2023
Care Provider Manual

Physician, Care Provider, Facility and Ancillary Hoosier

Care Connect

Doc#: PMG-20230822_060318

v65.11.2022

Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit requests. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic transactions on our website at **UHCprovider.com.**

Click the following links to access different manuals:

- Administrative Guide: **UHCprovider.com/guides.** Under Administrative Guide for Commercial, Medicare Advantage and DSNP, click on "**View Online Guide.**" Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com/guides > **Community Plan Care Provider Manuals for Medicaid Plans by State.**

Easily find information in this manual using the following steps:

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

If you have questions about the information or material in this manual, or about our policies, please call Provider Services at **877-610-9785**.

Important information about the use of this manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Participation agreement

In this manual, we refer to your Participation Agreement as "Agreement."

Terms and definitions as used in this manual:

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	877-610-9785
Training	UHCprovider.com/training	877-610-9785
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID. Or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html New users: UHCprovider.com > New User and User Access	855-819-5909
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	866-842-3278, option 1
Provider Portal Support	ProviderTechSupport@uhc.com	855-819-5909
Resource Library	UHCprovider.com > Resources > Resource Library	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

UnitedHealthcare Community Plan is privileged to help serve the most vulnerable members of the community through the Hoosier Care Connect program. UnitedHealthcare Community Plan supports the Indiana state goals of increased access, improved health outcomes and reduced costs by offering Hoosier Care Connect for the following eligible members:

- Individuals who are aged, blind, and/or disabled
- Children who are in foster care, newly adopted or wards of the state
- Individuals who are receiving Supplemental Security Income (SSI)
- Individuals who are enrolled through M.E.D. Works

The state of Indiana will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at **877-610-9785**.

How to join our network

You need to be enrolled in Indiana Medicaid before joining our network. Complete the Indiana Medicaid enrollment and credentialing forms at in.gov/medicaid.

For instructions on joining the UnitedHealthcare Community Plan provider network, go to UHCprovider.com/join. You will find guidance on our credentialing process, how to sign up for self-service and other helpful information. You may also email in_nm_team@uhc.com.

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile at UHCprovider.com > Our Network > Demographics and Profiles.

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Approach to health care

Care Model program

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care services, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns and then provides interventions to help members get the right care. These interventions address members' specific needs, resulting in better quality of life, improved access to health care and reduced expenses.

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

- Market-specific care management encompassing medical, behavioral and social care.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with primary medical providers (PMPs) and coordinating appointments. The Community Health Worker (CHW) 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 providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to PMPs and other needed services, measured by number of PMP visit rates within identified time frames.
- Identify and discuss behavioral health (BH) needs, measured by number of BH care professional visits within identified time frames.
- Use disease management to help members understand their chronic conditions as well as set health goals. They can meet them through education, counseling and support.
- 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 your UnitedHealthcare Community Plan member to Care Model, call Provider Services at **877-610-9785.**

Compliance

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The program breaks down linguistic and cultural barriers that can harm health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services to our members at any time, free of charge. More than 240 non-English languages

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and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card.

- If you need a professional interpreter during regular business hours, call Provider Services at 877-610-9785. After hours, call 877-261-6608.
- Enter the client ID 209677 (do not hit #). Press 1 for Spanish and 2 for all other languages.

• **Materials for limited English-speaking members:** We provide simplified materials for members with limited English proficiency or in the member's chosen language. We also provide materials for visually impaired members.
You must notify members of the availability of the services and you must arrange those services for members needing them.

For more information, go to **uhc.com/legal/nondiscrimination-and-language-assistance-notices**

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual for medical care determinations.

Obtaining an approved prior authorization does not guarantee payment. You must follow all applicable state and UnitedHealthcare Community Plan of Indiana Hoosier Care Connect billing guidelines and verify eligibility requirements.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide at UHCprovider.com > Resources > the UnitedHealthcare Provider Portal Resourcces > **Digital Solutions Comparison Guide.** Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior

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authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

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

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.com/api.**

Electronic Data Interchange

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

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

EDI also helps you:

- 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), and
  - Electronic remittance advice (ERA/835).

Visit **UHCprovider.com/EDI** for more information. Learn how to make the most of EDI at **UHCprovider.com/en/resource-library/edi/edi-optimization.html.**

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 of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca.**

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

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 also perform administrative tasks such as submitting prior authorization requests, checking claim

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status, submitting appeal requests and finding copies of PRAs and letters in Document Library. All is available at no cost to you and without needing to pick up the phone.

To access the portal, you will need to **create or sign in** using a One Healthcare ID. To use the portal: If you already have a One Healthcare ID (formerly known as Optum ID), simply go to **UHCprovider.com** and click Sign In in the upper right corner to access the portal. If you need to set up an account on the portal, follow **these steps** to register.

Here are the most frequently used portal tools:

- **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 authorizations and notifications —** Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan.**
- **Specialty pharmacy transactions —** Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile —** View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mpp.**
- **Document Library —** Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to **UHCprovider.com/documentlibrary.**

Go to **UHCprovider.com/portal** to learn more about the portal. You can access self-paced user guides for many of the tools and tasks available in the portal at **UHCprovider.com/training > Digital Solutions**

Direct Connect

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

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution time frames.
- 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 Provider Portal. On-site and online training is available.

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

Individual Health Record

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

PMPs and behavioral health providers are encouraged to review the IHR for your members at least each quarter. Find out more at **UHCprovider.com/ihr.**

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Privileges

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

Provider Services

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

Provider Services at **877-610-9785** can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

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How to contact us

Topic	Contact	Information
Behavioral Health & Substance Abuse	Optum **providerexpress.com** 800-888-2998 (toll-free) Fax 844-897-6514	Review eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required
Benefits	**UHCprovider.com/benefits** **in.gov/medicaid** 877-610-9785	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	**UHCprovider.com/cardiology** 877-610-9785 Fax 844-897-6514	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Model	**IN_CareManagement@uhc.com** 877-610-9785	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor Care	**myoptumhealthphysicalhealth.com** 800-873-4575 Call Provider Services at 877-610-9785 if you have questions about chiropractor claims, eligibility or benefits.	Services are covered with an in- or out-of-network chiropractor.
Claims	**UHCprovider.com/claims** 877-610-9785 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.

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Topic	Contact	Information
Claim Overpayments	Sign into **UHCprovider.com/claims** to access the Provider Portal 877-610-9785 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 Services	Access the provider portal at **uhcdentalproviders.com** 844-402-9118	Call for details about dental eligibility, benefits, authorizations and claims, or other key information.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at **UHCprovider.com/edi.**
Eligibility	**UHCprovider.com/eligibility** 877-610-9785	Confirm member eligibility.
Enterprise Voice Portal	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, Waste and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/INcommunityplan >**Integrity of Claims, Reports, and Representations to the Government.** Reporting: **uhc.com/fraud** 800-455-4521 or 877-401-9430	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Hearing Services	877-610-9785	The Indiana Health Coverage Programs (IHCP) provides coverage of hearing services for eligible members. UnitedHealthcare Hearing is one provider option offered through Medicaid. For more information, visit **in.gov/medicaid.**
Indiana Family and Social Services Administration	**in.gov/medicaid** 800-403-0864	Contact Indiana Medicaid directly.
Laboratory Services	UHCprovider.com > Our Network > **Preferred Lab Network** LabCorp 888-522-2677 Quest Diagnostics 866-697-8378	LabCorp and Quest Diagnostics are network laboratories. You can choose between either lab based on preference.

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Topic	Contact	Information
Medical Claim, Reconsideration and Appeal	UHCprovider.com/claims 877-610-9785 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	800-832-4643, TTY 711 for help accessing member account myuhc.com	Assist members with issues or concerns. Available 8 a.m. – 8 p.m. Eastern Time, Monday through Friday.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	800-832-4643 (members) 877-610-9785 (providers) TDD 711	Available 8 a.m. – 8 p.m. Eastern Time, Monday through Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Resource Team (NMRT)	networkhelp@uhc.com 877-842-3210	Self-service functionality to update or check credentialing information.
Network Management Team	in_nm_team@uhc.com	Ask about contracting and care provider services.
NurseLine	800-832-4643	Available any time.
Obstetrics/ Pregnancy and Baby Care	Notification of Pregnancy on the Indiana Provider Healthcare Portal: portal.indianamedicaid.com Healthy First Steps 800-599-5985 uhchealthyfirststeps.com Find the PMP Pre-Birth Selection Form at UHCCommunityPlan.com/in	Submit the **Notification of Pregnancy Form** using the Indiana Healthcare Portal. Ask the member to contact Healthy First Steps by calling or filling out the online form. Refer members to sign up for Healthy First Steps Rewards. Use the PMP **Pre-Birth Selection Form** to help the member select a PMP prior to a baby's birth.

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Topic	Contact	Information
One Healthcare ID Support	**LinkSupport@optum.com** 855-819-5909	Available 8 a.m. – 10 p.m. Eastern Time, Monday through Friday; 7 a.m. – 7 p.m. Eastern Time, Saturday; and 10 a.m. – 7 p.m. Eastern Time, Sunday.
Pharmacy Services	**professionals.optumrx.com** 866-215-5046 (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com** > Prior Authorization > **Clinical Pharmacy and Specialty Drugs** 800-310-6826	Request authorization for medications as required. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred Check coverage and price, including lower-cost alternatives.
Prior Authorization Requests/ Advance Admission Notification	To notify us or request a **medical** prior authorization: **EDI:** Transactions 278 and 278N **Online Tool: UHCprovider.com/paan** **Phone:** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call 877-610-9785 Fax 844-897-6514	Use the Prior Authorization and Notification Tool 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/lists: UHCprovider.com/INcommunityplan > PriorAuthorization and Notification**
Provider Services	**UHCprovider.com/INcommunityplan** 877-610-9785	Available 8 a.m. – 8 p.m. Eastern Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 877-610-9785 Fax 844-897-6514	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	UHCprovider.com > **Referrals** or use Referrals on the Provider Portal. Click Sign in at the top right corner of **UHCprovider.com**, then click Referrals. Provider Services 877-610-9785	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	**UHCprovider.com/INcommunityplan** > Current Policies and Clinical Guidelines Learn More > View Current Reimbursement Policies	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.

