ALL providers must be enrolled and credentialed in NC Medicaid through the department, or department's designated vendor, prior to contracting with the health plans and/or providing services to members.

Excluded from this process are those who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or

- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan® care provider

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements, as defined by NCDHHS. The credentialing process is managed by the Department's credentialing repository, NC Tracks.

The enrollment application is completed online by the NCTracks provider portal. To login to the provider portal you will need a NCID. Reference the "Getting Started" page of the portal for additional information.

Peer review

Recredentialing process

You must complete the Department's re-credentialing/re-verification process every 5 years through NC Tracks to help ensure your provider information is accurate and current. As part of this process, credentials and qualifications will be evaluated to help ensure they meet the professional requirements and are in good standing.

You will receive a re-credentialing/re-verification letter, or an invitation by NCTracks secure portal inbox or email, when scheduled to begin the recredentialing process.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. For instructions on submitting a Manage Change Request (MCR), contact the NCTracks Call Center at 1-800-688-6696. Providers will need to submit an MCR through the Provider Portal in NCTracks. Providers cannot submit an MCR over the phone by contacting the NCTracks Call Center. All providers must be enrolled and credentialed in NC Medicaid through the department., or department's designated vendor, prior to contracting with the health plans and/or providing services to members. If you have any questions regarding completion of the Provider Enrollment Online Application, please contact the CSRA Call Center by phone at **1-800-688-6696**, at 1-855-710-1965, or email at NCTracksprovider@nctracks.com.

Confidentiality

The credentialing/recredentialing process and the information obtained through it is confidential. All individuals with file access are responsible to assure that all credentialing/recredentialing information remains confidential, except as otherwise provided by law.

UnitedHealthcare Community Plan® is prohibited from using, disclosing or sharing your credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of you and the NCDHHS.

Medicaid-enrolled provider

You must be enrolled with the Department as a North Carolina Medicaid care provider, consistent with applicable provider disclosure, screening and enrollment requirements.

Health Insurance Portability and Accountability Act compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

- Oversight of the Ethics and Integrity program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by educating employees
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity

program staff to violations of law, regulations, policies and procedures, or contractual obligations

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

Reporting and auditing

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, callour Fraud, waste, and abuse hotline, or go to **uhc.com/fraud**.

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

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan® will work with the state of North Carolina 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 North Carolina Department of Health and Human Services.

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 North Carolina 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 North Carolina program standards.

You must cooperate with the state or any of its authorized representatives, the North Carolina Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan® and affiliates monitor complaints for quality of care (QOC) and services 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 PCP office sites to help ensure facility quality.

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

- Clean and orderly overall appearance.
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam rooms for providing member care
- Privacy in exam rooms
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

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

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

Chapter 11: Billing and submission

Key contacts

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

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

Claims process from submission to payment

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

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

National Provider Identifier

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

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan®, call **Provider Services**. Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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

Modifier codes

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

Member ID card for billing

The member ID card shows the UnitedHealthcare Community Plan® member ID. UnitedHealthcare Community Plan® prefers you bill with the member ID.

Acceptable claim forms

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

Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

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

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan® member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed
- Submit claims for all services by 180 days from the date of service for dates of service prior to 07/01/2023. Submit claims for all services by 365 days from the date of service for dates of service on or after 07/01/2023. Otherwise, we deny the claim for timely filing.

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

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

Care provider coding

UnitedHealthcare Community Plan® complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies.** Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

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

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

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

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

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

Clearinghouse and status reports

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

For clearinghouse options, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** at **1-800-638-3302** for help with online billing, claims, Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, see **Chapter 1** under **Online resources**.

For further information about EDI online, go to **UHCprovider.com** > Resources > **Resource Library** to find **Electronic Data Interchange** menu.

Electronic Payment Solution: Optum Pay

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and virtual card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

Submitting a predetermination/claim estimator

For UnitedHealthcare Community Plan® members in North Carolina, you can submit a predetermination of benefits using our Provider Portal. For step-by-step directions, please reference the **Submitting a Predetermination - UnitedHealthcare Community Plan of North Carolina** guide. Find it at **UHCprovider.com/NCcommunityplan** > Education and Training > Submitting a Predetermination - UnitedHealthcare Community Plan® of North Carolina.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Resources, then Resource Library to find the **EDI** section.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

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

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

Capitated services

Capitation is a payment arrangement for health 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 that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

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

10. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan® for such member.
11. 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 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 provider's name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider's NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPI

Subrogation and coordination of benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party is liable for medical bills related to 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 or remittance advice with the claim.

