2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Ohio

UnitedHealthcare Connected

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UnitedHealthcare Community Plan

Welcome

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

Click to access different care provider manuals

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

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

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

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

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-800-600-9007.**

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

Using this care provider manual

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

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

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

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-800-600-9007**
Training	**UHCprovider.com/training**	**1-800-600-9007**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
One Healthcare ID support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
Resource library	**UHCprovider.com/resourcelibrary**	

UnitedHealthcare Community Plan supports the Ohio state goals of increased access, improved health outcomes and reduced costs by offering benefits to the following Medicaid members in every Ohio county.

Ohio Medicaid covers members in the Covered Families and Children (CFC) program. This includes Healthy Start and Healthy Families, Foster Care, or the Aged, Blind, or Disabled (ABD) programs. CFC Medicaid consumers include families, children younger than age 19, and pregnant women.

ABD Medicaid consumers include adults age 65 and older and people who are blind or disabled at any age.

UnitedHealthcare Connected for MyCare Ohio serves members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Connected service area.

UnitedHealthcare Connected members must be eligible and enrolled in Medicare Part A, Medicare Part B, and Ohio Medicaid. UnitedHealthcare Connected is available in Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne Counties.

The Ohio Department of Medicaid (ODM) will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call **Provider Services** at **1-800-600-9007**.

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 how to sign up for self-service and other helpful information.

Already in the provider network and need to make a change?

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

Approach to health care

Care Management program

The Care Management program seeks to empower UnitedHealthcare Connected for MyCare Ohio members, care providers and our community to improve care coordination and elevate outcomes.

All MyCare Ohio members are entered into the program and assigned to a care manager, a community health worker, or a behavioral health care advocate, who then assist the member with addressing their needs holistically. The Care Management program examines medical, behavioral and social/ environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

These interventions address members' specific needs, resulting in better quality of life, improved access to health care and reduced expenses.

Care Management provides a care management/ coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities that UnitedHealthcare Community Plan serves. Care Management provides:

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

The Care Management program goals are to:

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

To refer a UnitedHealthcare Community Plan member to the Care Management program, call **Member Services** at **1-877-542-9236**, TTY **711**. You may also call **Provider Services** at **1-800-600-9007**.

Compliance

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

Cultural resources

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

- **Cultural competency training and education**

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

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

- **Translation/interpretation/auxiliary aide services**

  You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

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

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

  Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

  If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to the Virtual Visit.

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

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

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 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.
  As contractually required, you must provide language interpreter services to meet cultural and linguistic needs of members and patients you serve.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare uses evidence-based clinical guidelines from nationally recognized sources during review of our quality and health management programs. These clinical guidelines can by found on **UHCprovider.com/policies**.

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 a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer. This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

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

The benefit of using EDI is that it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging in to different payer websites to manually request information. This is why EDI is usually the first choice for electronic transactions. It makes it possible to:

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

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

Getting started

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

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

Point of Care Assist

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

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

UHCprovider.com

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

UnitedHealthcare Provider Portal

Chat support now available

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

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

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

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

- **Eligibility and benefits**

  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **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/priorauth**.
- **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 members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable network facilities or arrangements with a network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

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

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. **Provider Services** at **1-800-600-9007** works closely with all departments in UnitedHealthcare Community Plan.

How to contact us

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

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum® Provider Express **providerexpress.com** **1-866-209-9320**	Review eligibility, claims, benefits, authorization and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-800-600-9007**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** **1-800-600-9007**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care Management	Medical care management services: **1-800-508-2581 (Medicaid)** **1-877-542-9236 (MyCare)** Behavioral health care management: **1-800-888-2998**	Call Monday-Friday, 8 a.m. to 5 p.m., ET. Call 24 hours a day, 7 days a week for help with referrals, prior authorizations, admissions, discharges and coordination of members' care.
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** **1-800-600-9007** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 8207 Kingston, NY 12402	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. **1-800-600-9007** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.
Dental benefit providers	UHC Dental **UHCdentalproviders.com** **1-855-642-5483**	Call to find a network provider.

Topic	Contact	Information
Electronic Data Intake (EDI) Issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** **1-888-586-4766** (interactive voice response)	Confirm member eligibility.
Enterprise Voice Portal	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent.
Fraud, waste and abuse (payment integrity)	**UHCprovider.com/OHcommunityplan** > 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.
Healthy First Steps/ obstetrics (OB) referral	**1-800-599-5985**	Refer pregnant members to this program.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics questdiagnostics.com	Labcorp and Quest Diagnostics are network laboratories.
Medicaid (Ohio Department of Medicaid)	medicaid.ohio.gov 1-800-324-8680	Contact Medicaid directly.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-800-600-9007** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** **1-877-542-9236**/TTY **711** for help accessing member account	Helps members with issues or concerns. Available 8 a.m. – 8 p.m. ET, Monday-Friday. Voicemail available 24 hours a day, 7 days a week.
Mental health and substance use (behavioral health)	**1-800-888-2998**	Refer members for behavioral health services. (A PCP referral is not required.) *See behavioral, mental health and substance abuse row for more information.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-877-542-9236** TDD **711**	Available 8 a.m. – 8 p.m. ET, Monday-Friday. Voicemail available 24 hours a day, 7 days a week.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	**1-800-600-9007**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality for medical network care providers.
NurseLine	**1-800-542-8630**	Available 24 hours a day, 7 days a week.

Topic	Contact	Information
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal. **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form.
Oncology prior authorization	**UHCprovider.com/oncology** **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at **UHCprovider.com/chat.** **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 9 a.m.–6 p.m. CT, Sunday
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** Technical help desk: **1-877-889-6510**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-711-4555** Provider pharmacy prior authorization help desk: **1-833-491-0344**	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript® tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N **UHCprovider.com/priorauth** • Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-800-600-9007**	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/OHcommunityplan** > Prior Authorization and Notification

Topic	Contact	Information
Provider Services	**UHCprovider.com/OHcommunityplan** **1-800-600-9007** **UnitedHealthcare Community Plan** 9200 Worthington Road, 3rd Floor Worthington, OH 4308	Available 7 a.m.–5 p.m. CT, Monday–Friday.
Radiology prior authorization	**UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
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 **1-800-600-9007**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/policies** > For Community Plans	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 UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	Provide-A-Ride 1-800-269-4190	To arrange nonemergent transportation, please contact Provide-A-Ride at least 2 business days in advance.
Utilization management	Provider Services **1-800-600-9007**	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.

Topic	Contact	Information
Vision services	March Vision marchvisioncare.com 1-844-756-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from March Vision.
Website for Ohio Community Plan	**UHCprovider.com/OHcommunityplan**	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**	**1-800-600-9007**
General provider assistance		**1-877-842-3210**
Eligibility	**UHCprovider.com/eligibility**	**1-800-600-9007**
Referrals	**UHCprovider.com/referrals**	**1-800-600-9007**
Provider Directory	**UHCprovider.com/findprovider**	**1-800-600-9007**

General care provider responsibilities

Nondiscrimination

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

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

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

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with our ability to administer its quality improvement or utilization management 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 that you:

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

Provide official notice

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

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

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

Notify us within 30 calendar days if any of the following changes:

- TIN
- Address
- Additions or departures of health care providers from your practice and new service locations

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

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care.

For UnitedHealthcare Connected for MyCare Ohio, the Managed Care Plan (MCP) shall send the notice at least 45 calendar days prior to the effective date for the deletion to members who use the subcontractor as a PCP or behavioral health providers, and 30 calendar days for other service providers.

This may include providing service(s) for a reasonable time at our in-network rate. **Provider Services** at **1-800-600-9007** 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**.

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a care provider

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

After-hours care

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

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

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by the state's government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

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

Performance data

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

Comply with protocols

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

Compliance to standards of care

UnitedHealthcare Connected participating care providers must comply with all applicable laws and licensing requirements. In addition, furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare Connected standards, which include:

- Guidelines established by the Federal Center for Disease Control (or any successor entity)
- All federal, state, and local laws regarding the conduct of their profession

You must also comply with UnitedHealthcare Connected policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Prior authorization requirements and time frames
- Referral policies
- Care Management Program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Connected
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with UnitedHealthcare Connected personnel and fellow participating care providers
- Providing equal access and treatment to all Medicare and Medicaid members

Compliance process

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Connected
- Failure to pre-notify UnitedHealthcare Connected of admissions
- Member complaints/grievances that are determined against the provider
- Underutilization, over utilization, or inappropriate referrals
- Inappropriate billing practices

Non-supportive actions and/or attitude participating care provider noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken.

We recommend you advise UnitedHealthcare Connected members about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including providing enough information to provide an opportunity for members to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions
- The importance of preventive changes at no cost to the member. Such actions shall not be considered non-supportive of UnitedHealthcare Connected.

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of HIPAA and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

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

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through member handbooks and other communications.

Your Agreement

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

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

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

For more information on the American Arbitration Association guidelines, visit adr.org. If you have received a notice of contract termination and have a question, call **Provider Services** at **1-800-600-9007**.

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 our Medicaid website at **UHCCommunityPlan.com**. Locate the MyCare Member Handbook at **UHCCommunityplan.com/oh/medicaid/connected**.

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

Marketing

You may not develop and use any materials that market UnitedHealthcare Connected without the prior approval of UnitedHealthcare Connected in compliance with Medicare Advantage requirements.