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Topic	Contact	Information
Technical Support for the Provider Portal	**UHCprovider.com/en/contact-us/technical-assistance.html** 866-209-9320 for Optum support or 866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, if you cannot submit a form, etc.
Tobacco Free Quit Line	800-784-8669	Refer members to the Indiana Quitline for tobacco and vaping cessation services.
Transportation	Member Services 800-832-4643	Call Member Services to schedule transportation or for transportation assistance. To arrange non-emergent transportation, please call at least 48 hours in advance.
Utilization Management	Provider Services 877-610-9785	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 > Resources > **Health Plans, Policies, Protocols and Guides.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	800-701-0704	If VFC covers a vaccine, children on Indiana Medicaid must receive the VFC version of the vaccine.
Vision Services	MARCH Vision Care 844-486-2724 MARCH Vision Care Provider Reference Guide: **marchvisioncare.com/providerreferenceguides**	Contact MARCH Vision Care's provider relations department for information on benefits, lab order submissions, and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers, and federal tax identification numbers. Attend a training session on eyeSynergy. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
Website for Indiana Community Plan	**UHCprovider.com/INcommunityplan**	Access your state-specific Community Plan information on this website.

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Frequently asked questions

Q: When did the UnitedHealthcare Community Plan Indiana Hoosier Care Connect (IN HCC) program begin?

A: The UnitedHealthcare Community Plan program went live on April 1, 2021.

Q: What are the timely filing requirements?

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

Q: What is UnitedHealthcare Community Plan's time frame on processing a care provider's credentialing application?

A: We are required to credential providers within 30 days as required by the State of Indiana.

Q: Which member populations are included in the HCC program?

A: HCC covers a variety of individuals who are not eligible for Medicare, including:

- Individuals who are aged
- Individuals who are blind
- Individuals who are disabled
- Individuals receiving Supplemental Security Income (SSI)
- Individuals enrolled through M.E.D. Works
- Wards and foster children can voluntarily opt in

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

A: If you are not an existing Medicaid provider in Indiana, you must enroll with the State of Indiana to provide services to Indiana Medicaid members. Go to **portal.indianamedicaid.com.** Further clarification on provider enrollment can be found at **in.gov/medicaid.**

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

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

It can perform the following transactions:

- Provider eligibility and enrollment applications
- Member eligibility verification/identify member's plan, including whether member is in the Right Choices Program
- Verify any third party liability (i.e. presence of other health insurance such as commercial insurance)
- Managing your provider profile

Reminder: You may also use the UnitedHealthcare Community Plan web portal for Hoosier Care Connect transactions, such as claims, remits, prior authorization, adjustments, etc.

See page 6, Online Resources, for more information.

To access the portal, go to **portal.indianamedicaid.com.**

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Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	877-610-9785
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	877-610-9785
Prior Authorization	UHCprovider.com/paan UHCprovider.com/INcommunityplan > Prior Authorization and Notification	877-610-9785 Fax 844-897-6514
Provider Directory	UHCprovider.com > Our Network > Find a Provider	877-610-9785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

General care provider responsibilities

Non-discrimination

You can’t refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or intellectual and developmental disabilities, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

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

1. Educate them about the member’s 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.

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5. Departure from your practice for any reason.
6. Closure of practice.

You may use the Care Provider Demographic Information Update Form for demographic changes or to update NPI information for health care providers in your office. This form is located at **UHCprovider.com** > Our Network > Find a Provider > **Care Provider Paper Demographic Information Update Form.**

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com** > Our Network > **Find a Provider.**

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 health care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who:
   - Disenroll
   - Have not submitted claims for UnitedHealthcare Community Plan members for one year
   - Have voluntarily stopped participation in our network for one year

2.Inactivate any tax identification numbers (TINs) with no claims submitted for one 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

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at **irs.gov** > Forms & Instructions > **Form W-9.**
- Download the form at **UHCprovider.com** > Our Network > Find a Provider > My Practice Profile Tool >**Care Provider Paper Demographic Information Update Form.**
- To update your information online, go to **UHCprovider.com** > Our Network > Find a Provider > My Practice Profile Tool > **Go To My Practice Profile Tool.**
- To add a PMP, please complete the Indiana Health Coverage Programs (IHCP) MCE Practitioner Enrollment Form located at UHCprovider.com/INcommunityplan > **Provider Forms and References** .

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email on the bottom of the **Care Provider Demographic Change Request Form.**

Updating your practice or facility information

You can update your practice information through the Provider Data Management application on **UHCprovider.com.** Go to **UHCprovider.com** > Our Network > Demographics and Profiles > **My Practice Profile.** Or submit your change by:

- Completing the **Care Provider Demographic Change Form** and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 877-842-3210.

After-hours care

Life-threatening situations require the immediate

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services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If 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.

PMP access standards

PMPs must arrange for service coverage 24 hours a day, seven days a week (anytime). They must also offer members direct contact with the provider, or the provider's qualified clinical staff person, through a toll-free telephone number anytime. Each care provider must be available to see members at least three days per week for a minimum of 20 hours per week at any combination of no more than two locations. They must ensure the Hoosier Care Connect population is receiving accessible services equally with the provider's non-Hoosier Care Connect population.

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

Participate in quality initiatives

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

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 10 for more details 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 six years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

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

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It

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also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference Chapter 9 for Medical Record Standards.

Inform 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 look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement is governed, construed, and enforced in accordance with the laws of the state of Indiana, and any proceedings related to your Agreement must be brought in the state of Indiana.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com/Indiana** > Medicaid.

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

State of Indiana appointment, access and availability standards

Comply with the following appointment availability standards:

Primary care

PMPs should arrange appointments for:

- Urgent/emergent care triage: 24 hours/day
- Non-urgent symptomatic: 72 hours
- Routine physical exam: three months
- Initial appointment (non-pregnant adult): three months
- Routine gynecological examination: three months
- New obstetrical patient: within one month of date attempting to schedule an appointment
- Initial appointment well child: within one month of calling to schedule an appointment
- Children with special health care needs: one month

Specialty care

The appointment standards for specialty providers are:

- Emergency: 24 hours
- Urgent: 48 hours
- Non-urgent symptomatic: four weeks

Behavioral care

Behavioral care providers should arrange appointments for:

- Outpatient behavioral health exams: within 14 days of request
- Routine/new patient exam: within 10 days of request
- Outpatient treatment: within seven days of discharge

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date
- Post-psychiatric inpatient care: within seven days of discharge date

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 14 days of request
- Second trimester: within seven calendar days of request
- Third trimester: within three business days of request or immediately in an emergency
- High-risk: within three business days of request or immediately if an emergency
- Postpartum exam: between 3-8 weeks after delivery

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

Provider directory

You are required to tell us, within five business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

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

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our provider directory after 10 business days.

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

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

To help ensure we have your most current provider directory information, submit applicable changes to:

For delegated providers, email your changes to **delprov@uhc.com.**

For non-delegated providers, visit **UHCprovider.com** for the **Care Provider Demographic Change Submission Form** and further instructions.

The medical, dental and behavioral health care provider directory is located at **UHCprovider.com** > Our Network > **Find a Provider.**

Provider attestation

Confirm your provider data every quarter on the Provider Portal on **UHCprovider.com** or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access My Practice Profile App to make many of the updates required in this section.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to determine medical necessity. 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 Provider Portal at **UHCprovider.com/eligibility** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get from the Provider Portal or fax 844-897-6514.
  1. To access the app, go to **UHCprovider.com,** then login on top right to the Provider Portal.
  2. Select the **Notification app**.

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3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

Find the IHCP Prior Authorization Form at **in.gov.**

If you have questions, please call the UnitedHealthcare Web Support at **866-842-3278**, option 3, 8a.m.– 10p.m. Eastern Time, Monday through Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Requirements for PMP and specialists serving in PMP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PMPs are an important partner in the delivery of care, and UnitedHealthcare Community Plan Hoosier Care Connect members may seek services from any participating care provider. The UnitedHealthcare Community Plan Hoosier Care Connect program requires members be assigned to PMPs. We encourage members to develop a relationship with a PMP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

Medical doctors (M.D.s), doctors of osteopathy (DOs), nurse practitioners and physician assistants from any of the following practice areas can be PMPs:

- Family medicine
- Internal medicine
- General practice
- Pediatric medicine
- Obstetrics/gynecologist
- Advance practice registered nurse
- Nurse practitioner
- Physician assistant
- Clinical nurse specialist
- Nurse midwife

Nurse practitioners and physician assistants must enroll in Indiana Medicaid to be a PMP. Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot. Physician assistants must be part of a group practice.

Members may change their assigned PMP by contacting **Member Services** at any time during the month. Member Services is available 8 a.m. - 8 p.m. Eastern Time, Monday through Friday.

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

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care management system. The coverage will include anytime availability. During non-office hours, access by phone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PMP's nurse triage) will immediately page an on-call medical professional so services can be made for non-emergency services.

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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. This means:

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- If member has private insurance, file first with private insurance, which is primary. Then, submit the Medicaid claim to us with a copy of the paid claim EOB.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members for each practice location up to two locations per health plan/ MCE.
- Be available to members by phone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.
- Educate members about appropriate use of the urgent care center in non-emergent situations.

Responsibilities of PMPs and specialists serving in PMP role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring to Provider Services, Prior Authorization, UnitedHealthcare Community Plan Clinical, or Pharmacy, as appropriate.
- 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 and 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.
- Complying with the State of Indiana and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

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

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

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

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and other specialty services.

- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PMP checklist

Verify eligibility and benefits on UHCprovider.com. Click “Sign In” in the top right corner
to access the Provider Portal, or call Provider Services.

Check the member’s ID card at the time of service. Verify member identify with photo identification, if this is your office practice.

Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan. Visit UHCprovider.com/INcommunityplan > Prior Authorization and Notification to locate and view the current prior authorization information and notification requirements.

Refer patients to UnitedHealthcare Community Plan participating specialists when needed.

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.

Remember to revalidate your Indiana practice and practitioner information before the revalidation due date to avoid being terminated by the Indiana Health Coverage Programs.

Specialist responsibilities

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

- Contact the PMP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PMP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PMP copies of all medical data, reports and discharge summaries resulting from the specialist’s care.
- Note all findings and recommendations in the member’s medical record. Share this information in writing with the PMP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the State of Indiana Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PMPs and specialists serving in the PMP role must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PMP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PMP or obstetrician unavailability.
- Remember to revalidate your Indiana practice and practitioner information before the revalidation due date to avoid being terminated by the Indiana Health Coverage Programs.

