2022
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Pennsylvania

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as how to process a claim and prior authorization. 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:

- UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select 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 available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.

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

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.

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 "provider" refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this manual.
- "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.

Pennsylvania Medical Assistance Manual

Along with this manual, you need to be aware of the information in the Pennsylvania Medical Assistance Manual. This is found on the Commonwealth's website at: pacode.com.

The DHS website, dhs.pa.gov, is also a good resource for state specific information.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Training	UHCprovider.com/training	800-600-9007
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	800-600-9007
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
Provider Portal Support	email: ProviderTechSupport@uhc.com	855-819-5909
Resource Library	UHCprovider.com > Menu > 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 of Pennsylvania currently offers the following programs:

- UnitedHealthcare Community Plan Medicaid is offered through the product name UnitedHealthcare Community Plan for Families under HealthChoices program of the Pennsylvania Department of Human Services.
- UnitedHealthcare Community Plan Children's Health Insurance Program (CHIP) is offered through the product UnitedHealthcare Community Plan for Kids under CHIP administered by the Pennsylvania Department of Human Services.

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

How to join our network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to UHCprovider.com/join. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

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

Our approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, working with care providers and our community to help people lead healthier lives. We work with members with chronic complex medical conditions and may also be challenged by social determinants of health that impede access to care. The Care Model team is comprised of RN case managers, community health workers, and behavioral health advocates to provide a full range of support services.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty 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.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health advocate (CHA) 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 PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health (BH) needs, measured by number of BH care provider visits within identified time frames.
- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Health Plan Employer Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call Member Services at **800-414-9025, TTY 711**. You may also call Provider Services at **800-600-9007**.

Compliance

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan Cultural Competency Program.

UnitedHealthcare Community Plan offers the following support services:

- **Optum On Demand "Advancing Health Equity" educational series:** Earn continuing education units (CEUs) by taking our course at optumhealtheducation.com/wellness/advancing-health-equity.
- **Language Interpretation Line:** To find out how LanguageLine Solutions works, go to languageline.com > Client Services.

  You can open an account with LanguageLine Solutions® at languageline.com or call **800-752-6096**, **option 4**.

  Once you are ready to use the interpreter service, follow these instructions:
- **To conference in the limited-English Speaking Patient:**
  - Call LanguageLine Solutions at **800-752-6096**.
  - Request the language your caller speaks through our simple interactive voice response system.
  - When the interpreter is connected, explain the situation.
  - Conference in your patient.
- **To make a call to a limited-English speaking patient:**
  - Call LanguageLine Solutions at **800-752-6096**.
  - Request the language your client speaks through our simple interactive voice response system.
  - When the interpreter is connected, call your patient or the interpreter can place the call for you.
- **If you are face-to-face with a limited-English speaking patient:**
  - Call LanguageLine Solutions at **800-752-6096**.
  - Request the language your client speaks through our simple interactive voice response system.
  - When the interpreter is connected, use the LanguageLine Solutions phone or your speakerphone, or pass your handset back and forth.
- **Materials for limited-English speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to uhc.com > Language Assistance.
- **Sign Language Interpretation:** Preview Languages Unlimited, LLC services for American Sign Language, telephonic and on-site interpretation at languagesunlimited.com or call **800-864-0372**.
- **711 Relay:**
  - Dial 711 to use Hamilton Relay in Pennsylvania at hamiltonrelay.com/state_711_relay or call: TTY: **800-654-5984**
  - Voice: **800-654-5988**
  - Speech-to-Speech: **844-308-9292**
  - Spanish: **844-308-9291**
- **Translation services:** Get a quote for Accredited Language Services (ALS) International professional translation services in more than 200 languages at accreditedlanguage.com or call **800-322-0284**

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual (We previously used MCG Guidelines.) for medical care determinations.

Online resources

UHCprovider.com is your home for care provider information with access to Electronic Data Interchange (EDI), Provider Portal online services, medical policies and news bulletins. It includes great resources to support administrative tasks such as eligibility, claims, claims status and prior authorizations and notifications. Go to Self Service for Self Service Tool online training and information.

Electronic Data Interchange (EDI)

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

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

- Send and receive information faster

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

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

Getting Started

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

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

Provider Portal – secure care provider website

The Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the portal, go to **UHCprovider.com** and click Sign In on the upper right corner. For more information about all online services, go to **Self Service Tools and Eligibility** or go to the Provider Portal Self Service page at **UHCprovider.com/en/resource-library/link-provider-self-service.html**.

For Provider Portal training, go to Community Care **Provider Portal User Guide**.