Appointment standards (Ohio access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- Emergency care: immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment (no symptoms): within 6 weeks
- Routine appointment (recurring symptoms): no later than the end of the following working day after their initial contact with the PCP site
- Physical exam: within 6 weeks
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days

In addition, PCPs must adhere to the following standards:

- After-hours care phone number: 24 hours, 7 days a week
- In-office waiting for appointments: not to exceed 1 hour after the scheduled appointment time

Specialty care

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

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- Initial prenatal care appointment: within 2 weeks
- First trimester: within 10 business days of request
- Second trimester: within 5 business days of request
- Third trimester: within 4 business days of request
- High-risk: within 1 week, unless urgent need exists, then within 24 hours

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

Orthopedic surgery, allergy, dermatology, otolaryngology, neurology

- Urgent care appointments: within 48 hours of referral
- Routine appointments within 6 weeks for new patients, within 4 weeks for established patients

Behavioral health care

- Routine outpatient care: within 24 hours to member requests
- Initial mental health/substance use disorder appointment: within 10 business days of the request
- Urgent care: within 48 hours
- Non-life-threatening emergencies: within 6 hours
- Life-threatened emergencies: immediately
- Acute inpatient discharge appointment: within 7 days

All other care provider types

- Urgent care appointments: within 24 hours of referral
- Routine appointments: 4 weeks for new patients, 3 weeks for established patient

Provider maintenance

The provider network management (PNM) system serves as the system of record for care provider data for ODM and UnitedHealthcare Community Plan. As a result, data in the PNM system is used in both claims payment, the managed care organization (MCO)'s provider directory and ODM provider directory.

To ensure care provider information remains current, it is important for care providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider Agreement, you are responsible for notifying ODM of changes within 30 days (see OAC 5160-1-17.2 F). Updating the PNM system When there is a change in your information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update.

Self-service functions include, but are not limited to: location changes, specialty changes and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, the accepted information is sent to UnitedHealthcare Community Plan daily for use in the provider directories.

You must update your information in the PNM system first. UnitedHealthcare Community Plan is required to direct care providers back to the PNM system if there are changes.

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM provider call center at 1-800-686-1516 through the interactive voice response (IVR) system. It provides 24-hour, 7 days a week access to information regarding care provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m.–4:30 p.m. ET.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-800-600-9007**. If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

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

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services and/or medication.

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

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

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-800-600-9007**. 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.

Prior authorization for waiver services

If you are providing waiver services to a MyCare Ohio member, contact the member's UnitedHealthcare care manager. The care manager adds these services to the member's Waiver Service Plan (WSP).

The information you submit on the waiver claim (dates of service, procedure code, units etc.) must match the information listed on the member's WSP.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for PCP 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 the delivery of care, and UnitedHealthcare Community Plan members may seek services from any participating care provider.

The Ohio Medicaid program requires members be assigned to PCPs. 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."

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

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

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

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

Members may change their assigned PCP by contacting **Member Services**.

Customer service is available 7 a.m.–7 p.m. ET, Monday–Friday.

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

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

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

During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- Provide all well-baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care .This includes behavioral health. PCPs must screen UnitedHealthcare Connected members for behavioral health problems (e.g., chemical dependence) and mental health. File the completed screening tool in the patient's medical record.
- 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
- Be available to members by telephone at 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 and/or obstetrics/gynecology

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

- Act as a member advocate in recommending and arranging care, based on medical necessity

- 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 UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Make distinctions between care options that align with the member's cultural background. Provide consistent care across a variety of cultures.
- Provide care to members without regard to race, color, creed, gender, religion, age, national origin, marital status, gender orientation, language, health status, pre-existing conditions, and physical or mental handicap
- Refer services requiring prior authorization to **Provider Services** at **1-800-600-9007**, UnitedHealthcare Community Plan Clinical or Pharmacy departments as appropriate. If the provider feels member needs waiver services, they can contact their care manager.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical 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 based on UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the Ohio Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in this chapter.
- Comply with the UnitedHealthcare Community Plan Healthchek program for children younger than age 21.
- Work with us and local school districts to facilitate access to medically necessary services to schoolage children, helping ensure continuity of care and achieve the ODM's goals in this area

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-600-9007**
- 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/priorauth.**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic, federally qualified health clinic and primary care clinic

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

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:

  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **PCC**
  A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the 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 Ohio Access and Availability standards for scheduling routine visits. Appointment standards are covered in this chapter.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers. UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary care providers include:

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

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

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

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-600-9007**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/OH**	**1-877-542-9236**
Member handbook	**UHCCommunityPlan.com/OH** > Plan Details > Member Resources > View Available Resources	**1-800-600-9007**
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Prior authorization	**UHCprovider.com/priorauth**	**1-800-600-9007**
D-SNP, if applicable	**UHCprovider.com/OH** > Medicare > **Dual Complete Special Needs Plan**	**1-800-600-9007**

Benefits

Go to **UHCCommunityPlan.com/OH** or **UHCprovider.com/eligibility** for more information.

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**.

Members using UnitedHealthcare Connected for MyCare Ohio must choose a PCP to coordinate their care.

Choosing a primary care provider

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

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

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

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

Deductibles/copayments

Medicaid members have no copays for covered services. However, MyCare members may have to pay a "patient liability" for nursing facility or waiver services that are covered through their Medicaid benefit.

The County Department of Job and Family Services determines if a member's income and certain expenses require you to have a patient liability.

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

ODM 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. ODM makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end but may occur mid-month.

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

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

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, check the payer assignment of newborns daily.

Get eligibility information by calling **Provider Services** at **1-800-600-9007**.

Unborn enrollment changes

Encourage your members to notify the Ohio county offices when they know they are expecting. The offices notify Managed Care Organizations (MCOs) daily of an unborn when Ohio Medicaid learns a woman associated with the MCO is expecting.

The MCO or you may use the online change report through the Ohio website to report the baby's birth. With that information, ODM verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify ODM when the baby is born.

Members may call the Ohio Medicaid Consumer Hotline at 1-800-324-8680. Representatives are available 7:00 a.m. - 8:00 p.m. ET Monday-Friday 8:00 a.m. – 5:00 ET p.m. Saturday.

UnitedHealthcare Community Plan must first notify ODM of the birth. Prior to enrollment and assignment of a member ID number, bill for services rendered to the newborn using the mother's UnitedHealthcare Community Plan ID number. Eligibility begins on the date of birth and continue through the end of the 12th month.

Sometimes newborns are added effective on the date of their birth. 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 an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

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

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with ODM. It determines program eligibility. An individual who becomes eligible for the ODM program either chooses or is assigned to one of the ODM contracted health plans.

Enrollment is effective for new members on the first of the month. Members may check their eligibility at benefits.ohio.gov.

Member ID card

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

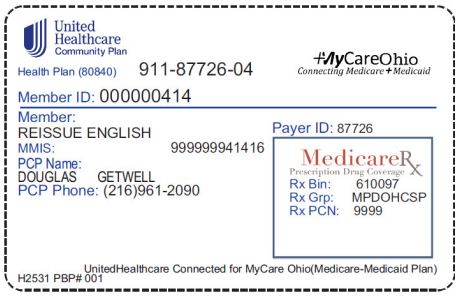
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the **Fraud, Waste and Abuse Hotline**.

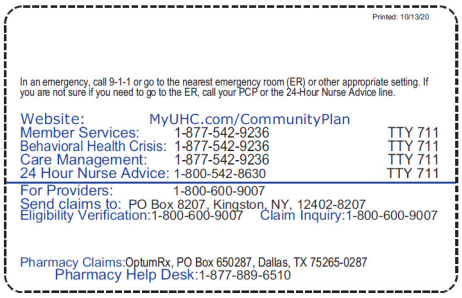
The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-800-600-9007**. Also document the call in the member's chart.

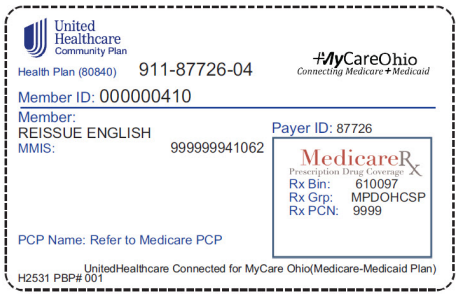
Member identification numbers

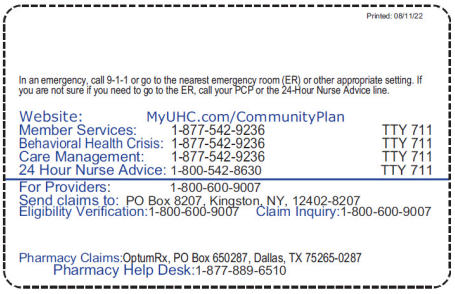
Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Ohio Medicaid number is also on the member ID card.

Sample health member ID card









PCP-initiated transfers

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

1. To transfer the member, call **Provider Services** at **1-800-600-9007**, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   5900 Parkwood Place, 5th Floor
   Dublin, OH 43016
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. 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.
4. 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 one 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:

- **UnitedHealthcare Provider Portal: UHCprovider.com/eligibility**
- **Electronic data interchange (EDI)**: Use the Eligibility & Benefit Inquiry & Response (270/271)
- **Phone**: Call the United Voice Portal at **1-877-842-3210**, or call the Customer Care number on the back of the members' ID card

No medical coverage outside the United States

We do not cover any health care services received while out of the country. Medicaid cannot pay for any medical services received outside of the United States.

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

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-800-600-9007**
Prior authorization	**UHCprovider.com/priorauth**	**1-800-600-9007**
Pharmacy	**professionals.optumrx.com**	**1-800-310-6826** fax **1-866-940-7328**
Dental	**UHCdentalproviders.com**	**1-855-642-5483**
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.