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

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

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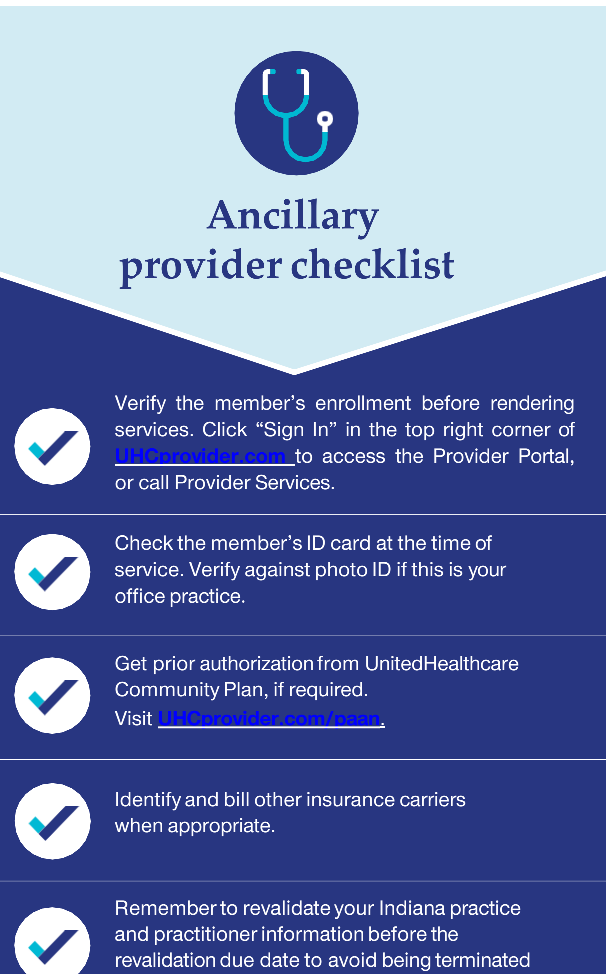
Ancillary provider responsibilities

Ancillary providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PMPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary enough and personnel to provide timely access to medically necessary covered services.



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Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	in.gov/medicaid UHCCommunityPlan.com/IN	800-832-4643
Member Handbook	UHCCommunityPlan.com/IN > Plan Details > Member Resources > View Available Resourcea	
Provider Services	UHCprovider.com	877-610-9785
Prior Authorization	UHCprovider.com/paan	877-610-9785
DSNP	UHCprovider.com/IN > Medicare > Indiana Dual Complete® Special Needs Plans	877-610-9785
Indiana Department of Health	in.gov/state of Indiana/	800-457-8283

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Member benefits

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

See Appendix A for the list of member benefits.

Assignment to PMP panel roster

Once a member is assigned a PMP, view the panel rosters electronically on the UHCprovider.com application on the Provider Portal. The portal requires a unique user name and password combination to gain access.

Each month, PMP panel size is monitored by reviewing PMP to member ratio reports. When a PMP’s panel approaches the max limit, it is removed from auto-assignment. To update the PMP panel limits, send a written request. PMPs serving in the UnitedHealthcare Hoosier Care Connect provider network must accept a minimum panel size of 150 members.

Go to UHCprovider.com > select the Sign In icon on the top right corner > enter your user ID and password to sign in > select 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.

Choosing a PMP

Based on federal rules, each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PMP. The assignment considers the distance to the PMP, the PMP’s capacity and if the PMP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PMP.

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Depending on the member's age, medical condition and location, the choice of PMP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PMP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PMP at any other time, the change will be effective on the request date.

PMP reassignment form

The purpose of this form is to add a UnitedHealthcare Community Plan Hoosier Care Connect Member to a PMP panel either at full capacity status or approved by us for a "hold" status. The PMP or office manager may complete the from if the member or the member's family member is an established patient. Established patients must have been treated in the past 24 months from today's date. You may also use this form if you would like to begin providing primary care services to that member.

Deductibles/copayments

Check the medical ID card for copayment amounts. You may also call Provider Services for more information.

Copays and member cost share

Members may be charged copays with some exceptions and limitations. The following is a list of common copay amounts:

- Non-emergent transportation- $1.00 each way (emergency transportation does not have a copay).
- Prescription medication- $3.00
- Non-emergency services provided in an emergency room setting- $3.00

There are no copays for:

- Children under age 18
- Members who are pregnant
- Members of Native American descent
- Members who have already met their 5% cost sharing limit
- Maternity services
- Preventative care services

Copays will be waived if a Hoosier Care Connect member's health care costs exceed 5% of the family's income for the quarter. You can see whether the member has met their cost share obligations in the UnitedHealthcare Provider Portal system.

Self-referral services and coverage

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

UnitedHealthcare Community Plan must include self-referral providers in our contracted network. We may direct members to seek self-referral care from providers contracted in our network. However, except for behavioral health and routine dental services, we cannot require the members to receive services from network providers. UnitedHealthcare Community Plan members may self-refer to any IHCP qualified to provide the service(s). When members choose to receive self-referral services from care providers who do not have contractual relationships with us, UnitedHealthcare Community Plan is responsible for payment to these care providers up to the applicable benefit limits and at 98% of Indiana Medicaid fee for service (FFS) rates.

Chiropractic services may be provided by a licensed chiropractor, enrolled as an IHCP within the scope of the chiropractic practice.

Eye care services, except surgical services may be provided by any IHCP licensed under Doctor of Medicine or doctor of osteopathy optometrist.

Podiatric services may be provided by any IHCP licensed under Doctor of Medicine or doctor of osteopathy, or doctor of podiatric medicine.

Psychiatric services may be provided by any IHCP licensed under Doctor of Medicine or doctor of osteopathy.

Behavioral health services are self-referral for in-network IHCP. Members may self-refer, within the UnitedHealthcare Community Plan's network, for behavioral health services not provided by a psychiatrist, including behavioral health, substance abuse and chemical dependency services by behavioral health specialty providers.

Family planning services requires freedom of choice of care providers and access to family planning services and supplies. Family planning services are those

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services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include initial diagnoses of sexually transmitted disease. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including care providers that are not in UnitedHealthcare Community Plan's network. Members may not be restricted in choice of a family planning service if the care provider is an IHCP provider.

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

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

Diabetes self-management services are available on a self-referral basis to any IHCP provider when the member obtains the services from an IHCP self-referral care provider. The state expects to include Diabetes Prevention Programs as a self-referral service in the future.

Routine dental services may be provided by any in-network licensed IHCP dental provider.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. You must document all services requiring medical necessity in the member's medical record.

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

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

Download a copy of the Member Handbook online by contacting UHCCommunityPlan.com/IN. Go to Plan Details > Member Resources > View Available Resources. Or call Provider Services.

Immediate enrollment changes

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

Get eligibility information by calling the Medicaid Inquiry line.

Unborn enrollment changes

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.

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PMP selection

Although unborn children cannot be enrolled with an MCE until birth, ask your members to select and contact a PMP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PMP selections. Find the PMP Pre-Birth Selection Form at **UHCCommunityPlan.com/in**.

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 Indiana's Medicaid program. The State of Indiana determines program eligibility. An individual who becomes eligible for the State of Indiana program either chooses or is assigned to one of the Indiana health plans.

Member ID card

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

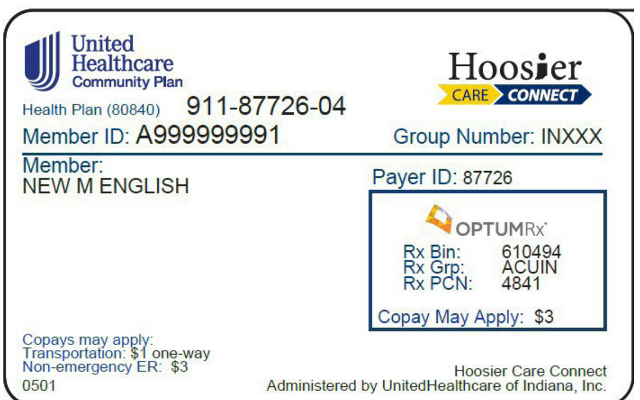
If a fraud, waste and abuse event arises from a care provider or a member, go to **uhc.com/fraud.** Or you may call the Fraud, Waste, and Abuse Hotline.

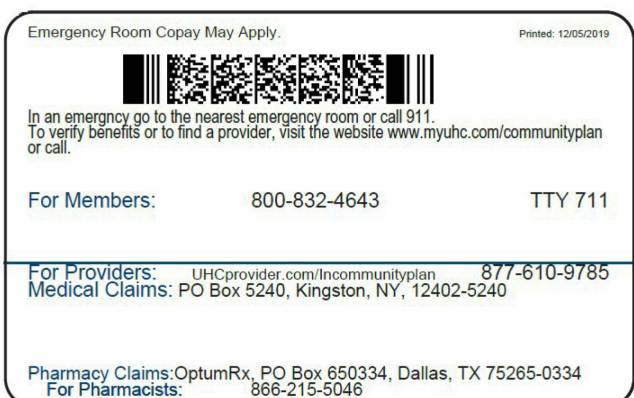
The ID card also shows the PMP assignment on the front of the card as well as copayment information. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

Member identification number

The Indiana member identification number is also on the member ID card. This is the same as the member's state issued recipient ID number.

Sample member ID card





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PMP-initiated transfers

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

1. To transfer the member, call Provider Services at **877-610-9785**, call the Member Services number on the back of the member's card or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   P.O. Box 5270
   Kingston, NY 12402-5270
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PMP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PMP member issue, we work with the member to find another PMP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PMP) stating they have five business days to contact us to select a new PMP. If they do not choose a PMP, we will choose one for them. A new ID card will be sent to the member with the new PMP information.

Verifying member enrollment

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

- Provider Portal: access the portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Services** is available from 8 a.m. - 6 p.m. Eastern Time, Monday through Friday.
- Indiana **Medicaid Eligibility System (MES)**

UnitedHealthcare Dual Complete (DSNP)

DSNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about DSNP, go to **uhc.com/medicaid/dsnp.**

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP on **UHCprovider.com/guides.**

For state-specific information, go to UHCprovider.com > Our Network > **Health Plans.** For Indiana-specific DSNP information, go to UHCprovider.com/IN > Medicare > **Dual Complete Special Needs Plans.**

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Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > **Referrals**	877-610-9785
Prior Authorization	**UHCprovider.com/paan**	Phone 877-610-9785 Fax 844-897-6514
Provider-Administered Drugs	UHCprovider.com/priorauth > **Clinical Pharmacy and Specialty Drugs**	877-610-9785
Dental Services	**uhcdentalproviders.com**	844-402-9118
Healthy First Steps	**uhchealthyfirststeps.com**	800-599-5985

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

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

Ambulance services

Air ambulance

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

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

Emergency ambulance transportation

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

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

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

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

Non-emergency ambulance transportation

Non-emergent stretcher/ambulance transportation services are covered when medically necessary. Bill claims for non-emergent ambulance services to UnitedHealthcare Community Plan.