Hospital and clinic method of billing professional services

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

Global days

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

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

National Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

UnitedHealthcare Community Plan® covers medically necessary, non-experimental transplants, including the transplant evaluation and work-ups. Obtain prior authorization for the transplant evaluation, including all required referrals and evaluations, to complete the pre-transplant evaluation process once the member is identified as a possible candidate.

Ambulance claims (emergency)

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

Electronic visit verification for Personal Care Services

The 21st Century Cures Act and CMS require states to use an Electronic Visit Verification System (EVV) for all PCS. Home health care services will begin using EVV in April 2023 and expand in July 2023.

With this requirement, all visits must be timestamped using EVV tools to record the member and caregiver information, location of the service, date of the service and the type of service performed.

This means all UnitedHealthcare Community Plan® network care providers must use EVV to submit all Personal Care Services (PCS) claims. You must use EVV to submit home health claims as of July 1, 2023.

Use HHAeXchange's free EVV system and billing tool to help meet this requirement. Failure to comply with EVV requirements will result in claim denials.

So that PCS claims are processed correctly, please use the appropriate Taxonomy Code (PCS- 253Z00000X and Home Health – 251E00000X).

To help ensure your agency is set up to use the HHAeXchange portal, please complete a provider questionnaire.

HHAeXchange platform options

There are 3 options for the agencies in our network:

- Agencies currently using HHAeXchange will be linked with new PHP contracts
- Agencies without an EVV solution will be set up to use the EVV tools from HHAeXchange
- Agencies currently using an EVV solution from another vendor can use their existing EVV system and import visit data into HHAeXchange using EDI

If you need help, call **Provider Services** at **1-800-638-3302.** You can also email your North Carolina Community Provider Enablement team at **NCEVV@UHC.com**.

If you have questions about HHAeXchange, please email support@HHAeXchange.com or visit hhaexchange.com/nc.

For more information about EVV Home Health processes, review the Home Health EVV Provider Training guide at **UHCprovider.com/NCcommunityplan** > Education and Training.

Interest and penalty for late claims payment

We will pay interest on late payments to you at the annual percentage rate of 18% beginning on the first day after the date the claim should have been paid, as specified in the Agreement. In addition, we will pay you a penalty equal to 1% of the claim for each calendar day following the date the claim should have been paid, as specified in the Agreement.

We will process claims based on requirements by the North Carolina Gen. Stat. § 58-3-225:

- We will, within 18 calendar days of receiving a medical claim, notify you whether the claim is clean or pend the claim and request from you all additional information needed to timely process the claim
- We will pay or deny a clean medical claim at lesser of 30 calendar days of claim receipt or the first scheduled care provider reimbursement cycle following adjudication
- A medical pended claim will be paid or denied within 30 calendar days of receipt of the requested additional information
- If the requested additional information on a medical claim is not submitted within 90 calendar days of the notice requesting the required additional information, we may deny the claim based on N.C. Gen. Stat. § 58-3-225(d)
- For purposes of actions which must be taken by us as found in the Prompt Pay Standards, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day is the date the required action must be taken
- If you submit an adjustment to a previously adjudicated claim, we adjudicate the new claim within the same time frames as the initial clean claim

National Drug Code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

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

Provider Services

Provider Services helps resolve claims issues. 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 Community Plan Provider Portal

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

Resolving claim issues

o 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 5280
Kingston, NY 12402-5280

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

For paper claims

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

- 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. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the 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, we must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

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

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

Balance billing

Do not balance bill members if:

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

You may balance bill the member for noncovered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT.

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.

UnitedHealthcare high-dollar and itemized bill reviews

UnitedHealthcare high-dollar pre-payment reviews requiring itemized bills will meet the following criteria:

- Submit the itemized bill to avoid payment delays for the below-dollar thresholds:
  - Hospital inpatient claims with a header or total billed amount at or more than $250,000
  - Hospital outpatient claims with a header or total billed amount at or more than $75,000
  - Professional claims with a header or total billed amount at or more than $25,000
- United Healthcare ensures the accuracy and validity of all claims submitted. We do not make any alterations to the claims you submit as a result of pre- and post-payment reviews
- Itemized bills may also be required in the event all days are not approved during an inpatient stay to allow for appropriate pricing
- Care providers may submit electronic attachments for itemized bills through the portal and EDI submission for pre- and post- payment reviews