Informed consent

Before delivering any of these services, obtain informed consent. Informed consent means the treatment was explained to the member. The member must understand their options and say "yes":

- Members must consent before receiving any treatment
- Sometimes the consent must be in writing
- If a member refuses medical treatment, their PCP should discuss other choices with them
- Members have the right to say yes or no

Ambulance services

Air ambulance

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

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

Nonemergent air ambulance requires prior authorization.

For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-800-600-9007**.

Emergency ambulance transportation

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

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

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

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

Nonemergency medical transportation

Nonemergency medical transportation (NEMT) services are arranged by Provide-A-Ride. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs.

Wheelchair service is provided if required by medical necessity.

UnitedHealthcare Community Plan will provide members with 30 one-way or 15 round trips per year to and from their PCP, WIC, pharmacy, or other participating health care providers, such as vision or dental. Additional trips can be requested if medically necessary.

Members may also request help to get to their Medicaid redetermination visits. If a member must travel 30 miles or more from their home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider's office. These services must be medically necessary and not available in the member's service area.

Members must also have a scheduled appointment (except in the case of urgent/ emergent care). Please contact Member Services at least 2 business days in advance of the member's appointment for assistance.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

Schedule transportation up to 30 days in advance

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

- Emergency room
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology 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 provider responsibility with termination of services notification of Medicare non-coverage

Skilled nursing facility, home health agency, and comprehensive outpatient rehabilitation facility notification requirements

As a participating UnitedHealthcare Skilled nursing facility (SNF), home health agency (HHA), and comprehensive outpatient rehabilitation facility (CORF) provider, you give members the Notice of Medicare Non-Coverage (NOMNC). This notice tells members when their service coverage ends and what they should do if they want to appeal the decision or need more information.

CMS has developed a single, standardized NOMNC designed to make notice delivery easy. It has 3 variable fields (patient name, ID/Medicare number and last day of coverage) for you to fill in.

When to deliver the notice of Medicare non-coverage

Based on when services should end, the SNF, HHA, or CORF delivers the Notice of Medicare Non-Coverage

(NOMNC) no later than 2 days before the end of coverage. If services are expected to end in fewer than 2 days, deliver the NOMNC upon admission.

If there is more than a 2-day span between services (e.g., home health setting), issue the NOMNC on the next to last time you furnish services.

We encourage SNF, HHA, and CORF providers to work with us so these notices can be delivered as soon as the service termination date is known.

How to deliver the notice of Medicare non-coverage

SNF, HHA, and CORF providers must carry out "valid delivery" of the NOMNC. This means the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by phone if personal delivery is not immediately available. In this case, notify the authorized representative of the notice contents. Document the call and mail the notice to the representative.

Expedited review process

If the member decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) by no later than noon the day before services are to end (as indicated in the NOMNC). The QIO for Ohio is Livanta. A member may call Livanta at 1-888-524-9900.

The QIO tells us and you of the request for a review. We provide the QIO and member with a detailed explanation of why coverage is ending. Based on the expedited time frames, the QIO decision should take place by close of business of the day coverage is to end.

Exclusions from notice of Medicare non-coverage delivery requirements

You do not have to deliver the NOMNC if coverage is ending for any of the following reasons:

1. Member's benefit is exhausted.
2. Denial of an admission to an SNF, HHA or CORF.
3. Denial of non-Medicare covered services.
4. A reduction or termination of services that do not end the skilled stay.

We issue members a Detailed Explanation of Non-Coverage (DENC) explaining why services are no longer medically necessary.

We notify the QIO no later than close of business (typically 4:30 p.m.) the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Find the form on CMS.gov > Medicare > Beneficiary Notices Initiative (BNI) > MA Expedited Determination Notices.

Chiropractic care

You must obtain prior authorization for people younger than age 21. We do not require prior authorization for chiropractic care for members 21 years and older. Adult members may access care in 15 visits per year. MyCare Ohio Chiropractic services covers diagnostic X-rays and corrective spine adjustments.

Dental services

Covered

A dental provider manual is available for detailed coverage information on **UHCdentalproviders.com**.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If the member is older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.

The following services are covered for children younger than 20 years, pregnant members, the blind and nursing facility residents:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

Noncovered

UnitedHealthcare Community Plan does not cover routine dental services for anyone 21 years and older. It does not cover orthodontia for any member.

Refer to the dental provider manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims.

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

Durable medical equipment

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

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

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

Obtain authorization for DME rentals or any purchase with a billable charge greater than $500. A list of items requiring prior authorization is located at **UHCprovider.com/priorauth**. Call **Provider Services** at **1-800-600-9007** to request prior authorization. You may also use the secure provider portal at **UHCprovider.com**.

Incontinence supplies

Edgepark Medical Supply provides all incontinence supplies for UnitedHealthcare Community Plan. Call Edgepark at 1-844-564-1008 for more information.

Respiratory supplies

Medical Service Company (MSC) provides respiratory supplies such as oxygen/continuous positive airway pressure (CPAP) machines, concentrators, nebulizers and other related supplies for Medicaid members age 7 and older. Call **1-888-50MyUHC** for more information.

Medical advances

When UnitedHealthcare Community Plan receives requests to cover newly developed medical equipment or procedures, our national Technology Assessment Committee reviews them. This committee includes physicians and other health care professionals.

The Committee uses national guidelines and scientific evidence from medical literature to help decide whether UnitedHealthcare Community Plan should approve the use of the equipment or procedures.

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 nonemergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

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

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

Emergency room care

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

Members have been told to call their 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:

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

Depending on the need, the member may be treated in the ER, in an inpatient hospital room or in another setting. These are called post-stabilization services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-800-600-9007**.

Emergency care resulting in admissions

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or,
- Serious dysfunction to any bodily organ or part.

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/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-800-600-9007**.

UnitedHealthcare Community Plan makes utilization management (UM) determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria.

UnitedHealthcare Community Plan does not reward 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 **1-800-600-9007** (UM Department, etc.).

The criteria are available in writing upon request or by calling **Provider Services** at **1-800-600-9007**. Call Utilization Management at **1-800-600-9007** for authorization for hospital admissions or call **1-800-888-2998** for approval for inpatient admissions for behavioral health.

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.

Post-stabilization services

UnitedHealthcare Community Plan covers poststabilization services as defined in federal Medicaid managed care regulation at 42 CFR 438.114(e) and 42 CFR 422.113(c) and OAC rule 5160-26-03(G) without requiring prior authorization. This is the case if any of the following situations exist:

- The post-stabilization services were pre-approved by UnitedHealthcare Community Plan
- The post-stabilization services were not preapproved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan did not respond to your request for the services within 1 hour of the request
- The post-stabilization services were not preapproved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan could not be reached to request pre-approval
- The post-stabilization services are not pre-approved by a UnitedHealthcare Community Plan Utilization Management representative and a UnitedHealthcare Community Plan medical director was not available for consultation; the treating provider may continue with the proposed plan of care until a plan medical director can be reached.
- The attending or treating care provider shall determine when the member is stable for transfer or discharge. UnitedHealthcare Community Plan shall defer to the treating care provider regarding the point of stabilization.

Hospital transfers

In the event of a transfer admission to or from the hospital, the sending and receiving hospital or the attending provider must contact the Utilization Management department. No party should assume the other has obtained prior authorization.

Outpatient surgical services

Prior authorization may be required for the procedure or surgery. The ordering Provider must make the request for such prior authorization.

The requesting care provider should make every attempt to request the above prior authorization at least 72 hours prior to admission unless contract guidelines stipulate otherwise.

In the event that a member's condition requires an immediate admission, prior authorization must be obtained for the admission. The ordering provider or the facility may make the request for such prior authorization. Please be sure that all claims include your appropriate Provider ID numbers and appropriate authorization information for each place of service.

Discharge planning

Discharge planning begins at the time a member is admitted to the hospital and continues through the concurrent review process. The utilization management nurse will use approved medical criteria as discharge indicators. In addition to the member's clinical status, the psychosocial situation and home environment are also taken into consideration when evaluating the member's discharge status.

Post-hospitalization services may include, but are not limited to, home health visits, DME, rehabilitation and pharmacy services. The Utilization Management nurse will refer pre-identified patients to a dedicated discharge team. This discharge team will assume responsibility for the finalization of the discharge plan and will serve as a resource to the attending provider, hospital team and the member.

The discharge team will perform the following discharge planning tasks:

- Confirm benefit levels
- Assist with the identification of participating care providers

- Facilitate the certification process of posthospitalization services
- Refer members to Care Management for continuity of care
- Identify high-risk patients for post-discharge followup contact to confirm the discharge plan was executed
- Assist provider with identification and resolution of unanticipated issues identified immediately postdischarge

The Utilization Management discharge team's focus is to assist the hospital staff and attending provider with the coordination of the member's discharge plan.

In addition, during the discharge planning process, the discharge team will identify those members who may be considered high-risk and will outreach to the member post-discharge to verify the discharge plan was executed as the treating provider intended.

Inpatient rehabilitation unit/long term acute care facility

UnitedHealthcare Community Plan care providers may use an inpatient rehabilitation unit only when prior authorized by the Utilization Management department.

The ordering care provider of the facility may make the request for such prior authorization. The requesting care provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission, unless contract guidelines stipulate otherwise.

Facility admission notification requirements

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

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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral.