To access the Provider Portal, the secure care provider website, go to **UHCprovider.com** and either sign in or create a user ID. You will receive your user ID and password within 48 hours.

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Bright Futures toolset.
- Search for CPT codes. Type the CPT code in the header search box titled "what can I help you find?" on UHCprovider.com. The search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our UHCprovider.com provider portal. You can now use certain direct URLs, which helps you find and remember specific webpages easily and quickly. You can access our most used and popular web pages on UHCprovider.com by typing in that page's direct URL identified by a forward slash in the web address, e.g. UHCprovider.com/claims. When you see that forward slash in our web links, you can copy the URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically. **To access the Provider Portal, go to UHCprovider.com, then Sign In**.

Here are most frequently used transactions on the Provider Portal:

- **Eligibility and Benefits** — View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
- **Prior Authorization and Notification** — Submit notification and prior authorization requests. For more information, go to UHCprovider.com/paan.
- **Specialty Pharmacy Transactions** — Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to UHCprovider.com/pharmacy for more information.
- **My Practice Profile** — View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mypracticeprofile.
- **Document Library** — Access reports and claim letters for viewing, printing, or download. The Document Vault Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to UHCprovider.com/documentlibrary.
- **Paperless Delivery Options** — The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters when we add them to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to Provider Portal One Healthcare ID password owners only.

Watch for the most current information on our self-service resources by email, in the Network Bulletin, or online at UHCprovider.com/EDI or the Provider Portal at UHCprovider.com then click Sign In.

*For more instructions, visit UHCprovider.com/Training or Self Service Tools for online self- service training and information.

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 timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

All users will access Direct Connect using Provider Portal. On-site and online training is available.

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

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 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.

How to contact us

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

Topic	Contact	Information
Behavioral Health	Optum providerexpress.com 800-888-2998 (toll-free)	Ask about eligibility, claims, benefits, authorization, and appeals.
Benefits	UHCprovider.com/benefits 800-600-9007	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology. 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Model (Care Management/ Disease Management)	For further details, contact the Special Needs Unit **877-844-8844**.	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
ChildLine	compass.state.pa.us/cwis 800-932-0313	Report suspected child abuse or neglect.
Chiropractor Care	myoptumhealthphysicalhealth.com 800-873-4575	This benefit does not need prior authorization.
Claims	Use the Provider Portal at UHCprovider.com/claims 800-600-9007 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 8207 Kingston, NY 12402-8207	Verify a claim status, ask about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal, then select the UnitedHealthcare Online app Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Client Support Center	800-249-3114	Ask about electronic claims submissions (not through Optum Insight).
Dental Services (UnitedHealthcare Specialty Dental Benefits)	800-508-4876	
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	To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility**. 800-600-9007	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: website: UHCprovider.com/PAcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** 844-359-7736 (UnitedHealthcare) 844-347-8477 (Pennsylvania DHS)	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.

Topic	Contact	Information
Healthy First Steps/ Obstetrics (OB) Referral	Pregnancy Notification Form on the Provider Portal Healthy First Steps: 800-599-5985 uhchealthyfirststeps.com	For pregnant members, contact Healthy First Steps by calling or filling out the Pregnancy Notification Form. Refer members to uhchealthyfirststeps.com to sign up for Healthy First Steps Rewards.
Interactive Voice Response (IVR) Line	800-600-9007	Available 24 hours a day, seven days a week to check member eligibility.
Laboratory Services	UHCprovider.com > Find Dr > Preferred Lab Network	Use a preferred lab provider in our network, such as LabCorp or Quest Diagnostics.
Medicaid (Department of Social Services)	Medicaid.gov 877-267-2323	Contact Medicaid directly.
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at UHCprovider.com or go to UHCprovider.com/claims for more information. 800-600-9007 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan** **Attn: Appeals and Grievance Unit** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	myuhc.com 800-414-9025 / TTY 711 for help accessing member account	Assist members with issues or concerns. Available Monday through Friday from 8 a.m. to 5 p.m. Eastern Time (ET), and on Wednesdays until 8 p.m. 24 hours, seven days a week service is available to assist members with urgent or emergent issues/concerns.