Non-emergency medical transportation

UnitedHealthcare Community Plan contracts with LCP Transportation to provide non-emergency medical transportation (NEMT). Submit claims to LCP for adjudication.

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.

Requesting services:

Members must call between 8 a.m. - 8 p.m. Eastern Time, Monday through Friday, to schedule transportation. If they have questions about their order, they may call Member Services.

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Non-emergent transportation must be requested at least 48 hours in advance.

Care coordination/ health education

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in complex care management. The care manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Chiropractic services

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

We provide members with up to 50 units per member per calendar year with an in- or out-of-network chiropractor. The 50 units can be a combination of office visits, spinal manipulation, or physical medicine services. Up to five of the 50 units can be office visits. Some chiropractic service require a prior authorization.

Use the following steps to access the fee schedules online:

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

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

Chronic condition management

We use educational materials and newsletters to remind members to follow positive health actions such as immunizations, wellness, and EPSDT screenings. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a fifth grade reading level. They are available in English as well as other languages. The materials are designed to support members as they begin to take responsibility for their health. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma,

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CHF, diabetes, COPD and CAD receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

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

Dental

In-network IHCP dental care providers may provide routine dental services.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services.

Facility services require a prior authorization.

The following services are covered. However, some limitations may apply:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics
- Orthodontics (younger than age 21 only)

Refer to the Dental Provider Manual for applicable exclusions, limitations and requirements at **uhcdentalproviders.com.**

Standard ADA coding guidelines apply to all claims.

To find a dental provider, go to UHCprovider.com > Our Network > Find a Provider > **Dental Providers by State, Network or Location.**

Durable medical equipment

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

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

See our Coverage Determination Guidelines at **UHCprovider.com** > Health Plans, Policies, Protocols and Guides > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.**

Emergency/urgent care services

Emergency services do not require prior authorization and are a self-referral service.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use and the use of Urgent Care Centers for non-emergent services. A PMP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds, and sore throats.

Covered services include:

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

Emergency room services are subject to diagnosis review against Indiana’s state ER autopay list. If a diagnosis billed on the claim does not appear on the emergency department autopay list, then the claim may

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be adjudicated non-emergent and paid at the contracted screening fee rate.

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

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

If the member was referred to the ER by the 24-hour nurse line, crisis line, or a PMP, the facility and professional claim will be reimbursed at 100% of the Indiana Medicaid fee schedule or specific contract rate. A copay will not be applied.

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

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

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 prior authorization is needed. Members have been told to call their PMP as soon as possible after receiving emergency care.

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

After the member has received emergency care, the hospital must seek approval within one 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 one hour and/or they need to speak with a peer (medical director), call 800-599-5985. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact Provider Services.

Emergency care resulting in admissions

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

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool at **UHCprovider.com/paan,** EDI 278N transaction at **UHCprovider.com/EDI,** or call Provider Services.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using IHCP

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medical policies, evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.)

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

For policies and protocols, go to UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans.**

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

Facility admission notification requirements

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

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

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

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

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

Non-covered items include:

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

Parenting/childbirth education programs

- Childbirth education is covered.
- Parenting education is not covered.

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the State of Indiana Regulations for more information on sterilization.

Hearing services

Monaural and binaural hearing aids are covered (except for in-the-canal [ITC] hearing aids) for members with a unilateral pure tone average greater than 30 decibels. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band

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headbands), replacement parts and batteries are covered for members 20 years or younger.

Services and materials include audiometric assessments, device fitting, follow-up care, batteries and repair. Members get one audiological assessment every three years and one hearing aid per ear every five years.

UnitedHealthcare Community Plan acts as a hearing provider for Indiana Medicaid. For more information, call Provider Services at **877-610-9785**.

Home Health program

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

Home health services include skilled nursing, home health aide services, and skilled therapies (physical therapy, occupational therapy, and speech-language pathology).

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

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

The qualifying treating care provider must certify the medical necessity for home health services. Home health services require prior authorization.

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

- Registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Physical therapists

For more information about home health, call Provider 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 care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to five 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 limited to 10 days per month.

Members receiving inpatient hospice services through a residential facility are covered under Managed Medicaid. The state of Indiana covers residential inpatient hospice services. The state of Indiana will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

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Laboratory

LabCorp and Quest are preferred lab providers. Contact the laboratories directly.

Use a network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PMP, other care providers or dentist in one of these laboratories do not require authorization except as noted on our PA list.

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

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

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

Maternity/pregnancy/ well-childcare

Notification of pregnancy

The Notification of Pregnancy (NOP) was developed to help identify pregnancy earlier with the goal of better health and birth outcomes for mothers and babies. The online form simplifies the process of completing paperwork to document pregnancies and evaluate any risks. If you electronically complete and submit the NOP to comply with IHCP guidelines and use the Provider Healthcare Portal, you may be eligible for a $60 incentive payment. Just answer four questions online with first OB visit once member is effective with Medicaid.

Bill the MCE for the NOP incentive payment using CPT code 99354 with modifier TH. The date of service on the NOP claim should be the date of the office visit on which the information on the NOP is based.

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

Call Healthy First Steps at **800-599-5985**. Also complete the Notification of Pregnancy form at the first prenatal visit. The form is on **portal.indianamedicaid.com.**

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate care management enrollment.
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings.
- Encourage members to stop smoking with our Quit for Life tobacco program.
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs.
- Act as a liaison between members, care providers, and UnitedHealthcare for care coordination.

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. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

- Identify UnitedHealthcare Community Plan members during prenatal visits.

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- Share the information with the member to talk about the program.
- Encourage the member to enroll in Healthy First Steps.

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

Pregnancy/maternity

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

For OB billing, refer to the OB billing section in the **Indiana Reference Module.**

For and maternity care, including out-of-plan and continuity of care, call **877-610-9785** or go to or go to **UHCprovider.com/paan.**

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

- The woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
- If she has an established relationship with a non-participating obstetrician.

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

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

Maternity admissions

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

For deliveries, submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/EDI,** the online and Notification tool at **UHCprovider.com/paan,** or by calling Provider Services.

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

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

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

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

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

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

You must furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner, physician assistant 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.

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Post maternity care

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

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members. See **PMP section** in Chapter 3 for assigning a newborn a PMP using the Pre-Birth Selection Form.

Bright Futures Assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the **US Department of Health and Human Services, Health Resources and Services Administration (HRSA),** Maternal and Child Health Bureau (MCHB).

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

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to *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, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early childcare 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 services

The discharge planner ordering home care should call Provider Services 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 she was told before the surgery that the procedure will result in permanent sterility. Hysterectomies require prior authorization.

Find the form on the Indiana Medicaid website: **in.gov/medicaid/providers/470.htm.**

See "Sterilization consent form" section for more information. The IHCP does not require informed consent if:

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

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

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Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the woman's life, or due to rape or incest. These procedures are considered family planning and may be self-referred. In this case, follow the Indiana consent procedures for abortion.

Allowable pregnancy termination services do not require a prior authorization from the member's PMP. Members may choose their care provider.

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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

You may also find the form on the Indiana Department of Social Services website **in.gov/fssa**.

Have three 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 (NICU) case management

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

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

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and Utilization Management nurses, health plan registered nurses and social worker care managers to

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support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Resources > Plans, Polices, Protocols and Guides > For Community Plans > **Clinical Guidelines.**

Pharmacy

Preferred Drug List

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

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

If a member requires a non-preferred medication, call Pharmacy at **800-310-6826** or use the online and Notification tool on the Provider Portal. In addition, you may use CoverMyMeds or Surescripts to submit a medication authorization request at **UHCprovider.com** > Prior Authorization > Clinical Pharmacy and Specialty Drugs > **Forms and Additional Resources** .

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

Pharmacy prior authorization

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

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

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one 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.**

Cardiology program

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

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if performed in the following places of service:

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

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

Request prior authorization:

- Online: **UHCprovider.com/cardiology** > Go to Prior Authorization and Notification Tool.
- Phone 877-610-9785
- Fax 844-897-6514

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a crosswalk, and or the evidence-based clinical guidelines, go to **UHCprovider.com/cardiology** > Specific Cardiology Programs.

Radiology program

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

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

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire approval 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: **UHCprovider.com/radiology** > Go to Prior Authorization and Notification Tool.
- Phone 877-610-9785
- Fax 844-897-6514

Make sure the medical record is available.

For a current list of CPT codes that require prior authorization, a crosswalk table, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Specific Radiology Programs.

Right Choices Program

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

The member will have a care coordination team led by a primary medical professional and include a care/case manager, lock-in PMP, lock-in pharmacy and any other approved specialty care providers. Members can be locked-in to both a PMP and pharmacy or just one, depending on their needs and goals. PMPs must make referrals to any non-locked-in care providers. Add care providers by logging into the **IHCP Provider Healthcare Portal,** notify us by fax or call Provider Services.

The RCP PMP can add providers to the member's lock-in file on the IHCP Provider Healthcare Portal website or send to the UnitedHealthcare RCP admin so they can be added to the member's lock-in file.

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

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

If the member is auto-assigned a PMP because of failure

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to respond to their initial PMP selection notification, the member is allowed to change primary lock-in care providers one time during tenure in the RCP. Members are required to submit a written request to the RCP Administrator detailing the reasons for the requested changes. If there is a change in the member's lock-in care providers, he or she receives a letter with the new providers' information. The new lock-in providers also receive letters.

To make an RCP referral, find the RCP Referral Form on **UHCprovider.com/INcommunityplan** > Provider Forms and References. This is a PDF, so either send a secure email or fax it. Fax to 888-843-6007 or email to **In_rcp@uhc.com.**

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

Screening, Brief Interventions, and Referral to Treatment (SBIRT) services

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.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- An Evaluation and Management (E/M) exam takes place 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 four sessions per patient, per provider per calendar year.

What is included in SBIRT?

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 s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the county where the member resides for treatment.**

SBIRT services are covered when all the following are met:

- The billing and servicing providers are SBIRT certified.
- The billing provider has an appropriate taxonomy to bill for SBIRT.
- The diagnosis code is V65.42.
- The treatment or brief intervention does not exceed four encounters per client, per provider, per year.