They may also seek family planning services at the care provider of their choice. The following services are included:

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

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

Noncovered items include:

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

Parenting/child birth education programs

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

Voluntary sterilization

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

Out-of-network services require prior authorization.

View the ODM regulations for more information on sterilization.

Hearing services

Monaural and binaural hearing aids are covered. This includes fitting, follow-up care, batteries and repair. Bilateral cochlear implants – including implants, parts, accessories, batteries, charges and repairs – are also covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are also covered for members.

Home health care

Our utilization management oversees the authorization of home health care services. Home health care may include:

- Well-baby/post partum care
- Skilled nursing
- Physical therapy
- Respiratory therapy
- Occupational therapy
- Speech therapy
- IV therapy
- DME

Order home health care from any participating home health care provider. Obtain prior authorization for all home health care services.

Hospice

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

Home hospice

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

Respite hospice

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

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

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

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

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

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

Long-term services and supports

UnitedHealthcare Connected members may get longterm services and supports (LTSS), also called Medicaid "waiver services."

LTSS help members 18 years or older who are fully eligible for both Medicare and Medicaid and enrolled in MyCare Ohio stay in the community instead of going to a nursing home or hospital. If members are eligible for waiver services, their care manager helps meet their needs.

The plan covers the following home and community-based waiver services:

- Adult day health services
- Alternative meals service
- Assisted living services
- Choices home care attendant
- Chore services
- Community transition
- Emergency response services
- Enhanced community living services
- Home care attendant
- Home delivered meals
- Home medical equipment and supplemental adaptive and assistive device
- Home modification, maintenance, and repair
- Homemaker services
- Independent living assistance
- Nutritional consultation
- Out-of-home respite services
- Personal care services
- Pest control
- Social work counseling
- Vehicle modifications
- Waiver nursing services
- Waiver transportation

Transition period

A transition period applies to individuals who were enrolled on any of the Ohio Medicaid waivers (PASSPORT, Choices, Assisted Living, Ohio Home Care, or Transitions Carve-Out) before enrolling on the MyCare Ohio Waiver. Exact periods are shown in the Transition Requirements table below.

During this period, we keep members' existing service levels and care providers for a pre-determined amount of time, depending upon the service.

Exceptions

We may change the member's existing care provider during the transition period in the following cases:

- The member requests a change
- The care provider gives appropriate notice of intent (typically 30 days) to stop a member's services
- We identify care provider performance issues that affect a member's health

When the transition period ends, the member's services or care providers won't necessarily change. UnitedHealthcare Connected for MyCare Ohio only has the option to make changes to the member's services after this period. Before the end of the transition period, the member's Waiver Services Coordinator reviews their waiver service plan and discusses any needed changes with members. If a care provider change is required for any reason, the member is given information about other available care providers.

Email questions to UnitedHealthcare Connected for MyCare Ohio at **icdsprovider@uhc.com**. Members may call **Member Services** at **1-877-542-9236** (TTY: **711**).

Transition requirements				
Type	**Wavier consumers**	**Non-waiver consumbers with LTC needs (HH and PDN use)**	**NF consumers** **AL consumers**	**No LTC need consumers**
Physician	- 90 days for individuals identified for high-risk care management - 365 days for all others			
Medicaid DME	Must honor prior authorizations (PAs) when item has not been delivered and must review ongoing PAs for medical necessity			
Scheduled surgeries	Must honor specified care provider			
Chemo/radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified care provider			
Organ, bone marrow, hematopoietic stem cell transplant	Must honor specified care provider			
Dialysis treatment	90 days with same provider and level of service; and comprehensive plan of care documents successful transition planning for new provider.			
Medicaid vision and dental	Must honor PAs when item has not been delivered			
Medicaid home health and PDN	Keep service, care provider and Medicaid reimbursement rate at current levels. No changes unless: • A significant change occurs as defined in OAC 5160-45-01. • Member wants to self-direct services. • 365 days have passed.	Keep existing service for 90 days. Then review for medical necessity after an in-person assessment with care provider observation.	For AL: Keep existing service for 90 days. Then review for medical necessity after an in-person assessment with care provider observation.	N/A
Assisted living waiver service	N/A	N/A	Care provider maintained at current rate for the life of demonstration.	N/A
Medicaid nursing facility services	N/A	N/A	Care provider maintained at current Medicaid rate for the life of demonstration.	N/A
Waiver services - direct care: • Personal care • Waiver nursing • Home care attendant • Choice home care attendant • Out-of-home respite • Enhanced community living • Adult day health services • Social work counseling • Independent living assistance	Keep service, care provider and Medicaid reimbursement rate at current levels. No changes unless: • A significant change occurs as defined in OAC 5160-45-01. • Member wants to self-direct services. • 365 days have passed.	N/A	N/A	N/A
Waiver services - all others	Keep current service level for 365 days and existing service provider for 90 days. Plan-initiated change in service provider only occurs after an in-home assessment and a transition plan.	N/A	N/A	N/A
Behavioral health services	Maintain service provider, level and rate documented in the BH plan of care at enrollment for 365 days.			

Maternity/pregnancy/well-child care

Notification of a pregnancy

Evaluate OB needs using the criteria indicated on the Pregnancy Risk Assessment Form (PRAF). Submit the form to the NurtureOhio. You may also submit the form to the pregnancy care manager at any time during prenatal care if a member's condition constitutes a change of risk status.

Pregnancy/maternity

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code. Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

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

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

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

In-office surgery

Any surgeries a gynecologic provider performs in the office do not require authorization prior to rendering services.

Maternity admissions

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

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

Complete the online Risk Assessment form to initiate case management outreach.

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 and provider ID
- Facility name (provider ID)
- Vaginal or Caesarean delivery

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

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

Nonroutine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the member'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 N.P., P.A. or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

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

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

Post maternity care

UnitedHealthcare Connected for MyCare Ohio Plan covers post discharge care for the mother and her newborn. A post-partum visit should occur with the mother between 7 and 84 days following the delivery.

Newborn enrollment

The hospital must notify the county of all deliveries, including UnitedHealthcare Community Plan members.

The hospital provides enrollment support by providing 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** at **1-800-600-9007** to arrange for home care.

Hysterectomies

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

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

Find the form at the Ohio Department of Medicaid (medicaid.ohio.gov).

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

Exception: ODM 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. You cannot bill members if you do not submit consent forms.

Pregnancy termination services

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

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

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures is based on the member’s documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

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

Sterilization informed consent

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

Sterilization consent form

- Complete all applicable sections of the consent form before submitting it with the billing form. The Ohio 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 United States Department of Health and Human Services website at hhs.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 utilization management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** or call **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

With a few exceptions, UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan) members must use network pharmacies to get their outpatient prescription drugs covered. Generally, we only cover drugs filled at an out-of-network pharmacy when a network pharmacy is not available.

To find out what drugs are covered, go to **UHCprovider.com**. For Medicaid, bill prescriptions filled through retail pharmacies to OptumRx. All written prescriptions must be tamper resistant.

BIN/Processor Control Number/Group Numbers Claims Processor (MyCare - Medicaid only)

- Name of Processor: OptumRx
- Bank Identification Number (BIN): 610494
- Processor Control Number (PCN): 9999
- Submitted Group (Group): ACUOHMMP

For UnitedHealthcare Connected, bill prescriptions through retail pharmacies to OptumRx. All written prescriptions must be tamper-resistant.

BIN/Processor Control Number/Group Numbers Claims Processor (UnitedHealthcare Connected for MyCare Ohio - fully integrated)

- Name of Processor: OptumRx
- Bank Identification Number (BIN): 610097
- Processor Control Number (PCN): 9999
- Submitted Group (Group): MPDOHCSP

We cover the following:

- Drugs administered in a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center. Previous prior authorization requirements still apply.
- Some medical supplies such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers and peak flow meters. Find more information on our drug list.

Members may receive prescriptions at any network pharmacies. If a member is planning to travel out of state, work with the member to make sure they have enough of their medication. Members may call **Member Services** (TTY Relay: **711**).

Pharmacy drug list

We cover drugs listed on our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or network mail order pharmacy service, and other coverage rules are followed.

We have additional coverage requirements or limits for certain prescription drugs. If an enrollee requires a non-formulary medication, call **Pharmacy Prior Authorization** at **1-800-711-4555** or use the online Prior Authorization and Notification tool in the **UnitedHealthcare Provider Portal**.

Pharmacy prior authorization

The rules apply to drugs and to those affected by a clinical prior authorization edit. To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-711-4555**. We review expedited requests within 24 hours and standard requests within 72 hours.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our 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**.

Radiology

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

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

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

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

- Emergency room
- Observation unit
- Urgent care
- Inpatient stay
- Other community settings

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 care provider within the scope of their practice. Care providers:

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

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

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

Screening

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

Brief intervention

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

Referral to treatment

Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.

SBIRT services will be covered when all are met:

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

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

- Primary care centers
- Trauma centers
- Other community settings as determined by SAMSA and regulators
- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC
- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter

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

Medication-assisted treatment

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

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

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT care provider in Ohio:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Medical Care Directory."
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 **Provider Services** at **1-800-600-9007** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Opioid resources

- Interagency Guideline on Prescribing Opioids for Pain: agencymeddirectors.wa.gov > Interagency Guidelines > AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain
- National Center for Biotechnology Information: ncbi.nlm.nih.gov > enter either "3218789" or "The Role of Psychological Interventions in the Management of Patients with Chronic Pain" in search engine
- Opioid Use Disorder Diagnostic Criteria from the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, 2013

Treatment helpline

Free, confidential service for UnitedHealthcare members. Specialized licensed clinicians provide treatment advocate services 24 hours a day, 7 days a week.