Topic	Contact	Information
Mental Health & Substance Abuse (CHIP members: Optum Behavioral Health; Medicaid members: Managed Care Organization by county)	**Optum:** 866-261-7692 **Community Behavioral Health Philadelphia:** 888-545-2600 **Community Care Behavioral Health Organization:** Adams: 866-738-9849 Allegheny: 800-553-7499 Bedford: 866-773-7891 Berks: 855-520-9715 Blair: 866-773-7892 Cameron: 866-878-6046 Carbon: 866-473-5862 Centre: 866-878-6046 Chester: 866-622-4228 Clarion: 866-878-6046 Clearfield: 866-878-6046 Clinton: 855-520-9787 Columbia: 866-878-6046 Elk: 866-878-6046 Erie: 855-244-1777 Forest: 866-878-6046 Huntington: 866-878-6046 Jefferson: 866-878-6046 Juniata: 866-878-6046 Lackawanna: 866-668-4696 Luzerne: 866-668-4696 Lycoming: 855-520-9787 McKean: 866-878-6046 Mifflin: 866-878-6046 Monroe: 866-473-5862 Montour: 866-878-6046 Northumberland: 866-878-6046 Pike: 866-473-5862 Potter: 866-878-6046 Schuylkill: 866-878-6046 Snyder: 866-878-6046 Somerset: 866-773-7891 Sullivan: 866-878-6046 Susquehanna: 866-668-4696 Tioga: 866-878-6046 Union: 866-878-6046 Warren: 866-878-6046 Wayne: 866-878-6046 Wyoming: 866-668-4696 York: 866-542-0299	**UnitedHealthcare Community Plan – Medicaid** Behavioral health services are carved out of the agreement between UnitedHealthcare Community Plan and the Department of Human Services (DHS). Members contact the following organizations at the numbers listed based on the counties they reside in for behavioral health services. **UnitedHealthcare Community Plan for Kids-CHIP** UnitedHealthcare Community Plan contracts with Optum Behavioral Health to provide benefits to UnitedHealthcare Community Plan – CHIP members. Outpatient therapy with a participating provider does not require prior authorization. Care providers seeking authorization of services can call 866-261-7692.

Topic	Contact	Information
Mental Health & Substance Abuse (CHIP members: Optum Behavioral Health; Medicaid members: Managed Care Organization by county) (continued)	**Value Behavioral Health:** Armstrong: 877-688-5969 Beaver: 877-688-5970 Butler: 877-688-5971 Crawford: 866-404-4561 Fayette: 877-688-5972 Greene: 877-688-5973 Indiana: 877-688-5974 Lawrence: 877-688-5975 Mercer: 866-404-4561 Venango: 866-404-4561 Washington: 877-688-5976 Westmoreland: 877-688-5977 **Magellan Behavioral Health of Pennsylvania:** Bucks: 877-769-9784 Cambria: 866-404-4562 Delaware: 888-207-2911 Lehigh: 866-238-2311 Montgomery: 877-769-9782 Northampton: 866-238-2312 **Perform Care:** Cumberland: 888-722-8646 Dauphin: 888-722-8646 Franklin: 866-773-7917 Fulton: 866-773-7917 Lancaster: 888-722-8646 Lebanon: 888-722-8646 Perry: 888-722-8646	
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	TDD 711	Available 8 a.m. – 5 p.m. ET, Monday through Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	https://nppes.cms.hhs.gov 800-465-3203 Correspondence: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059	Apply for a National Provider Identifier (NPI).

Topic	Contact	Information
Network Management	800-791-2067 1818 Market Street, Suite 1900 Philadelphia, PA 19103 800-414-5349 2 Allegheny Center Suite 600 Pittsburgh, PA 15212	Ask about contract, demographic and network related issues.
Network Management Resource Team	800-600-9007 **Networkhelp@uhc.com**	Self-service functionality to update or check credentialing information.
NurseLine	866-351-6827	Available 24 hours a day, seven days a week.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > **Oncology** Optum 888-397-8129 Monday -Friday 7am – 7pm CST	View current list of CPT codes that require prior authorization for oncology.
One Healthcare ID Support Center	email: **ProviderTechSupport@uhc.com** 855-819-5909	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services	UHCprovider.com/pacommunityplan > **Pharmacy Resources and Physician Administered Drugs** 800-310-6826 Pharmacy Help Desk for Pharmacists: 888-306-3243	OptumRx oversees and manages our network pharmacies. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com/priorauth** 800-310-6826	Request authorization for medications as required.

Topic	Contact	Information
Prior Authorization Requests/Advance and 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."	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: UHCprovider.com/ PAcommunityplan > **Prior Authorization and Notification**.
Provider Services	800-600-9007	Available 8 a.m. – 5 p.m. ET, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	UHCprovider.com > Menu > **Referrals** or use Referrals on the Provider Portal. Click Sign In in the top right corner of **UHCprovider.com**, then click Referrals. Provider Services 800-600-9007	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	UHCprovider.com/PAcommunityplan > **Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Sales and Marketing (CHIP)	877-289-1917	Available to assist members in obtaining CHIP insurance.
Special Needs Unit	877-844-8844	Available to assist members and care providers with various special needs issues.
Technical Issues	866-209-9320 email: **ProviderTechSupport@uhc.com**	Call if you have issues logging in the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/ smoking.