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

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

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

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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 complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

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 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 provider in Indiana:

1. Go to **UHCprovider.com**
2. Select "Our Network" then "Find a Provider"
3. Search for and select "Search for Care Providers in the General UnitedHealthcare Plan Directory"
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

For more SAMHSA waiver information:
Physicians — **samhsa.gov**
Nurse practitioners and physician assistants — **samhsa.gov**

If you have questions about MAT, please call Provider Services at **877-610-9785**, enter your TIN. Then say "Representative," and "Representative" a second time, then "Something Else" to speak to a representative.

Tuberculosis (TB) screening and treatment; direct observation therapy (DOT)

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

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

Vision

UnitedHealthcare Community Plan uses MARCH® Vision Care as a contracted vision provider. Contact March directly either through their eyeSynergy web portal or fax to refer a member. Call **844-486-2724** for more information.

To access eyeSynergy®, log onto our website at **marchvisioncare.com** and click on the orange and blue eyeSynergy® link located at the top of the page.

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

For more information, use the March Vision Care Reference Guide at **marchvisioncare.com.**

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Medical management guidelines

Admission authorization and guidelines

If you have questions, go to your state's page at UHCprovider.com/INcommunityplan > **Prior Authorization and Notification.**

All prior authorizations must have the following:

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

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within 7 calendar days. May suspend request if additional information is required but will finalize within 14 calendar days of the suspend day.	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 72 hours of request receipt	Within 72 hours of the request	Within 72 hours 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 two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 days of determination	Within 30 days of determination

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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 one business day of admission. We review clinical information to determine medical necessity for a continued inpatient stay. Concurrent review may be done by phone or record review.

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

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

UnitedHealthcare Community Plan uses InterQual, 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 and 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 an intellectual or developmental disability, 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 specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or 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.**

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Medical and drug policies and coverage determination guidelines

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

Referral guidelines

We do not require a written referral. However, you must document in the member's medical record the referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization for all out-of-network services that are not self-referral services. 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.

Learn about managing referrals at **UHCprovider.com/referrals.**

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 at **UHCprovider.com/eligibility,** contacting UnitedHealthcare Community Plan's Provider Services Department, or the IHCP Provider Healthcare Portal.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.
- Submit claim using Indiana Medicaid and UnitedHealthcare Community Plan guidelines.
- Bill using revenue codes and/or procedure codes required by the IHCP and/or UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary.
- Non-covered 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 state of Indiana. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PMP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PMP and treating care provider, if different. The member may help the PMP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **877-610-9785**.
- Once the second opinion has been given, the member and the PMP discuss information from both evaluations.

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- If follow-up care is recommended, the member meets with the PMP before receiving treatment.

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by an in-network care provider from our list of contracted providers (except emergency treatment and self-referral services, excluding behavioral health and dental)
  - Visit UHCCommunityPlan.com/IN for current member plan information including sample member ID cards, provider directories, dental plans, vision plans and more.
  - For a list of in-network providers, see our directory at UHCprovider.com > Our Network > Find a Provider.
- Any care covered by Medicaid but not through managed care:
  - Certain prescription drugs covered only by FFS Medicaid.
  - Long-term care services in a nursing home not to exceed 30 days.
  - Nursing facility services in a SNF stay of up to 30 days.
  - Intermediate care facilities for members with intellectual and developmental disabilities.
  - Home- and community-based waiver services (HCBS).
- Sunglasses and photo-gray lenses.
- Infertility services.

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek within the following time frames

- **Emergency or urgent facility admission:** two business days.
- **Inpatient admissions; after ambulatory surgery:** two business days.
- **Non-emergency admissions and/or outpatient services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Utilization management guidelines

Call **877-610-9785** to discuss the guidelines and utilization management.

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

Utilization management (UM) appeals

UM appeals are considered medical necessity appeals. They contest such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decision may file a UM appeal. See Appeals in Chapter 12 for more details.

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

Key contacts

Topic	Link	Phone Number
EPSDT/HealthWatch	provider.indianamedicaid.com	877-610-9785
Vaccines for Children	in.gov/state of Indiana/17203.htm	800-219-3224

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Care must include any medical necessary services or treatment discovered during EPSDT/HealthWatch screening for members younger than 21 years of age.

Necessary treatment as a result of a diagnosis from an initial or periodic screening may be provided, subject to any prior authorization requirements for the service. If a service is not covered, it is still available to EPSDT members, subject to prior authorization requirements of 405 IAC 5-4, if it is necessary to correct or improve defects, physical and mental illnesses and conditions discovered by the screening services.

Care providers performing screening or treatment services as a result of an EPSDT screening referral are subject to the same limitations for the services.

Disability services

The Indiana Division of Disability and Rehabilitative Services (DDRS) helps members with developmental disabilities become more independent. The DDRS provides in-home services, supported employment, independent living and nutrition assistance. It also supports members with hearing loss, blindness and hearing impairment. In addition, the DDRS helps eligible members get Social Security disability. Learn more at in.gov/fssa/2328.htm.

First Steps program

The First Steps program is handled by the state of Indiana and provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families.

Referring a child-refer a child to First Step services if the child has a visual, hearing, or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

Find out more about First Steps at in.gov/fssa/firststeps . For how to make a referral, click “Parents,” then “Steps to First Steps.” Locate a local office and start the referral at in.gov/fssa/firststeps/first-steps-offices.

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Next steps – The First Steps team will evaluate your request to determine eligibility, then a service coordinator will be assigned to help the child's parents through the process. The assigned coordinator from First Steps, who is employed by the state, will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the Individualized Family Service Plan (IFSP). UnitedHealthcare Community Plan provides member care management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment (Use the Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

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

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

Members between the age of 9 and 12 months should receive a blood lead screening test and again at 24 months of age. An initial screening should be performed at the 6 months visit and repeated at 12 and 24 months visits if deemed at risk for lead exposure. Children between the ages of 36 months and 72 months must receive a blood lead screening if they have not been previously tested.

Call Provider Services if you find a child has a lead blood level over 5ug/dL Children with elevated blood lead levels will be offered enrollment in a care coordination program.

SAFE/CARE Examinations

You must report actual or suspected child neglect or abuse to the Indiana Child Abuse and Neglect Hotline at **800-800-5556**. You must also report suspected neglect, batter or exploitation of an endangered adult to law enforcement or the Adult Protective Service (APS) unit. The APS hotline is **800-992-6978**.

Vaccines for Children program (VFC)

The Vaccines for Children program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

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

Contact **VFC** if you have questions.

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

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

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Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	877-610-9785
Healthy First Steps Rewards	uhchealthyfirststeps.com	800-219-3224
Value-Added Services	UHCCommunityPlan.com/IN > View Plan	877-610-9785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

UnitedHealthcare developed enhanced services to address the multiple and complex needs of the Hoosier Care Connect population, affect Indiana’s most pressing health issues, and align with the state’s strategic quality improvement objectives. Our integrated approach to care will support the physical, social and behavioral health needs of Hoosier Care Connect members, enhance their overall health, well-being, quality of life, and promote their ability to live in the community and setting of their choice. The services will also help the member achieve their care plan goals.

If you have questions or need to refer a member, call Provider Services at **877-610-9785** unless otherwise noted.

Alternative healing

Up to $100 annual reimbursement is available to members who provide evidence of purchases and or services such as herbal medications/herbal remedies, vitamins and minerals, therapeutic massage or acupuncture.

Community health workers

Face-to-face support is available for qualifying members with chronic and complex health conditions. Community health workers use an integrated care model that serves members’ medical, behavioral and social needs.

Customer engagement center

Every Hoosier Care Connect member is assigned a Member Services Advocate (MSA) who can help resolve issues with coordinating care and resolving issues with providers, including specialty care, behavioral health and home and social supports.

MSAs can also assist with challenges due to insurance and payment, care delivery and family welfare. This includes education and assistance connecting with SNAP (Supplemental Nutrition Assistance) and WIC (Women Infants and Children) program benefits.

Healthy First Steps Rewards

Healthy First Steps™ (HFS) Rewards is a specialized care management program designed to aid all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional 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 800-599-5985.

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High school equivalency

Members age 16 and older can receive free support to pursue completion of secondary education requirements.

Indiana tobacco quitline

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

Refer patients and employees for help with quitting tobacco. Learn more at **in.gov/quitline.**

Low-cost internet

Resources are available for home internet services that range from $5-$10 per month through AT&T or Xfinity/ Comcast.

Mobile app

The UnitedHealthcare smartphone app enables members to complete their Health Needs Screening, review health benefits, access claims information, locate in-network care providers and access details about programs and services.

Mom's Meals

A Care Manager can arrange 14 home meals, delivered to members with chronic conditions and post-acute discharge following an inpatient stay.

NurseLine

NurseLine is available at any time at no cost to our members. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PMP. Our nurses also help educate members about staying healthy. Call 1-866-801-4407, TTY 711 to reach a nurse.

On My Way

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

Preventive health rewards

Members earn rewards for completing needed preventive services, such as:

- Diabetic HbA1c screening
- Yearly well child visit or adolescent well care (3 to 21 years old)
- Lead screening (under age 2)
- Annual dental visit

SafeLink phones

Member Services Advocates work with members with limited access to a mobile phone through the SafeLink program provided by TracFone Wireless.

UHC Latino

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

UnitedHealthcare Doctor Chat

There are many reasons members may not see their PMP when appropriate. They may have difficulty leaving their home to see the doctor or may have trouble finding a provider because of where they live in Indiana. Our UHC Doctor Chat highlights our commitment to bring statewide, forward-looking solutions to expand and deliver access to care throughout Indiana. Members will be able to receive non-emergent care using an

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innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device. A board-certified ER physician will assess the severity of the member's situation, provide treatment and recommend additional care as needed. Virtual visits can improve access to care, help people in rural areas and other who have difficulty accessing routine care to maintain their health and stability, and reduce avoidable ER use for chronic conditions such as diabetes, asthma and mild to moderate behavioral health needs. care managers receive alerts that the person they are assisting with care management has used the tool, which prompts the care manager to follow up with to address acute needs or close gaps in care.

Government assistance programs

Supplemental Nutritional Assistance Program (SNAP)

SNAP provides food assistance to low- and no-income people and families living in the United States. In Indiana, the Family and Social Services Administration is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Visit **in.gov > fssa > dfr > about snap** for details, including eligibility and application requirements.