- Phone: **1-855-780-5955**
- Website: **liveandworkwell.com**

For other questions, call **1-888-362-3368**.

Tuberculosis screening and treatment

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

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance and follow-up of members. 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

All members receive an eye exam every 12 months. They also have a choice of glasses or $125 toward any type of contacts (must use at one time) every 12 months.

UnitedHealthcare Community Plan also offers an additional frame selection beyond what Medicaid covers at no cost to the member. Refer to the Provider Directory for a list of optometrists in the UnitedHealthcare Community Plan network to set up eye appointments.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

Call **Provider Services** at **1-800-600-9007** or use the Provider Portal to obtain a medical prior authorization. For **behavioral health services**, call **1-800-888-2998**.

If you have questions, go to Ohio's prior authorization page at **UHCprovider.com/OHcommunityplan** > Prior Authorization and Notification Resources.

Additional requirements include:

- Ohio Medicaid managed care plans must respond to electronically submitted prior authorizations within 48 hours for urgent services and 10 calendar days for any non-urgent care services. This time period begins once the plan receives the request with all required information.
- Responses to prior authorization requests must indicate whether the request is approved, denied, or incomplete. When the response to a prior authorization is denied, the managed care plan must provide the specific reason.
- If the prior authorization request is incomplete, the department or its designee shall indicate the specific additional information that is required to process the request.

Some dental services require prior authorization. Submit requests to:

UnitedHealthcare Dental Authorizations
P.O. Box 2126, Milwaukee, WI 53201 or call **1-855-642-5483** (8 a.m. - 6 p.m. ET Monday-Friday).

The Utilization Management (UM) department will respond to prior authorization requests within 10 days. If the member's condition requires an expedited response, notify intake/prior authorization to consider the request as urgent.

Prior authorization requests are generally reviewed and decided within 72 hours of the request; however, you may be granted an extension of up to 10 days from the date of the original request to provide additional information. For peer-to-peer discussions, call the **UM prior authorization** line at **1-800-600-9007**.

See the following table for more information about requirements.

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

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses MCG (formerly Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings.

This includes:

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

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and guidelines

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

Referral guidelines

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

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

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

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

Reimbursement

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

- Determine if the member is eligible on the date of service by using the Determine if the member is eligible on the date of service by using the **UnitedHealthcare Provider Portal**, or contacting our **Provider Services** at **1-800-600-9007** department, or the Ohio Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the ODM. 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. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact **Provider Services** at **1-800-600-9007**.
- 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

Covered services for Medicaid only

Medicaid helps with medical costs for certain people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and may also pay for Medicare deductibles, co-insurance and co-payments except for prescriptions. Medicaid covers long-term care services such as home and community based "waiver" services, which includes assisted living services and long-term nursing home care. It also covers dental and vision services.

Because a member chose or was assigned to only receive Medicaid-covered services from our plan, Medicare will be the primary payer for most services.

The member can choose to receive both your Medicare and Medicaid benefits through UnitedHealthcare Connected so all of your services can be coordinated.

If a member must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Connected will provide transportation to and from the provider's office. These services must be medically necessary and not available in member's service area. A member must also have a scheduled appointment (except in the case of urgent/emergent care).

In addition to the transportation assistance that UnitedHealthcare Connected provides, members can still receive assistance with transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program.

If a member has been determined eligible and enrolled in a home and community-based waiver program, there are also waiver transportation benefits available to meet the member's needs.

As a UnitedHealthcare Connected member, they will continue to receive all medically necessary Medicaid-covered services at no cost to the member. These services may or may not require an okay before the member receives the service. Please see the following lists to determine if the member's benefits require approval.

- Acupuncture (for the treatment of low back pain and migraines)
- Ambulance transportation
- Assisted living services
- Dental services
- Durable medical equipment and supplies
- Family planning services and supplies
- Free-standing birth center services at a freestanding birth center (please see the following charts for more information)
- Medicaid home health and private duty nursing services
- Hospice care in a nursing facility (care for terminally ill, e.g., cancer patients)
- Mental health and substance abuse services (please see the following charts for more information)
- Nursing facility and long-term care services and supports (please see the following charts for more information)
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Prescription drugs (certain drugs not covered by Medicare Part D) (please see the following charts for more information)
- Services for children with medical handicaps (Title V)
- Hearing services, including hearing aids
- Vision (optical) services, including eyeglasses
- Waiver services
- Yearly well adult exams when Medicare does not cover these

Services not covered by UnitedHealthcare Community Plan Medicaid-only services

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

- Services considered not "reasonable and necessary," based on Medicare and Medicaid standards, unless we list the services as covered under our plan
- Experimental medical and surgical treatments, items and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or our plan
- Experimental treatment and items not generally accepted by the medical community
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when medically needed
- Personal items in a member's room at a hospital or a nursing facility, such as a phone or a television
- Inpatient hospital custodial care
- Full-time nursing care in the member's home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to correct a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after

a mastectomy and for treating the other breast to match it.
- Chiropractic care other than diagnostic X-rays and manual spinal manipulation correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided based on Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the mother's life
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if younger than age 21 or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Paternity testing
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)
- Equipment or supplies that condition the air, wigs and their care, and other primarily non-medical equipment
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), unless Medicare criteria are met
- Medicaid-excluded services

The following items and services are not covered by our plan:

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan
- Experimental treatment and items are those that are not generally accepted by the medical community
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when it is medically needed
- Inpatient hospital custodial care
- Full-time nursing care in the home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless needed due to an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic X-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if younger than 21 years old or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Paternity testing
- Naturopath services (the use of natural or alternative treatments)

- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)
- Equipment or supplies that condition the air, wigs, and their care, and other primarily non-medical equipment
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), unless Medicare criteria are met
- Immunizations for foreign travel

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

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

Utilization management guidelines

Call **1-800-600-9007** to discuss the guidelines and utilization management.

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

Utilization management appeals

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

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

Peer-to-peer discussion

Prior authorization requests are reviewed by a physician medical director prior to any denial. We base the review on the information the ordering provider sends.

We review and decide prior authorization requests within 72 hours of the request. However, you may get up to 10 days from the date of the original request to provide more information. Ordering care providers who disagree with a denial may contact the prior

authorization area for a peer-to-peer discussion with the physician medical director. We recommend this intervention before filing an appeal.

To start a peer-to-peer discussion, call the **UM prior authorization** line at **1-800-600-9007**.

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

Key contacts

Topic	Links	Phone number
EPSDT	medicaid.ohio.gov> Families & Individuals > Programs & Initiatives > Healthchek	1-800-324-8680
Vaccines for Children	medicaid.ohio.gov > For Ohioans > VFC	1-800-282-0546

Healthchek is Ohio's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. It provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 21, including pregnant members. EPSDT screening includes the following:

- Immunizations
- Hearing
- Vision
- Speech screening and nutritional assessments
- Dental screening
- Growth and development tracking

For complete details about diagnoses codes as well as full and partial screening, examination and immunization requirements, go to the EPSDT schedule at medicaid.ohio.gov.

Healthchek

The UnitedHealthcare Community Plan pediatric service requirements includes Healthchek screenings for children up to age 21. The PCP is responsible for complying with and coordinating services related to Healthchek.

It is essential that children enrolled in UnitedHealthcare Community Plan receive screening exams at the appropriate ages. The PCP member roster identifies those members who are due for a Healthchek screen in the upcoming month. UnitedHealthcare Community Plan will assist the PCP in notifying members due for a Healthchek screen. The PCP is also responsible for Healthchek outreach and follow-up care. Learn more at medicaid.ohio.gov > Families & Individuals > Programs & Initiatives > Healthchek.

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 disabilities include intellectual disability, 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 to adulthood.

Referral

If you determine supportive services would benefit the member, refer the member to DDS for approval and assignment of a regional center case manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the regional center interdisciplinary team. While the regional center does not provide overall case management for their clients, they must assure access to health, developmental, social and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of Care

The regional center will determine the most appropriate setting for eligible HCBS and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. 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 currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary and therapeutic covered services

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. 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.

Lead screening/treatment

Call **Provider Services** at **1-800-600-9007** if you find a child has a lead blood level over 10 ug/dL. Ohio law requires all health care providers to administer blood lead test to children at age 1 and 2 years, or up to age 6 if no previous test has been completed.

PCPs must use a participating lab service for collection. PCPs may draw the blood in the office and use the selected lab's courier service if available. Direct the member to the selected lab's nearest draw site

Pediatric services

During the Healthchek screening, PCPs should identify the need for other medically necessary services. Children younger than 21 years old may receive other medically necessary services, including speech therapy, occupational therapy, physical therapy, nutritional counseling, specialized nursing care, behavioral health, psychological services and mental health wrap-around services. Submit requests for these services to the Utilization Management department.

Sexual Assault Findings Examination/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 SAFECARE services through Ohio Medicaid on a fee-for-service basis. Call Ohio Medicaid for more information.

Target case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational and other services provided by a regional center or local governmental health program as appropriate.

Identification

The 5 target populations include:

1. Children younger than 21 at risk for medical compromise.
2. Medically fragile individuals.
3. Individuals in frail health, older than 18 and at risk of institutionalization.
4. Members in jeopardy of negative health or psychosocial outcomes.
5. Members infected with a communicable disease, including TB, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed.

Referral

Members who are eligible for TCM services are referred to a regional center or local governmental health program as appropriate for the provision of TCM services.