Chapter 12: Claim reconsiderations, appeals and grievances

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

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

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

Situation	Definition	Who may submit?	Digital Submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan® response time frame
Care provider missing claims information (Resubmission)	Resubmitting a claim originally submitted with missing information or documentation. The new claim is now being submitted with the required information.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	UHCprovider.com/claims	**1-800-638-3302**	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims.	PAR -180 calendar days from the date of notice (i.e., remittance advice/PRA. NONPAR - 180 calendar days from the date of notice (i.e., remittance advice/PRA.	30 calendar days
Care Provider Corrected Claim	Submitting a claim to replace a previously submitted claim with changes or corrections. The changes may include changes to billed amounts, clinical or procedure codes, dates of service, and/or member information. When submitting a corrected claim use frequency code 7 in box 22 on HCFA and box 4 on UB claims forms.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-800-638-3302**	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims.	Prior to 07/01/2023: PAR - 180 calendar days from the date of notice (i.e. remittance advice/PRA) NONPAR - 180 calendar days from the date of notice (i.e. remittance advice/PRA) Effective 07/01/2023 and forward: PAR - 365 calendar days from the date of notice (i.e., remittance advice/PRA) NONPAR - 365 calendar days from the date of notice (i.e., remittance advice/PRA)	30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

Situation	Definition	Who may submit?	Digital Submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan® response time frame
Care Provider Reconsideration Request (step 1 of dispute)	A request from a provider to have a claim or benefit determination re-reviewed and/or adjusted because the provider disagrees with the decision. For examples, a request to refund an overpayment, underpayments, and/or denial in whole or in part of an original or corrected claims benefit determination.	Care Provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-800-638-3302**	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims.	PAR - 180 calendar days from the date of notice (i.e. remittance advice/PRA) NONPAR - 180 calendar days from the date of notice (i.e. remittance advice/PRA)	N/A
Care Provider claim Appeal Request (step 2 of dispute)	A written request for a second review of a claim or situation for which you did not agree with the outcome of the reconsideration.	• Care provider • Attorney with proof of representation	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-638-3302**	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims.	Within 30 calendar days on which the provider receives written notice of the reconsideration decision giving the right to appeal. The timeframe may be extended by an additional 30 calendar days when a provider submits evidence of a good-cause such as the voluminous nature of required evidence to support the appeal.	Acknowledge within 5 calendar days of receipt of the request. Resolve within 30 calendar days.
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-638-3302**	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of **UHCprovider.com**, then click Claims.	No time limit	Acknowledge within 5 calendar days of receipt of the request. Resolve within 30 calendar days.
Member Appeal	A request to change an adverse benefit determination that we made.	•Member •Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364	**providerforms.uhc.com/ProviderAppealsandGrievance.html** AOR Consent Form on this site for member appeals	Member Services: **1-800-349-1855**		60 calendar days from the date on the adverse benefit determination notice	Acknowledge within 5 calendar days for standard appeals. Expedited appeals resolved within 72 hours.* Standard appeals resolved within 30 calendar days.* *May be extended by 14 calendar days.

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

Situation	Definition	Who may submit?	Digital Submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan® response time frame
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	•Member •Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		Member Services: **1-800-349-1855**		No time limit	Acknowledge within 5 calendar days for standard grievances. 5 calendar days to resolve expedited grievance. 30 calendar days* (all other grievances). *May be extended by 14 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 provider agreements than described in the standard process.

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

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

When to use:

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

How to use:

Use the claims reconsideration application 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 5280
Kingston, NY 12402-5280

Additional Information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

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

- Errors in member demographic data – name, age date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

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

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.

UnitedHealthcare Community Plan
P.O. Box 5280
Kingston, NY 12402

Warning! If your claim was denied and you resubmit it, you will receive a **duplicate claim rejection**. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim reconsideration (step 1 of claim payment dispute)

What is it?

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

When to use:

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

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
- **Phone:** Call **Provider Services** at **1-800-638-3302** 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.

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.

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

  UnitedHealthcare Community Plan
  P.O. Box 5280
  Kingston, NY 12402

This form is available at **UHCprovider.com/claims**.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-800-638-3302** 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. 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, phone or mail with the following information:

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

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.

UnitedHealthcare Community Plan
P.O. Box 5280
Kingston, NY 12402

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

Additional Information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan® finds an overpaid claim, send us the overpayment within 60 days. If your payment is not received by that time, we may apply the overpayment against future claim payments based on our Agreement and applicable law. If you prefer we recoup the funds from your next payment, call Provider Services.