Women, Infants and Children supplemental nutrition program (WIC)

The state also has programs such as Women, Infants, and Children Supplemental Nutrition programs (WIC) to help with nutritional needs for low-income families.
Contact Information:

800-522-0874

in.gov/isdh/19691.htm

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Chapter 7: Behavioral Health and Substance Use

Key contacts

Topic	Link	Phone Number
Optum Behavioral Health-Clinical	**providerexpress.com**	800-888-2998 for clinical questions
Optum Provider Services-Network	**providerexpress.com**	877-614-0484 Network or contract questions, claims questions, Provider Services
Indiana Community Plan	**UHCprovider.com/ INcommunityplan**	Call: 877-610-9785 for prior authorization Fax: 844-897-6514 for prior authorization

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

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

The National Optum Behavioral Health 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.

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

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

- Community behavioral health centers
- Outpatient behavioral health clinics
- Psychiatrists
- Health service care provider in psychology
- Psychologist
- Licensed Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addiction counselor (LCAC)
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master’s degree in nursing, with a major in psychiatric or mental health nursing, from an accredited school of nursing

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

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

- Psychiatrist or physician
- Health service provider in psychology (HSPP)

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

They must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan. Find out how to get an NPI at **nppes.cms.hhs.gov**.

To request an ID number, go to **in.gov/medicaid/providers/591.htm** > Provider Enrollment > Become a Provider. Also check out the **Indiana Provider Enrollment Application Process**.

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How to Join Our Network
Credentialing information is available at **providerexpress.com** > Clinical Resources >Guidelines/Policies & Manuals > Credentialing Plans > Optum.

If you have questions about network participation, credentialing, or your provider record, please go to providerexpress.com > **Contact Us.**

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for behavioral, emotional and substance use disorders. We offer care management to help members, clinicians, and PMPs using and offering behavioral health services. We provide information and tools for behavioral health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place. Liveandworkwell.com is accessed through a link on myuhc.com, and includes behavioral health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

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

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute) including substance abuse disorder
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Intensive outpatient treatment
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Low and high intensity SUD residential

Autism/Applied behavior analysis

UnitedHealthcare Community Plan is one of the selected health plans providing coverage to Indiana Medicaid members. Coverage of applied behavioral analysis (ABA) therapy is available for the treatment of autism spectrum disorder (ASD) for members 20 years of age and younger. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Indiana Hoosier Care Connect members. Your participation in our network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

BCBAs are covered providers and require an NPI and enrollment in Indiana Medicaid with an ABA specialty type. The BCBA performs skills assessments and provides direct supervision of BCBAs/Behavior technicians in joint sessions with client and family. Non-licensed provider types in this category may not be separately enrolled as individual care providers to receive direct reimbursement. BCBAs/Behavior technicians can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. The employer or supervising BCBA bills for the services. Prior authorization is required.

Learn more about applying to the network and the clinical protocols required in this unique network by going to providerexpress. com > Clinical Resources > **Autism/Applied Behavioral Analysis.**

Excluded services

- Long Term Institutional Care
- Psychiatric Treatment in a State Hospital
- Psychiatric Residential Treatment Facilities-
- HCBS waivers

UnitedHealthcare Community Plan will provide care

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coordination services for transition and discharge planning.

These excluded benefits are available under traditional Medicaid.

Residential substance use disorder services

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

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

1. ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
2. ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

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

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

For more information about ASAM, go to **asam.org**

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at **UHCprovider.com** or fax 844-897-6514.

Authorizations

Members may access all behavioral health outpatient services (behavioral health and substance use) without a referral. Prior authorization is 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 non-emergent services. Get prior authorization by going to **UHCprovider.com/INcommunityplan** or calling 877-610-9785 or fax 844-897-6514.

Notifications

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

Collaboration with other care providers

Coordination of care

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

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

Please talk to your patients about the benefits of sharing essential clinical information. Go to **UHCprovider.com** then login to the Provider Portal to find the member's PMP, who is the coordinator, or other participating care providers.

No form is required to participate in coordination of care.

Release of information

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

Find the ROI at **UHCprovider.com/INcommunityplan.** Go to Provider Forms and References. Fax to 844-386-9286.

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

Portal access

Website: **UHCprovider.com**

Access the Provider Portal by selecting the Sign In button on the top right. This is the gateway to UnitedHealthcare Community Plan's online services. Use these services to verify eligibility, review electronic claim submission, view claim status, and submit notifications/ prior authorizations.

View the list, find forms and access the care provider manual. Or call Provider Services at **800-888-2998** to verify eligibility and benefit information (available 8 a.m. – 8 p.m. Eastern Time, Monday through Friday).

Website: **providerexpress.com**

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

For more information about adding patients to existing panel rosters, go to Reassignment of a PMP section in Chapter 3 of this manual.

Claims

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

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

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention:
  - Prevent OUD before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support care 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 mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/ OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also need

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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 > Resources > **Drug Lists and Pharmacy.** Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prescribing opioids

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

Pharmacy lock-in

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

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

Expanding MAT 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 services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

Only state certified opioid treatment programs (OTP) may prescribe and provide methadone.

To find a behavioral health MAT provider in Indiana:

1. Go to **UHCprovider.com,**
2. Select "Our Network," then "Find a Provider"
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "(state)" for options
6. If needed, refine the search by selecting "Medication Assisted Treatment"

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

To find medical MAT providers, see the **MAT section** in the Medical Management chapter.

Mental Health Parity and Addiction Equality Act (MPAEA)

By providing BH benefits, you must comply with MPAEA. This includes, but is not limited to:

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques applied to medical and surgical benefits
- Ensuring compliance with MHPAEA for any benefits you offer Hoosier Care Connect members beyond those specified in Indiana's Medicaid state plan
- Making criteria and guidelines available to any current or potential member, or contracting care provider when requested
- Providing a reason for denial of reimbursement or payment benefits to members

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

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Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/IN	800-832-4643
Member Handbook	UHCCommunityPlan.com/IN> Community Plan > Member benefits	800-832-4643

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

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 PHI

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

Amendment of PHI

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, six 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

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.

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.

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Right to request confidential communications

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

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCCommunityPlan.com/IN > Medicaid.

Native American access to care

Native American members can access care to tribal clinics and Indian hospitals and can be in or out of network.

Member rights

Members have the right to:

- Receive information about UnitedHealthcare Community Plan, its services, its practitioners and providers and member rights and responsibilities regardless of cost or benefit coverage.
- Participate in decision-making about their health care.
- Be treated with respect and with due consideration for your dignity and privacy
- Receive information about treatment options and alternatives, in a way that is understandable
- Talk to care providers and the health plan about medical care and treatment plan
- Refuse treatment directly or through an advance directive
- Be free from any action of being held against will or cut off from others when these actions are intended to pressure member into doing something, punish, or show revenge
- Review medical records and request changes and/ or additions to any area member feels is needed
- Change PMP at any time for any reason.
- Tell us if not satisfied with treatment or with us; can expect a prompt response.
- Know they will not be treated poorly if they exercise their right to file a complaint or appeal about the health plan or the care provided.
- Make suggestions about our member rights and responsibilities policies.
- Talk to a Member Services Advocate or care manager to ask questions, get help or better understand health care.
- Receive information in the format needed, such as Braille, large print or audio and/or in language needed.

Member responsibilities

Members should:

- Ask questions if they do not understand rights or plan of treatment.
- Keep appointments.
- Cancel appointments in advance when they cannot keep them.
- Contact PMP first for non-emergency medical needs.
- Understand when they should and should not go to an emergency room.
- Know whom to call if needing a ride to the doctor or for other covered services.
- Treat you and your staff with respect and dignity.
- Oversee planning meeting.
- Ask anyone they want to come to planning meetings.
- Choose goals to work on and what is on their plan.
- Schedule person-centered planning meeting at a time and place when the people whom they want to attend are available.
- Agree to the services they want from the choice of services they can have.
- Pick an available care provider they want for services.
- Know they may need help from a guardian, family and/or friends to make good choices.

Members should give information:

- Tell PMP and member services advocate or care

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manager about health and changes in health.
- Tell member services advocate about changes in private insurance. This includes adding or ending other insurance.
- Talk to care providers and care manager about health care. Ask questions about how health problems can be treated.
- Notify care manager and the Indiana FSSA if family size changes, if they move, or if income changes.
- Work as a team with PMP and care manager to decide what care is best
- Understand how what they do can affect their own health
- Do the best they can to stay healthy
- Treat you and your and staff with respect. This includes no disparaging remarks, racial or ethnic slurs, or profanity towards providers, caregivers and/or care managers.

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

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

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Chapter 9: Medical Records

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

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 care providers.
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements. • Keep in a secure area accessible only to authorized personnel.

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Topic	Contact
Procedural Elements	• 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. *
History	An initial history (for members seen three or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

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<table>
<tr><th>Topic</th><th>Contact</th></tr>
<tr><td>Problem Evaluation and Management</td><td>Documentation for each visit includes:
• Appropriate vital signs (Measurement of height, weight, and BMI annually)
- Chief complaint*
- Physical assessment*
- Diagnosis*
- Treatment plan*
• Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines.
• Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT).
• Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets.
• Treatment plans are consistent with evidence-based care and with findings/diagnosis:
- Timeframe for follow-up visit as appropriate
- Appropriate use of referrals/consults, studies, tests
• X-rays, labs consultation reports are included in the medical record with evidence of care provider review.
• There is evidence of care provider follow-up of abnormal results.
• Unresolved issues from a previous visit are followed up on the subsequent visit.
• There is evidence of coordination with behavioral health care provider.
• Education, including lifestyle counseling, is documented.
• Member input and/or understanding of treatment plan and options is documented.
• Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.</td></tr>
</table>

***Critical element**

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Member copies

UnitedHealthcare Community Plan care providers must provide a copy of a member's medical record upon reasonable request by the member at no charge. You must facilitate the transfer of the member's medical record to another provider at the member's request.

Medical records must be legible, signed (manually or electronically) and dated and maintained for at least seven years as required by state and federal regulations.

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than two 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 three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want 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 PMP 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)

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Chapter 10: Quality Management (QM) Program and Compliance Information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team at **Networkhelp@uhc.com**	877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	**uhc.com/fraud**	800-455-4521

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

What is the Quality Improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

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

We require your cooperation and compliance to:

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

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Care provider satisfaction

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

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

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

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

Credentialing standards

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

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current DEA certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Criteria includes:

- Required medical or professional education and training
- Verification of post-graduate education or training and/or board certification
- Current license or certification
- DEA certificate and number, if applicable
- Medicare/Medicaid Program Participation Eligibility
- Work history
- Professional liability insurance
- Malpractice history
- Sanction and limitation on Licensure
- Hospital staff privileges, if applicable
- Office site review on primary medical providers (PMPs) and OB/GYNs

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider.