Continuity of Care

UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the contract.

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Healthy First Steps program	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/OH** > View plan details	**1-800-600-9007**

We offer the following services to our UnitedHealthcare Community Plan members. if you have questions or need to refer a member, call UnitedHealthcare **Provider Services** at **1-800-600-9007** unless otherwise noted.

Adult pain management/ chiropractic services

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

We 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.

Use the following steps to access the fee schedules online:

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

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

Chronic condition management

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

Members at highest risk with conditions such as asthma, congestive heart failure, diabetes, chronic obstructive pulmonary disease and coronary artery disease receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification

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

Referral

PCPs may make referrals to support practice-based interventions by contacting the **Health Services team** at **1-866-270-5785.**

Early Intervention program

Early Intervention promotes the development of infants and toddlers with developmental challenges and delays. It also covers certain disabling conditions. The program provides services to eligible children from birth to 3 years old and their families.

Foster care

Peer support specialist

We have a foster care peer support specialist working with youth in the foster care system and their families. The specialist works with the member and the family to define the member's recovery goals. The specialist helps the member develop life skills and provides phone and/or face-to-face communications to members. The member and foster family receive support and help improve the member's overall physical and behavioral health. This benefit can also help to reduce hospitalizations and ER visits related to behavioral conditions in youth in foster care services.

Healthy First Steps program

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

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

How it works

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

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

How you can help

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

Babyscripts

Babyscripts™ is a mobile app based maternity engagement and rewards platform for pregnant members, designed to drive better compliance with prenatal and postpartum care and target Social Determinants of Health (SDoH).

Babyscripts partners with March of Dimes (MOD), the American College of Obstetricians and Gynecologists (ACOG), National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC) to combine best practices in maternity care with the latest trends in digital health.

Goals of the Babyscripts program:

- Improve maternal and child health outcomes
- Drive member engagement
- Improve NPS scores
- Improve HEDIS scores (PPC, W15)
- Demonstrate innovation and competitive advantage

The Babyscripts™ program aims to achieve these goals by:

- Offering rewards when enrolling and completing important doctor visits
- Engaging members via a variety of platforms (app notifications, email, and text messages)
- Including educational articles, appointment reminders and customizable tools

The Babyscripts myJourney app can be downloaded via the App Store or Google Play.

Hypoallergenic bedding

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

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

JOIN for ME

JOIN for ME® 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. JOIN for ME is for members ages 6–17. Call **Provider Services** at **1-800-600-9007** for more information.

Just Plain Clear Glossary

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

Mobile apps

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

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

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-866-351-6827** to reach a nurse.

On My Way

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

Quit For Life

The **Quit For Life®** program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching and web-based learning tools, this 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.

UHC Doctor Chat—virtual visits

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

Women, Infants and Children Supplemental Nutrition

State-funded program

The state also has programs such as the Women, Infants, and Children Supplemental Nutrition program (WIC) to help with nutritional needs for low-income families. For more information about WIC, call 1-614-644-8006 , email OHWIC@odh.ohio.gov or go to odh.ohio.gov.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-800-888-2998**

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

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

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

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

To request an ID number, go to the ODM website at medicaid.ohio.gov > Providers > Enrollment and Support > Provider Enrollment.

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 plus articles on health conditions, addictions and coping. It also provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, 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.

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telehealth
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Rehabilitation services
- Day treatment/intensive outpatient

- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Self-referred services

Some services are available without a referral:

- Dental care
- Vision care
- Women's routine and preventive health care services provided by a women's health specialist (obstetrics, gynecology, certified nurse midwife)
- Specialty care (except for chemotherapy and pain management specialist services)
- Emergency care
- Services provided by qualified family planning providers (QFPP)
- Medicaid Community Mental Health Centers (CMHCs), certified Medicaid providers affiliated with the Department of Mental Health and Addiction Services (MHA) and certified providers affiliated with the MHA and any outpatient participating care provider for routine outpatient therapy.
- Mental health and substance abuse services
- Services provided at FQHC)/RHC
- Dialysis
- Radiation therapy
- Mammograms

Access to behavioral health services rendered by other care providers requires prior authorization. This includes outpatient ECT, home health and psychological testing.

Members must use a participating care provider for all self-referred services except for emergency care or for services provided at FQHC/Rural Health Clinics, QFPP, community mental health centers, and Ohio Department of Alcohol and Drug Addiction Services facilities, which are Medicaid providers

Eligibility

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

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering nonemergent services. Request prior authorization using the Prior Authorization and Notification tool on the **UnitedHealthcare Provider Portal** or by calling **1-866-604-3267.**

Collaboration with other care providers

Coordination of care

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

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

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

Portal access

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

Claims

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

Monitoring audits

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

Training resources and materials

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

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

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.

Additionally, pain management toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain.

Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

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

Prescribing opioids

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

Pharmacy lock-in

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

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 health MAT care provider in Ohio:

1. Go to **UHCprovider.com/findprovider.**
2. Click on Behavioral Health Directory.
3. Click on Medicaid Plans.
4. Click on applicable state.
5. Select applicable plan.
6. If needed, refine the search by selecting "Medication Assisted Treatment."

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

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

OhioRISE

UnitedHealthcare Community Plan is not required to cover behavioral health services for members enrolled in the OhioRISE Plan, except for certain behavioral health services in accordance with the OhioRISE Mixed Services Protocol developed by ODM.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/OH**	Medicaid: **1-800-895-2017** MyCare: **1-877-542-9236**
Member handbook	**UHCCommunityPlan.com/OH** > Community Plan > Member benefits	

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

Privacy regulations

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

Access to protected health information

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

Amendment of protected health information

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

Accounting of disclosures

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

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

Right to request restrictions

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

Right to request confidential communications

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

Member right and responsibilities

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

Native American access to care

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

Members rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights (ODJFS) with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:
  - **Office for Civil Rights**
    United States Department of Health and Human Services
    233 N. Michigan Ave., Suite 240
    Chicago, IL 60601
    1-312-886-2359 (TTY: 1-312-353-5693)
  - **Bureau of Civil Rights Ohio**
    Department of Job and Family Services
    30 E. Broad St., 30th Floor
    Columbus, OH 43215
    1-614-644-2703; 1-866-227-6353 (TTY: 1-866-221-6700)
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force designed to get them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit covered
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply
- To change their PCP to another PCP on UnitedHealthcare Community Plan's panel at least monthly. UnitedHealthcare Community Plan must send members something in writing that says who the new PCP is and the date the change began.

- To be free to carry out their rights and know that the MCP, the MCP's providers, or ODJFS will not hold this against them

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) ID card along with any other insurance they may have
- Choose their PCP
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

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

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

Chapter 9: Medical records

Medical record charting standards

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

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 24 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel
Procedural elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

***Critical element**

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

***Critical element**

Member copies

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

Medical record review

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

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or note the member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by 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
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-800-455-4521** (NAVEX)

What is the Quality Improvement program?

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

The program consists of:

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

As a participating care provider, you may offer input through representation on our QI committee and your Provider Services representative/provider advocate. Our Provider Advisory Committee offers a structured forum to review current Quality Improvement activities, and provide input and recommendations for program design.

Cooperation with quality-improvement activities

You must comply with all QI activities. These include:

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

We require your cooperation and compliance to:

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

Care provider satisfaction

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

- Regular visits
- Town hall meetings
- Provider Advisory Council input

We elicit provider feedback in our Provider Advisory Council committees.

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 and recredentialing process

ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the provider network management system. This process adheres to NCQA and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process.

Medical students, residents, fellows and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

Health Insurance Portability and Accountability Act compliance – your responsibilities

Health Insurance Portability and Accountability Act compliance – your responsibilities (HIPAA) aims to improve the efficiency and effectiveness of the United States health care system. While the act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations — as are all care providers who conduct business electronically.

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations. Find additional information on HIPPA regulations on cms.hhs.gov

Ethics and integrity

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

Compliance program

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

1. Oversight of the Ethics and Integrity program.
2. Development and implementation of ethical standards and business conduct policies.
3. Creating awareness of the standards and policies by educating employees.
4. Assessing compliance by monitoring and auditing.
5. Responding to allegations of violations.
6. Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
7. Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

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

Reporting and auditing

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

The UnitedHealthcare Community Plan special investigations unit (SIU) is an important part of the compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities. To report questionable incidents involving members or care providers, call our fraud, waste and abuse line, go to **uhc.com/fraud,** or refer to the **Fraud, waste, and abuse section** of this care provider manual for additional details.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and

policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

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

Cooperation in meeting CMS requirements

UnitedHealthcare Connected must provide to CMS information necessary for CMS to administer and evaluate the UnitedHealthcare Connected program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare and Medicaid services. Such information includes plan quality and performance indicators such as disenrollment rates; information on member satisfaction; and information on health outcomes. You must cooperate with UnitedHealthcare Connected in its data reporting obligations by providing to UnitedHealthcare Connected any information that it needs to meet its obligations.

Certification of diagnostic data

UnitedHealthcare Connected is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a provider, supplier, physician, or other practitioner (encounter data). Participating care providers that furnish diagnostic data to assist UnitedHealthcare Connected in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Risk adjustment data

You are encouraged to comprehensively code all members' diagnoses to the highest level of specificity possible. All members' medical encounters must be submitted to UnitedHealthcare Connected.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Ohio 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 Ohio DHHS.

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 Ohio program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. Retain records based on Ohio Administrative Code. 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 Ohio program standards.