Topic	Contact	Information
Transportation	Medical Assistance Transportation Program (MATP) for non-emergency transports: Refer to the appendix for phone numbers based on county.	To arrange non-emergent transportation, please contact MATP at least three business days in advance.
UnitedHealthcare of Pennsylvania Hearing Impaired Access	Languages Unlimited: 800-864-0372 ALS International: 800-322-0284	
Utilization Management	Provider Services 800-310-6826	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM Policies and Protocols, go to UHCprovider.com > **Policies and Protocols**.
Vaccines for Children (VFC) Program (Medicaid Only)	**health.pa.gov** **888-646-6864** **kids.phila.gov** (Philadelphia County only) **215-685-6728** (Philadelphia County only)	Vaccines are provided free of charge to care providers for Medicaid members 0–18 years old.
Vision Services	**marchvisioncare.com**	Prior authorization is required for all routine eye exams and hardware.
Website for Pennsylvania Community Plan	**UHCprovider.com/pacommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	800-600-9007
Referrals	UHCprovider.com > Menu > Referrals	800-600-9007
Provider Directory	UHCprovider.com > Find Dr.	800-600-9007

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 mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else. Please refer to Appendix D for more information.

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 (UM) or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

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

Provide official notice

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

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

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

You may use the care provider demographic information update form for demographic changes or to update National Provider Identifier (NPI) information for care providers in your office. This form is at the Provider Portal at UHCprovider.com then Sign In > Provider Practice Profile.

Transition member care following termination of your participation

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

Arrange substitute coverage

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

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com > Find Dr.

Administrative terminations for inactivity

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

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.
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 health 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 Care Provider Demographic Information Update Form using the Provider Portal at UHCprovider.com > Sign In > My Practice Profile.
- To update your care provider information online, go to the Provider Portal at UHCprovider.com > Sign In My Practice Profile.

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 listed on the bottom of the demographic change request form.

Updating your practice or facility information

You can update your practice information through the Provider Portal application on UHCprovider.com. Go to UHCprovider.com > then select Sign In. Or submit your change by:

- Completing the 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 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 and you can't fit them in your schedule, refer them to the appropriate level of care.

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 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 describes where arbitration proceedings are held.

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

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

Reportable conditions

As a licensed Pennsylvania medical care provider, you must follow guidelines for reportable conditions found on the Pennsylvania Bulletin at pacodeandbulletin.gov). Follow these when you identify a patient with any diagnosis on the list located at health.pa.gov/topics/Reporting-Registries/Pages/Reportable-Diseases.aspx.

To report these conditions electronically, go to health.pa.gov/topics/Reporting-Registries/Pages/PA-NEDSS.aspx.

If you have questions related to this requirement, call the Special Needs Unit hotline at **877-844-8844**.

Appointment standards (PA DHS access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, seven days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 10 business days
- EPSDT/Bright Futures appointments: within 45 days of enrollment
- Health assessments, general physical exams and first exams: within three weeks of enrollment
- New members with HIV or AIDS: within seven days of enrollment
- New Supplemental Security Income (SSI) members: within 45 days of enrollment
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for:

- Urgent care: within 24 hours of request
- Routine care: within 10 business days of referral
- New members who have HIV or AIDS: within seven days of enrollment unless the member is under active care of the specialist
- New SSI members: within 45 days of enrollment unless the member is already under the active care of the specialist

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- After-hours care: Obstetricians are expected to respond to calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations.
- High-risk pregnancies: within 24 hours of identification of high-risk status or immediately if an emergency exists
- First trimester: within 10 business days
- Second trimester: within five business days
- Third trimester: within four business days

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

Care 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 Provider Directory 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 care provider directory after 10 business days.

If we receive notification the Provider 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 Provider Demographic Change Submission Form and further instructions.

The medical, dental and mental health care provider directory is at UHCprovider.com. Click Find Dr. icon.

Provider attestation

You must confirm your provider data every quarter. You may do this through 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 the My Practice Profile in the Provider Portal 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 cover costs. Prior authorization requests may include procedures, services, and/or medication.

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

You should 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 prior authorization:
  1. To access the Prior Authorization app, go to UHCprovider.com, then click Sign In.
  2. Select the **Prior Authorization and Notification app**.
  3. View notification requirements.

You may also find information on UHCprovider.com/pacommunityplan > Prior Authorization and Notification.