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 101760
Atlanta, GA 30392

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

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

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

We make claim adjustments without requesting additional information from you by taking the claim data from the claim system and submitting it to the state as encounter data. Once the payment has been recovered, you see the adjustment on the EOB or Provider Remittance Advice (PRA). We submit the adjustment to the state in the encounter submission as either a replacement or void and new day, depending on the original encounter status. When additional information is needed, we ask you to provide it.

Sample overpayment report

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

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

Claim appeals (step 2 of claim payment 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/file:

If you do not agree with the outcome of the claim reconsideration, use the claim appeal process. Also refer to the Other Provider Appeals Situations section of this chapter.

Timely Filing:

You must submit an appeal within 30 calendar days from receipt of UnitedHealthcare Community Plan®'s response or determination, or from the date when we should have taken action but did not do so.

Exception:

We may extend the time frame by an additional 30 calendar days if you submit a large amount of good cause evidence to support the appeal.

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 appeal request. You may have an attorney represent you.

- **Electronic claims:** Use the Claims Management application on the Provider Portal. You may upload attachments.

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.

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

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

Other care provider appeals situations

In some cases, when you submit a care provider appeal, we appoint a committee to review and issue a decision.

When to use:

If you are a network care provider, and you do not agree with the claim reconsideration outcome in step 1, use the claim appeal process in the following cases:

- Program Integrity-related findings or activities
- Finding of fraud, waste, or abuse by UnitedHealthcare Community Plan®
- Finding of or recovery of an overpayment by UnitedHealthcare Community Plan®.
- Withhold or suspension of a payment related to fraud, waste, or abuse concerns
- Termination of, or determination not to renew, an existing contract for LHD care management services
- Determination to lower an AMH care provider's tier status
- Violation of terms between you and us

If you are an out-of-network care provider, follow the claim appeal process when the following occurs:

- An out-of-network payment arrangement
- Finding of waste or abuse by the UnitedHealthcare Community Plan®
- Finding of or recovery of an overpayment by UnitedHealthcare Community Plan®

We will offer you an in-person or phone hearing when you are appealing whether we have good cause to withhold or suspend payment to you. We will schedule the hearing and issue a written decision about whether we had good cause to suspend or withhold payment within 15 business days of receiving the appeal.

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

Care provider grievance

What is it?

Grievances are complaints where remedial action is not requested.

When to file:

You may file a grievance about:

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

How to file:

File online, verbally or in writing.

- **Online:** UHCprovider.com
- **Phone:** Call **Provider Services** at **1-800-638-3302**
- **Mail:** Send care provider name, contact information and your grievance to:

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

You may only file a grievance on a member's behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

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

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

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

When to use:

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

Where to send:

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

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

Phone: Call Member Services toll-free at 1-800-349-1855 Monday-Saturday, 7 a.m.-6 p.m. ET, including state holidays.

How to use:

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

- Receive a copy of the rule used to make the decision
- Ask UnitedHealthcare Community Plan® Member Services for help writing the letter
- 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 documents considered for the appeal
- Ask for an expedited appeal if waiting could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

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

We resolve an expedited appeal as quickly as the member's condition requires and provide written notice. We must make reasonable effort to give oral notice of resolution no later than 72 hours of receipt of the request.

We may extend the response up to 14 calendar days if the member requests that we take longer. We may also extend it if it we request more 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**.

Member grievance

What is it?

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

When to use:

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

Where to send:

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

Mailing address:

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

Phone: Call **Member Services** toll-free at **1-800-349-1855** Monday-Saturday, 7 a.m.- 6 p.m. ET, including state holidays.

We will send an answer within 30 calendar days from when you file the grievance or as quickly as the member's health condition requires. If an extension is needed, we will send an answer no longer than 44 calendar days from when you file the grievance. If the grievance involves us denying a member's request to expedite an appeal decision, we send an answer within 5 calendar days.

State fair hearings

What is it?

A state fair hearing (SFH) lets members share why they think North Carolina Medicaid services should not have been denied, reduced or terminated.

When to use:

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

How to use:

To request an SFH, call The Office of Administrative Hearings at 1-984-236-1850 or write to the North Carolina Office of Administrative Hearings, Hearings Division and Clerks' office:

Mail: Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609
Phone: 984-236-1850

Fax: 1-984-236-1871

For Medicaid-Specific inquiries:
Office of Administrative Hearings

Medicaid Hotline
Phone: 984-236-1860

Website: oah.nc.gov > Hearings Division > Medicaid Recipient Appeals > Filing a Contested Medicaid Recipient Appeal

Email: nc_sfh@uhc.com

- 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.