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

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

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

Delegating and subcontracting

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

Delegation oversight

We may assign medical management to a medical group/ Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a "delegate." Care providers associated with these delegates may use the delegate's office and protocols for authorizations. The delegate's medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance.

Delegates who do not achieve compliance within the established timeframes may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals

When we review a member or care provider's adverse determination appeal from a delegate, we use Interqual as the externally licensed medical management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

Semi-annual reporting

The delegate provides UnitedHealthcare Community Plan with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

Purpose of Medical Management Program

The Medical Management Program helps determine if medical services are:

- Medically necessary
- Covered under the UnitedHealthcare Community Plan benefit
- Performed at both the appropriate place and level of care

Determining medical necessity

Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, delegates use UnitedHealthcare Community Plan's medical policies. If other nationally recognized criteria disagree with Medicaid coverage guidelines, delegates follow Medicaid coverage guidelines.

Members may call the delegate's general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make UM decisions.

The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

Care provider requirements

Render covered services at the most appropriate level of care based on nationally recognized criteria. With few exceptions, we do not reimburse for non-covered services and those not medically necessary. We do not reimburse for the wrong procedures (e.g., notification requirements, preauthorization, verification guarantee process). Authorization receipts do not affect how payment policies determine reimbursement.

We nor the member are responsible for reimbursing medical services, admissions, inappropriate facility days, and/or medically necessary services if you did not obtain required prior authorization. Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services after UnitedHealthcare Community Plan or the delegate deny preauthorization, no care provider, facility or ancillary services will be reimbursed. The delegate's medical director can discuss the decisions and criteria with the member. The delegate also makes the medical policy decisions available upon request

Medical management denials/ adverse determinations

UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

Denials, delays or modifications

UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials.

We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member's medical condition, based on applicable state and federal law. We base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board-certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate.

Determination rules include:

- You may not review your own referrals
- Care providers qualified to make an appropriate determination will review referral requests considered for denial
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individuals who can hold financial ownership interest in the organization may not influence the clinical or payment decision

Possible request for authorization determinations include:

- Approved as requested – No changes
- Approved as modified – Referral approved, but changed the requested care provider or treatment plan. (e.g., requested chiropractic, approved physical therapy)
- Extension – Delay of decision (e.g., need additional information, require consultation). CMS allows an extension when a Medicaid member requests one.
- Delay in Delivery – Postpone access to an approved service until a certain date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization request for health care services

Reasons for denials of requests for services include:

- Not a covered benefit – The requested service(s) is excluded under the member's benefit plan

- Not medically necessary or benefit coverage limitation – Specify criteria or guidelines used to make the determination
- Member not eligible at the time of service
- Benefit exhausted - Include what benefit was exhausted and when
- Not a participating care provider – A participating care provider/service is available within the medical group/ IPA in-network
- Experimental or investigational procedure/treatment
- Self-referred/no prior authorization (for nonemergent post-service)
- PCP can provide requested services

Written denial notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion
- Member-specific information about how the member did not meet criteria
- Appeal rights
- An alternative treatment plan, if applicable
- Benefit exhaustion or planned discharge date

CMS requires the use of the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/ NDMC) for Medicaid plan members. Do not alter this template except to add text to the requested areas. Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan will provide appropriate and approved templates to the delegates.

Minimum content of written or electronic notification

Written or electronic notices to deny, delay or modify a health care services authorization request must include the following:

- The requested services
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification, or partial approval, including:
  - Clear, understandable explanation of the decision
  - Name and description of the criteria used
  - How those criteria were applied to the member's condition
- Notification the member can get a free copy of the benefit provision, guideline, protocol or other criterion used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary
- Appeal and grievance processes, including:
  - When, when, how and where to submit a standard or expedited appeal
  - The member's right to appoint a representative to file the appeal
  - The right to submit written comments, documents or other additional relevant information
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
- The name and phone number of the health care professional responsible for the decision

Medical group/Independent Physician Association's responsibilities related to member grievance and appeals

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:

- Within 1 hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated timeframe. (Standard appeals with 24 hours, expedited appeals within 2 hours. Timeframes apply to every calendar day.)
- Comply with all final UnitedHealthcare Community Plan determinations.
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or State Fair Hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.

- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested timeframes on adverse determinations reversals
- Respond to requests for proof of overturned appeals

Referrals

Referral authorization procedure

The delegate may initiate a member referral. (Refer to the delegated group's pre-authorization list, as applicable.) The following capitated medical services are examples of when a referral authorization may be needed:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/ IPA's facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:

- Review the service request for medical necessity.
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member.
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination.

If the request is not approved, the delegate must issue the member a denial letter.

Referral authorization form

The delegate may design its own authorization form, without approval from UnitedHealthcare Community Plan. The form should include all the following:

- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/ IPA address)
- Verification of member eligibility

The delegate provides this form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office

The delegate does so within 36 hours of receipt of information necessary to make a decision. This includes 1 working day and does not exceed 14 calendar days. If UnitedHealthcare Community Plan is financially responsible for the services, the delegate submits the authorization information to the plan.

Continuity of care

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It is intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out- of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of 1) 60 calendar days or 2) until the member has transferred without disruption of care to an in-network care provider
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation

Members in their third trimester of pregnancy may receive services from their prenatal care provider (whether in-network or out-of-network) without any form of prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a nonparticipating care provider without formal approval by UnitedHealthcare Community Plan or the delegate. Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member's responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member's condition and the potential effect on the member's treatment.

We also consider how changing the care provider can affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including facility privileging, utilization review, peer review and quality assurance requirements; and
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services who are not capitated and are practicing in the same geographic area.

Notification requirements for facility admissions when UnitedHealthcare pays claims

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient cases. This information is needed to verify eligibility, authorize care, and initiate concurrent review and discharge planning. In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

Authorization log and denial log submission

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted at least twice a week to the Authorization Log Unit at **clinicaloperations@uhc.com**. When no inpatient acute, observation statuses or skilled nursing facility cases are active, the delegate must submit its weekly authorization log indicating either "no activity" or "no admissions" for each designated admission service type specified in this section and for the applicable reporting time.

Authorization logs covering facility and skilled nursing facility daily information includes the following:

- Member ID
- Member name
- Member date of birth
- Attending care provider: (Name and address, with TIN if available)
- Facility care provider: (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your provider advocate.

Office site quality

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

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

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

Criteria for site visits

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

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

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-800-210-8315**

Our claims process

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

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

Claims process from submission to payment

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

If you think we processed your claim incorrectly, please see the **Claims reconsiderations, appeals and 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** at **1-800-600-9007**. Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Payment in full

Based on OAC Rule: 5160-1-60, payment by UnitedHealthcare Community Plan is considered payment in full. Participating and non-participating care providers may not bill a member unless all the following are met:

1. You notified the member of the financial liability before the service delivery.
2. You gave the notification in writing, specific to the service being rendered. It clearly states the member is financially responsible for the service.
3. The member dates and signs the notification.
4. The reason we don't cover the service is specified and is one of the following reasons:
   - The service is a benefit exclusion.
   - The care provider is not in network, so we have denied approval for the service because it is available from a contracted provider.
   - The care provider is not in network and has not requested approval to provide the service.

Fee schedule

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

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

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

Clean claims and submission requirements

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

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

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

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

Submit paper claims to:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Care provider coding

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

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

Electronic claims submission and billing

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

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

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

Electronic data interchange companion documents

The UnitedHealthcare Community Plan electronic data interchange (EDI) companion documents are intended to share information within implementation guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

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

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

The companion documents are located 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 **1-800-600-9007** for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

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

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

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for automated clearinghouse (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment. The only alternative to a virtual card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose automated clearinghouse/ direct deposit?

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

What does this mean to you?

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

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/ resourcelibrary** to find the **EDI** section.

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

Additional claim submission requirements

Follow these tips for 837 claim formats:

- Use the 2010AA Billing Provider loop when the billing and rendering provider are the same.
- Use the 2310B Rendering Provider loop when the rendering and billing provider are NOT the same.
- You may use the 2420A Rendering Provider Line Level when there are multiple rendering providers.
- However, for claims that process on the Facets system, use 1 rendering provider per claim. Claims with multiple rendering providers will have to be formatted at separate claims.

Completing the UB-04 form

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

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

Capitated services

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

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

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

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

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

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

Form reminders

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

Subrogation and coordination of benefits

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

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

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

Hospital and clinic method of billing professional services

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

Hospitals should submit claims to the UnitedHealthcare Connected (MyCare Ohio) claims address as soon as possible after service is rendered, using the standardUB-92 form or electronically.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member's date of birth and sex
- Member's UnitedHealthcare Connected ID number
- Indication of:
  - Job-related injury or illness, or
  - Accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Provider's ID number and locator code, if applicable
- Provider's Tax ID number
- Name/address of participating provider

Global days

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

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

National Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical laboratory improvements amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Reporting birth weight on newborn claims

You must report newborn weight to UnitedHealthcare Community Plan.

To report this data, use the appropriate value code:

- **UB-04**: Report in block 39, 40 or 41 using value code "54" and the newborn's weight grams.
- **If billing electronically**, please report birth weight in loop 2300, segment HI, with the qualifier BE and the value code "54" in HI01-2 and the newborn's weight in grams in HI01-5.