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Health facilities

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

- State and federal licensing and regulatory requirements and an NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an accrediting body.
- Have malpractice coverage/liability insurance that meets contract minimums.
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions.

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

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

To submit a request for provider participation, apply online at **uhcprovider.com** or email us at **Networkhelp@uhc.com**

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

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

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

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have three chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

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

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You also have the right to receive the status of your credentialing or recredentialing application, when you ask for it. Check for status of your application by calling the United Voice Portal at **877-842-3210** and follow prompts: Other Professional Services > Credentialing > Medical > Get Status. You can also email us at **networkhelp@uhc.com.** Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare representative will be in touch with you within two business days from when we receive your request.

Confidentiality

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

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

Care provider participation

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

Resolving disputes

Contract concerns

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

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

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

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

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

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and Chapter 12 of this manual.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

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

Unique identifier

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

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National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

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

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

Reporting and auditing

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud, Waste and Abuse line or go to **uhc.com/fraud.**

Please refer to the Fraud, Waste and Abuse section of this manual for additional details.

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

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

Extrapolation audits of corporate-wide billing

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

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Indiana program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

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

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and service (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded

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and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PMP office sites to help ensure facility quality.

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

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

The State of Indiana requires the MCE credentialing and recredentialing processes include a site visit to the offices of all primary medical providers, including all obstetricians and gynecologists (OB/GYNs). There must be a structured review that evaluates the site against the MCE standards. The site visit must also document evaluation of the medical recordkeeping practices at each site to help ensure conformity with medical record maintenance.

If you are already a participating care provider with another UnitedHealthcare product, you will be recredentialed and have a site visit on your recredentialing anniversary. If you are not already participating under another UnitedHealthcare product and are new, you will be initially credentialed and have an initial site visit to meet all state credentialing and recredentialing policies.

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	One complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

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Chapter 11: Billing and Submission

Key contacts

Topic	Link	Phone Number
Claims	**UHCprovider.com/claims**	877-610-9785
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov**	800-465-3203
EDI	**UHCprovider.com/EDI**	877-610-9785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP on **UHCprovider.com/guides.**

Claims: 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.

Claims reconsideration and appeals
If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this 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 by calling Provider Services at 877-610-9785.

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 or obtaining prior authorization 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 non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

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Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding. Refer to the IHCP Fee Schedule for procedure code or revenue code coverage at **in.gov/ medicaid.**

Modifier codes

Use the appropriate modifier codes on your claim form. The modifier must be used based on the date of service.

For more information, visit Reimbursement Policies at UHCprovider.com > Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan > **Community Plan Reimbursement Policies.**

Recipient ID card (RID) for billing

The recipient ID card has the state's member identification number. Use the RID when billing UnitedHealthcare Community Plan.

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

Follow and IHCP and/or UnitedHealthcare Community Plan required billing guidelines to submit your claim. We may require additional information for some services, situations or state requirements.

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

Care provider coding

UnitedHealthcare Community Plan complies with 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 Administrative Guide for Commercial, Medicare Advantage and DSNP at **UHCprovider.com/guides.** You can also Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol.**

Electronic claims submission and billing

You may submit claims by EDI. EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 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

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(NUBC) guidelines for HCFA 1500 and UB-04 forms.

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

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices.
- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

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

The companion documents are located on **UHCprovider.com/EDI** > Go to **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 **877-610-9785** for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

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

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

Electronic payment solution: OptumPay™

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment.**
- If your practice/health care organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards, you don't need to take action.

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- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment.**

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

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/EDI.**

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

Completing the UB-04 form

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

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

Form reminders

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

Subrogation and coordination of benefit

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

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

Hospital and clinic method of billing professional services

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

Global days

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

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value

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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 > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan > **Global Days Policy, Professional – Reimbursement Policy – UnitedHealthcare Community Plan.**

Correct Coding Initiative

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

Comprehensive and Component Codes

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get 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, ZIP and the appropriate modifier.

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.

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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 UnitedHealthcare Community Plan Provider Services and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to **UHCprovider.com.** Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number
- Claim denial edits if available.

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

UnitedHealthcare Community Plan Provider Portal

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

The Provider Portal lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls, paperwork.

You can even customize the screen to put these common tasks just one click away.

Find training on **UHCprovider.com/en/resource-library/training.html.**

Claim processing time frames

Paper claims are processed within 30 calendar days of receipt and electronic claims are processed within 21 calendar days of receipt.

Resolving claim issues

To resolve claim issues, contact Provider Services, use the Provider Portal at **UHCprovider.com/claims,** 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 30 days for UnitedHealthcare Community Plan to process payment for initial claims and adjustment requests.

For paper claims

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

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

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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 explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

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

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

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

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

Out of network providers have 180 days from date of service or date of discharge to submit the claim for processing.

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

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

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

Charging for missed appointments

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

If you don't know who your provider advocate is, email **IN_PR_Team@uhc.com**. A provider advocate will get back to you.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (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, the claim may then be submitted 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.

Third party liability information is available on the member's eligibility verification, which is on the provider portal at **in.gov/medicaid** or on the UnitedHealthcare Community Plan eligibility verification.

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Chapter 12: Claims Reconsiderations, Appeals and Grievances

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

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

For claims, billing and payment questions, go to **UHCprovider.com/claims**. Please use our online options or phone number.

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR MAIL	CONTACT PHONE NUMBER	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIME FRAME	UnitedHealthcare Community Plan RESPONSE TIME FRAME
Care Provider Claim 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 normally receive a duplicate claim rejection on your resubmission.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	UHCprovider.com/claims	877-610-9785	Use Claims Management or Claims on the Provider Portal. Uhcprovider.com, then Sign In on top right.	must receive within 90 calendar days from denial paid date	30 business days
Care Provider Claim Reconsideration	The first step to dispute how a claim was paid or to submit a corrected claim. If you disagree with the outcome of the reconsideration, move to a formal appeal process.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	N/A	877-610-9785	Use Claims Management or Claims on the Provider Portal. Uhcprovider.com, then Sign In on top right.	must receive within 90 calendar days from denial date	30 calendar days

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APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIME FRAME**	**UnitedHealthcare Community Plan RESPONSE TIME FRAME**
Care Provider Claim Formal Appeal	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	**UnitedHealthcare Community Plan of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	877-610-9785	Use Claims Management or Claims on the Provider Portal. UHCprovider.com, then Sign In on top right.	60 calendar days	30 calendar days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider	**UnitedHealthcare Community Plan of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	877-610-9785	Use Claims Management or Claims on the Provider Portal. UHCprovider.com, then Sign In on top right.	120 calendar days	30 calendar days
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 of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims *AOR Consent Form on this site for member appeals	800-832-4643, TTY 711	N/A	Standard appeals-60 calendar days from date of denial.	Urgent appeals We will resolve within 48 hours Standard appeals acknowledgement letter sent within 3 business days Resolution of non-urgent appeal within 30 calendar days
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	*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 of Indiana** P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	800-832-4643, TTY 711	N/A	standard grievance is 60 calendar days from date of occurrence.	Grievance will be acknowledged within 3 business days Resolution will be within 30 calendar days

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

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

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Denial

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

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

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

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

Other top reasons for denial include:

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

Claim lacks information. Basic information is missing, such as a person's date of birth; or incorrect information, 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 Provider Portal. To access, go to **UHCprovider.com/claims,** then to the Provider Portal by selecting Sign In on top right. Login using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

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

Additional Information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

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

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

How to use:

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

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

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Claim reconsideration (step one 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.

Emergency services:

- Medical records for prudent lay review

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

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

- **Phone:** Call Provider Services at **877-610-9785** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

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

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

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call Provider Services 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. Prenatal care, well child and preventative pediatric services, including EPSDT, are exceptions to cost avoidance.
- 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.

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- 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 by phone, or mail with the following information:

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

Additional Information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

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

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- MID 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 timeframe as listed in your contract.

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

We make claim adjustments without requesting additional information from you. 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.

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

Appeals (step two of dispute)

What is it?

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 one, use the claim appeal process.

How to use/file:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, 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 Provider Portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims. You may upload attachments.
- **Mail:** Send the appeal to:

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

Questions about your appeal or need a status update?

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

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

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How to file:

File verbally or in writing.

- **Phone:** Call Provider Services at **877-610-9785**
- **Mail:** Send care provider name, contact information and your grievance to:

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

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

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

An adverse 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

Toll-free: **800-587-5187** (TTY **711**)

You'll need to sign an Authorization of Representation form on **UHCprovider.com/claims.** If needed, an appeals representative will provide you with this form.

How to use:

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

- Receive a copy of the rule used to make the decision.
- 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 provider, you cannot ask for a continuation. Only the member may do so.

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

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

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

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

A copy of the form is online at **uhcprovider.com.**

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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

Toll-free: **800-832-4643** (TTY **711**)

We will send an answer within 30 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

State fair hearings

What is it?

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

When to use:

Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter. They must exhaust the health plan's appeal process before requesting a State Fair Hearing.

How to use:

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

Office of Administrative Law Proceedings
Attn: Hearing and Appeals
402 W. Washington St. RM E034
Indianapolis, IN 46204

- 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.

External review

An alternative to a State Fair Hearing is an External Review (ER) by an independent review organization (IRO). The rules for an SFH also apply to an ER. Members can share why they think Indiana Medicaid services should not have been denied, reduced or terminated. The member must complete the first level appeal before asking for an ER. Members have up to 120 calendar days from the receipt of the 1st level appeal decision letter to ask for an ER. The IRO will make their decision within 15 business days. Whatever the decision is from the IRO, we will comply. If a member does not agree with the IRO's decision, they may go ahead and ask for a state fair hearing.

The UnitedHealthcare Community Plan member may ask for an ER by writing a letter to:

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

-or-

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

Processes related to reversal of our initial decision

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

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

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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 toll-free 877-401-9430 Fraud, Waste, and Abuse Hotline to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

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

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

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

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

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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.