Processes related to reversal of our initial decision

If the SFH 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 or
2. No later than 72 hours from the date we receive the determination reversal.

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

Fraud, waste and abuse

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

UnitedHealthcare Community Plan®'s Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan® paid for such claims. We also refer suspected fraud, waste and abuse cases to the NCDHHS and the Medicaid Investigation Division according to 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 Anti-Fraud, Waste and Abuse Program. 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 NCDHHS and the Medicaid Investigation Division 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/NCcommunityplan** > Integrity of Claims, Reports and Representatives to the Government.

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

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

Exclusion checks

First-tier, downstream and related entities (FDRs) must review federal (HHS-OIG and GSA), System of Award Management (SAM), Social Security Administration Death Master File (SSADMF), National Plan and Provider Enumeration System (NPPES), the Office of Foreign Assets Control (OFAC), and state exclusion lists before hiring/contracting persons with an ownership

or controlling interest in the health plan, agents and managing health plan employees, network care providers, delegated entities and subcontractors. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month.

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

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

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.

Prepayment review

The UnitedHealthcare Community Plan® of North Carolina aims to detect and deter fraud, waste, and abuse and verify whether services are billed accurately and supported through documentation. UnitedHealthcare follows the guidelines as outlined in § 108C-7- Prepayment Claims Review.

A provider is subject to prepayment when, but not limited to, deciding if the services and supplies claimed on a bill are accurate for the member determining whether the charges are payable based on the member's benefit plan terms, conditions and exclusions, and UnitedHealthcare reimbursement policies.

Claims are reviewed by UnitedHealthcare to determine if they meet federal and state law, rules and regulations, all documentation requirements and criteria set forth in the applicable Clinical Coverage Policy, Basic Medicaid Billing Guide, Medicaid bulletins and implementation updates as required by your Medicaid Provider Participation Agreement, that are applicable for the services at issue, CPT guidelines, UnitedHealthcare reimbursement policies and member benefit limits.

The provider shall remain subject to the prepayment claims review process until the provider achieves 3 consecutive months with a minimum 70% clean claims rate, provided that the number of claims submitted per month is no less than 50% of the provider's average monthly submission of Medicaid claims for the 3-month period prior to the provider's placement on prepayment review.In accordance with § 108C-7(f), a provider may not appeal or otherwise contest a decision of placement on prepayment review.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider education	**UHCprovider.com** > Resources > **Resource Library**	**1-800-638-3302**
News and bulletins	**UHCprovider.com/news**	**1-800-638-3302**
Care provider manuals	**UHCprovider.com/guides**	**1-800-638-3302**

Communication with care providers

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

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

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/NCcommunityplan**: The UnitedHealthcare Community Plan® of North Carolina page has state-specific resources, guidance and rules.
- **Policies and protocols**: **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans** library includes UnitedHealthcare Community Plan® policies and protocols.
- **North Carolina health plans**: **UHCprovider.com/NC** is the fastest way to review all of the health plans UnitedHealthcare offers in North Carolina. 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.
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.

- You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
- This includes the communication formerly known as the Network Bulletin. Receive personalized Network News emails twice a month by subscribing at **UHCprovider.com/subscribe**.
- You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

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

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

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

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. 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 ad determine which provider advocate to contact based on your location at **UHCprovider.com/NCcommunityplan** > Contact Us.

Business continuity planning

UnitedHealthcare Provider Services has a frequently asked questions (FAQ) document that contains information and guidance about the medical emergency exceptions and preparations that UnitedHealthcare Community Plan® receives from North Carolina Division of Medicaid at time of disaster. Provider Services will reference the FAQ when communicating with providers to ensure adequate care of members in an emergency.

Provider Services has operational resiliency to handle a surge in provider calls. Provider Services can route calls to trained resources to handle additional volumes and can provide basic training to alternate Provider Services agents at time of event if needed. Provider Services can be made available 24/7 in a crisis.

Care provider manual

UnitedHealthcare Community Plan® publishes this manual online based on the guidelines in its contract with North Carolina. The care provider manual includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. To request a physical copy of the manual, write to your provider advocate or call Provider Services.

State website and forms

Find the following forms on the state's website at medicaid.ncdhhs.gov/forms:

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

Provider relations team support

Physician and hospital advocates regularly visit care providers. We also have daily availability of our provider relations team by email. We do this to create program awareness, promote compliance and assist with revenue cycle questions and issues.