We reference the following codes to identify newborn claims. Therefore, include birth weight on all claims containing these codes:

ICD-10 procedure codes:

- 72.x Forceps, vacuum, and breech delivery
- 73.51 Manually assisted delivery; Manual rotation of fetal head
- 73.59 Manually assisted delivery; Other
- 74.0 Cesarean section and removal of fetus; Classical cesarean section
- 74.1 Cesarean section and removal of fetus; Low cervical cesarean section
- 74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
- 74.4 Cesarean section and removal of fetus; Cesarean section of other specified type
- 74.99 Cesarean section of unspecified type

ICD-10 diagnosis codes:

- 080 Normal Delivery
- V27.x Outcome of Delivery

The following codes must have a 5th digit equal to 1 or 2:

- 640-648 Complications mainly related to pregnancy
- 651-659 Normal delivery and other indications for care in pregnancy, labor, and delivery
- 660-669 Complications occurring mainly during the course of labor and delivery
- 670-676 Complications of the puerperium

CPT codes:

- 59409 Vaginal delivery (with or without episiotomy or forceps)
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Reporting date of last menstrual period

You must report the date of a member's last menstrual period to UnitedHealthcare Community Plan. If billing on paper, report the date of the last menstrual period as follows:

- **UB-04**: Report anywhere in blocks 32-36 using occurrence code "10" in one block with the date of the last menstrual period in the next block.
- **CMS-1500:** Report in block 14 using the date of the last menstrual period.

If billing electronically, please report the date of the last menstrual period as follows:

- **837I**: Report using occurrence code "10" and the date of the last menstrual period in loop 2300, segment HI, qualifier BH.
- **837P**: Report the date of the last menstrual period in loop 2300, segment DTP, qualifier 484.

Billing guidelines for transplants

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

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

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

You can ask about claims through **Provider Services** at **1-800-600-9007** and the **UnitedHealthcare Provider Portal.**

Provider Services

Call **1-800-600-9007**. Have the following information ready before you call:

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

- Your ID number
- Claim number

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

UnitedHealthcare Provider Portal

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

Resolving claim issues

To resolve claim issues, contact **Provider Services** at **1-800-600-9007** through the **UnitedHealthcare Provider Portal**, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

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

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

For paper claims

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

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

Timely filing

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

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

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

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

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

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

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

Balance billing

Do not balance bill members if:

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

You may balance bill the member for noncovered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, connect with 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.

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 claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 8207 Kingston, NY 12402	**UHCprovider.com/claims**	**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Must receive within 45 days	30 business days
Care provider claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with	Care provider	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 8207 Kingston, NY 12402	**UHCprovider.com/claims**	**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims.	45 calendar days	45 business days
Care provider claim formal appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration	Care provider	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		**1-800-600-9007**	Use the Claims Management or Claims on the portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims.	45 calendar days	30 business 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 appeal	A request to change an adverse benefit determination that we made	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364	**providerforms.uhc.com/ProviderAppealsandGrievance.html** • AOR Consent Form on this site for member appeals	**1-800-895-2017,** TTY **711**		Urgent appeals – must receive within 5 business days Standard appeals – 60 calendar days	Urgent appeals – we will respond within 48 hours Standard appeals - 15 days
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-895-2017,** TTY **711**		N/A	Access related – 2 business days Non-claims related – 30 calendar days Claims related – 60 calendar days

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

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

Denial

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

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  The level of care billed wasn't approved as medically necessary

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

Other top reasons for denial include:

- **Duplicate claim**
  One of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information**
  Basic information is missing, such as a person's date of birth; or information is incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired**
  Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.
- **Claim not covered by UnitedHealthcare Community Plan**
  Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired**
  This is when you don't send the claim in time.

Claim correction

What is it?

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

When to use:

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

How to use:

Use the claims reconsideration application on the UnitedHealthcare Provider Portal.

To access the **UnitedHealthcare Provider Portal,** sign in to using your One Healthcare ID.

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

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

For those care providers exempted from this requirement, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Additional information

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

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

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

Reconsiderations can be done repeatedly but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed. You have 45 days from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) to submit your claim reconsideration.

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

For medical necessity denials –

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

How to use:

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

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

- **Phone –** Call **Provider Services** at **1-800-600-9007** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.

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

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

For those care providers exempted from this requirement, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

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

  UnitedHealthcare Community Plan
  P.O. Box 8207
  Kingston, NY 12402

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 **1-800-600-9007** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

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

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

How to use:

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

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

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

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

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

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

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

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-800-600-9007**.

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

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

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

Where to send:

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

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

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

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See **Chapter 10, Resolving disputes** section.

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

Sample overpayment report

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

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

Appeals (step 2 of dispute)

What is it?

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

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process. We resolve disputes within 45 days of receiving the disputed claim and remittance advice.

How to use:

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

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

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

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

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

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

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

Questions about your appeal or need a status update?

Call **Provider Services** at **1-800-600-9007** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure **UnitedHealthcare Provider Portal**.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Initial decisions

The "initial decision" is the first decision UnitedHealthcare Connected makes regarding coverage or payment for care. In some instances, you, acting on behalf of UnitedHealthcare Connected, may make an initial decision about whether a service will be covered.

If a member asks us to pay for medical care the member has already received, this is a request for an initial decision about payment for care.

If you or a member asks for preauthorization for treatment, this is a request for an "initial decision" about whether the treatment is covered by UnitedHealthcare Connected.

If a member asks you for a specific type of medical treatment, this is a request for an initial decision about whether the treatment the member wants is covered by UnitedHealthcare Connected.

UnitedHealthcare Connected will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UnitedHealthcare Connected will cover medical care can be a standard decision that is made within the standard time frame (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 48 hours).

A decision about whether UnitedHealthcare Connected will cover medical care can be a standard decision made within the standard time frame (typically within 15 days) or it can be an expedited decision that is made more quickly (within 48 hours).

A member can ask for an expedited decision only if the member or any physician believes that waiting for a standard decision could seriously harm the member's health or ability to function. The member or a physician can request an expedited decision. If a physician requests an expedited decision, or supports a member in asking for one, and the physician indicates that waiting for a standard decision could seriously harm the member's health or ability to function, UnitedHealthcare Connected will automatically provide an expedited decision.

At each encounter with a UnitedHealthcare Connected member, you must notify the member of their right to receive, upon request, a detailed written notice from UnitedHealthcare Connected regarding the member's services. Your notification must provide the member with the information necessary to contact UnitedHealthcare Connected and must comply with any other CMS requirements. If a member requests UnitedHealthcare Connected to provide a detailed notice of your decision to deny a service in whole or part, UnitedHealthcare Connected must give the member a written notice of the determination.

If UnitedHealthcare Connected does not make a decision within the time frame and does not notify the member about why the time frame must be extended, the member can treat the failure to respond as a denial and may appeal.

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

When to use:

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

Where to send:

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

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

Phone – 1-800-895-2017 (TTY **711**)

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

How to use:

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

The member has the right to:

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

We resolve a standard appeal 15 calendar days from the day we receive it.

We resolve an expedited appeal 48 hours from when we receive it.

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

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

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-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 anytime to:

Mailing address:

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

Phone – 1-877-542-9236 (TTY **711**)

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

Further appeal rights

If UnitedHealthcare Connected denies the member's appeal in whole or part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of UnitedHealthcare Connected. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Department Appeal Board (DAB). If the Department Appeal Board (DAB) refuses to hear the case or issues an adverse decision, the member may be able to appeal to a District Court of the United States.

State hearings

What is it?

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

When to use:

Members have 90 calendar days from the date on the UnitedHealthcare Community Plan adverse appeal determination letter.

How to use:

For details, visit jfs.ohio.gov. The UnitedHealthcare Community Plan member may ask for a state hearing by writing a letter to:

ODJFS Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

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

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

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

Fraud, waste and abuse

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

The UnitedHealthcare Community Plan anti-fraud, waste and abuse efforts focus on prevention, detection and investigation of false and abusive acts committed by you and plan members. The effort also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

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

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

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

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

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

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

State laws

States where UnitedHealthcare Community Plan does business have laws that contain civil or criminal penalties for false claims and statements that are in addition to the penalties provided in the Act. Certain states also have whistle-blower protections similar to the Act. In Ohio, the applicable laws are ORC Sections 5164.35, 5162.15, 2913.40, 124.341, 4113.52, and 3901.44. For more information on a specific state law, please contact the UnitedHealthcare Community Plan compliance officer or legal department.

Exclusion checks

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

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

What you need to do for exclusion checks

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

Sanctions under federal health programs and state law

You must help ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the participating care provider.

You must disclose to UnitedHealthcare Connected whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of Ohio, the federal government, or any public insurer.

Notify UnitedHealthcare Connected immediately if any such sanction is imposed on you, a staff member or subcontractor.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-800-600-9007**
News and bulletins	**UHCprovider.com/news**	**1-800-600-9007**
Care provider manuals	**UHCprovider.com/guides**	**1-800-600-9007**

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 8 a.m.–8 p.m. ET, Monday–Friday, chat support can help with claims, prior authorizations, 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/OHcommunityplan**
  The UnitedHealthcare Community Plan of Ohio page has state-specific resources, guidance and rules
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Ohio health plans**
  UHCprovider.com/OH is the fastest way to review all of the health plans UnitedHealthcare offers in Ohio. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.

  - You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
  - This includes the communication formerly known as the Network Bulletin. Receive personalized Network News emails twice a month by subscribing at **UHCprovider.com/subscribe**.
  - You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

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 and promote compliance and problem resolution.

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

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online. It includes an overview of the program, a toll-free number for **Provider Services** at **1-800-600-9007** and a list of additional care provider resources. You can request a hard copy of this care provider manual by contacting **Provider Services**.

State websites and forms

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

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