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Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > **Resource Library**	877-610-9785
News and Bulletins	UHCprovider.com > Resources > **News**	877-610-9785
Provider Manuals	**UHCprovider.com/guides**	877-610-9785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Connect with us on social media:

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:

- **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/INcommunityplan:** The UnitedHealthcare Community Plan of Indiana page has state-specific resources, guidance and rules.
- **Policies and protocols**: UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols.
- **Indiana health plans**: **UHCprovider.com/IN** is the fastest way to review all of the health plans UnitedHealthcare offers in Indiana. To review information for another state, use the drop-down menu at **UHCprovider.com > Resources > Health Plans.** Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **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 manual or by visiting **UHCprovider.com/portal.** You can also access **UHCprovider.com/training > Digital Solutions** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News:** Bookmark UHCprovider.com > Resources > **News.** 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

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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 **cloud.provideremail.uhc.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.**

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

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

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

State website and forms

Find the following forms on the state's website at **in.gov/fssa:**

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

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Glossary

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

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2)The reduction, suspension, or termination of a previously authorized service.

(3)The denial, in whole or in part, of payment for a service.

(4)The failure to provide services in a timely manner, as defined by the state.

(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.

(6) For a resident of a rural area, the denial of a member's request to exercise his or her right, to obtain services outside the network.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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

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

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

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

Care Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary medical provider (PMP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

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

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

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

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

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

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

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

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

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

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, behavioral health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

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

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

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

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

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

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Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FQHC
Federally Qualified Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

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

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

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

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

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

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

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

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

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

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

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

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

Primary Medical Provider (PMP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), NPs, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Provider Group

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

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Remittance Advice

A provider remittance advice is an summary of adjudicated sent to a provider on all claims submitted.

Recipient ID

This number refers to the state's recipient ID number. It appears on the member's UnitedHealthcare Community Plan insurance card.

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

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by State of Indiana.

Specialist
A care provider licensed in Indiana and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

Third Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Timely filing limit required by UnitedHealthcare Community Plan's contract with the state of Indiana. Contracted providers are 90 days from date of service or date of discharge and out of network 180 days from date of service or date of discharge.

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

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

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Appendix A

Indiana state benefits

Benefit	Coverage Definitions and Limitations
Chiropractic services	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five (5) visits and fifty (50) therapeutic physical medicine treatments per member per year.
Dental services	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to one (1) set per recipient every three (3) years, one (1) set per recipient every twelve (12) months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient. A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient. Topical fluoride is not covered for recipients twenty-one (21) years of age or older. Prophylaxis is limited to one (1) unit every (6) months for non-institutionalized children ages twelve (12) months up to their twenty-first birthday and one unit every twelve (12) months for non-institutionalized recipients over age (21). Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed. In accordance with Federal law, all medically necessary dental services are provided for children under age twenty-one (21) even if the service is not otherwise covered
Diabetes self-management training services	Diabetes Self Management Training services are intended to enable the member to, or enhance the member's ability to, properly manage the member's diabetic condition, thereby optimizing the member's own therapeutic regimen. Limited to sixteen (16) units per member per year. Additional units may be prior authorized.
Legend drugs	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid.
Non-legend drugs	Medicaid covers non-legend (over-the-counter) drugs on its formulary.
Early Intervention Services (Early Periodic Screening, Diagnosis and Treatment [EPSDT])	Covers comprehensive health and developmental history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the IHCP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch Provider Reference Module.

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Benefit	Coverage Definitions and Limitations
Emergency services	Emergency services are provided to individuals who require immediate medical attention and covered subject to the prudent layperson standard of an Emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an Emergency medical condition are covered.
Eye care, eyeglasses and vision services	Must be provided by licensed Ophthalmologists or Optometrists within their scope of practice. Coverage for the initial vision care examination will be limited to one (1) examination per year for a member under twenty-one (21) years of age and one (1) examination every two (2) years for a recipient twenty-one (21) years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year for members under twenty-one (21) years of age and one (1) pair every five (5) years for members twenty-one (21) years and older. Other vision-related services, such as pharmaceutical services, surgeries, and diabetes self-management training, are covered services when determined to be medically necessary.
Family planning services and supplies	Family planning services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines
Federally qualified health centers (FQHCs)	Coverage is available for services provided by a physician, physician assistant, nurse practitioner, a clinical psychologist, licensed clinical addiction counselor, licensed marriage and family therapists, licensed mental health counselors or a clinical social worker.
Food supplements, nutritional supplements, and infant formulas	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs. Coverage is also not available in cases in which the item is to be used for other than nutritional purposes.
Hospital services inpatient	Inpatient services (acute, psychiatric and rehabilitation) are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital services outpatient	Outpatient services are provided by an acute care hospital, psychiatric hospital, an ambulatory surgical center or other treatment rook setting (i.e. birth center) to individuals who are registered as patients with the facility but not admitted as inpatients. Services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

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Benefit	Coverage Definitions and Limitations
Home health services	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. Services must be certified and ordered in writing by a physician and performed on a part-time or intermittent basis in accordance with a written plan of treatment
Hospice care	Home and Institutional setting- Hospice is available under Medicaid if the recipient is expected to die from illness within six (6) months. Coverage is available for two (2) consecutive periods of ninety (90) calendar days followed by an unlimited number of periods of sixty (60) calendar days. Covered services include palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness. Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.
Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)	Covered for up to 60 days. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services.
Laboratory and radiology services	Services must be ordered by a physician or other practitioner authorized to do so under state law. The order must include a condition-related diagnosis that necessitates the laboratory services.
Long term acute care hospitalization	Long term acute care services are covered if ordered in writing by a physician. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (include prosthetic devices, implants, hearing aids, dentures, etc.)	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when they serve a medical purpose, ordered in writing by a physician, optometrist or dentist and are part of the treatment plan and are medically necessary.
Mental health/behavioral health services - inpatient	Covered when provided in a freestanding psychiatric hospital or in the psychiatric unit of an acute care hospital. The need for admission must be certified and ordered in writing by a physician and be medically necessary. Medicaid Rehabilitation Option services are carved out of the Hoosier Care Connect Program and is provided on a fee for service (FFS) basis. Psychiatric Residential Treatment Facilities (PRTFs) are excluded from managed care. The member will need to be suspended from managed care and moved into FFS. UnitedHealthcare Community Plan provides care coordination services and associated services related to PRTF services before and after admission. Mental health and addiction services are included.

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Benefit	Coverage Definitions and Limitations
Mental health/behavioral health services - outpatient	Coverage includes outpatient mental health services provided by physicians or licensed behavioral health professionals. In addition, we provide coverage for partial hospitalization services, clinic option services, peer recovery, intensive outpatient therapy, crisis intervention, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for higher levels of outpatient care MRO services are carved out and not covered by the health plan. Coverage requirements include treatment plans and progress notes explaining medical necessity and effectiveness of treatment.
Nurse-midwife services	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse practitioners	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Nursing facility services (Long-term)	Covered for up to 60 days while the LOC determination is pending. Coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to vocational/habilitation service programs.
Nursing facility services (Short-term)	The MCE may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.
Occupational therapy	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.

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Benefit	Coverage Definitions and Limitations
Organ transplants	All transplants and services related to the transplant are covered if medically necessary. Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike. Prior authorization is required. Both transplant donor's hospital and surgical expenses for the removal of donor tissue and organ during the inpatient admission is covered when the member is an IHCP member, the member meets criteria for the transplant and the transplant is medically necessary.
Orthodontics	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate. Coverage allows for phased orthodontic treatment that incorporates both an interceptive phase and a comprehensive phase, with specific objectives at various stages of dentofacial development.

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Benefit	Coverage Definitions and Limitations
Out-of-state medical services	Out-of-state health care providers must enroll in the IHCP to receive reimbursement for services provided to IHCP members. Out-of-state provider rules are found in Indiana Administrative Code 405 IAC 5-5. All out-of-state services are subject to the same limitations as in state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization), Pharmacy services that are exempt from PA, and Telemedicine services . Services may be obtained in the following designated out-of-state cities: IHCP members may require healthcare services when they are outside the state of Indiana under specifically defined circumstances. If an IHCP member requires healthcare services, he or she should inquire (if possible, before receiving services) whether the organization is enrolled as an IHCP provider. In cases where an out-of-state provider who is not enrolled in the IHCP delivers services to an IHCP member in need of care while traveling, a retroactive provider enrollment date of up to 6 months may be considered for approval by the Indiana Family and Social Services Administration (FSSA). Metropolitan statistical area out-of-state counties: • Cincinnati area • Louisville/Jefferson County area Chicago-Naperville-Elgin area: • Cook (Illinois) • DeKalb (Illinois) • DuPage (Illinois) • Grundy (Illinois) • Kane (Illinois) • Kendall (Illinois) • Lake (Illinois) • McHenry (Illinois) • Will (Illinois) • Boone (Kentucky) • Bracken (Kentucky) • Brown (Ohio) • Butler (Ohio) • Campbell (Kentucky) • Clermont (Ohio) • Gallatin (Kentucky) • Grant (Kentucky) • Hamilton (Ohio) • Kenton (Kentucky)

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Benefit	Coverage Definitions and Limitations
	• Pendleton (Kentucky) • Warren (Ohio) • Bullitt (Kentucky) • Henry (Kentucky) • Jefferson (Kentucky) • Oldham (Kentucky) • Shelby (Kentucky) • Spencer (Kentucky) • Trimble (Kentucky) • Evansville area • Henderson (Kentucky) • South Bend-Mishawaka area • Cass (Michigan) Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.
Physicians' surgical and medical services	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of thirty (30) per calendar year per member per provider without prior authorization. New patient office visits are limited to one (1) per recipient, per provider within the last three (3) years.
Physical therapy	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.

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Benefit	Coverage Definitions and Limitations
Podiatrists	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six (6) routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Prior Authorization is required for inpatient hospital stays, corrective footwear for patients under age twenty-one (21) and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative unit services - inpatient	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.
Residential substance use disorder (SUD) services	Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Respiratory therapy	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within thirty (30) calendar days (up to thirty (30) units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Rural health clinics	Coverage is available for services provided by a physician, physician assistant nurse practitioner, a clinical psychologist, licensed clinical addiction counselor, licensed marriage and family therapists, licensed mental health counselors or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.

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Benefit	Coverage Definitions and Limitations
Sexually transmitted infections (STIs).	Coverage if medically necessary including initial diagnosis and ongoing treatment of sexually transmitted diseases and sexually transmitted infections after diagnosis.
Smoking cessation and tobacco dependence treatment services	Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.
Speech, hearing and language disorders	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by physician prior to discharge, or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility’s established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.

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Benefit	Coverage Definitions and Limitations
Transportation - emergency	Coverage has no limit or prior authorization requirement for Emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation – Non-emergency medical	Non-emergency medical travel is available for unlimited trips of less than fifty (50) miles per year without prior authorization when another alternative is not available.

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