You can obtain prior authorization by calling **800-366-7304** Monday through Friday, 8 a.m. to 5 p.m. Eastern Time.

For any discharge or urgent needs, call **800-366-7304**.

Identify and bill other insurance carriers when appropriate.

If you have questions on the Provider Portal, please call our Web Support team at **866-842-3278**, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and PA Department of Human Services (DHS) members may seek services from any participating care provider. The Pennsylvania DHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

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

NPs may enroll with the state as solo providers, but PAs cannot. They must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer service is available 7 a.m. - 7 p.m., Monday through Friday.

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

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

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

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well-baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

Responsibilities of PCPs and specialists serving in PCP role

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

In addition to meeting the requirements for all care providers, PCPs 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 prior authorization to Provider Services or our Clinical or Pharmacy departments 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 in accordance with 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 Disabilities (ADA) standards.
- Comply with the PA DHS Access 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 as PCP

Members may choose a rural health clinic (RHC), a federally qualified health center (FQHC) or a primary care clinic (PCC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PCP 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 with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- 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.

Specialist care providers responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
  - Members can self-refer for in-network:
    - Dental
    - Vision
    - OB/GYN
    - Chiropractor care
  - Members can self-refer to any qualified care provider or facility for:
    - Family planning
    - Emergency services
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 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 Pennsylvania DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

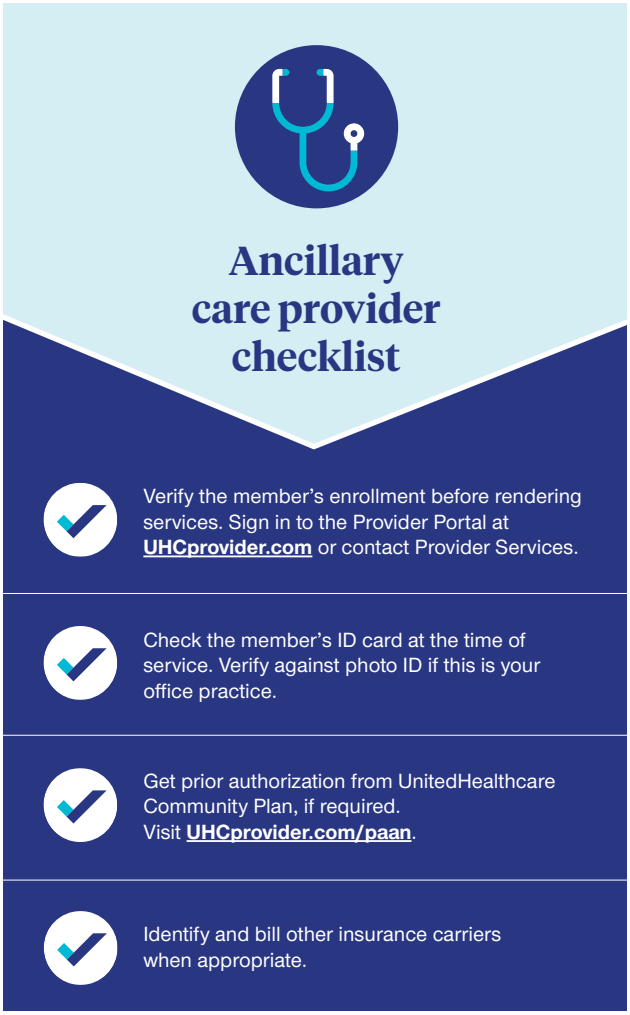
UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary care providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy,

ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialist care providers must use the UnitedHealthcare Community Plan ancillary network.

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



Chapter 3: Care Provider Office Procedures

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/PA	800-414-9025
Provider Services	UHCprovider.com	800-600-9007
Prior Authorization	UHCprovider.com/paan	800-600-9007
DSNP	UHCprovider.com > Health Plans by State > Pennsylvania > Medicare > Dual Complete® Special Needs Plans	800-600-9007

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

View member benefit coverage information online at UHCprovider.com > Eligibility and Benefits. Members may also access UHCCommunityPlan.com/PA for benefits. The following benefits are not all-inclusive.

Find medical policies and coverage determination guidelines on UHCprovider.com/pacommunityplan > Policies and Clinical Guidelines.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Abortions	Covered. Must meet current federal and state guidelines and be medically necessary.		Covered. Must meet current federal and state guidelines and be medically necessary.
Allergy Testing	Covered.		Covered.
Audiology	Covered.		Covered. One routine hearing and audiometric examination per calendar year. One hearing aid or device per ear every two calendar years. No limit on the purchase of hearing aids or devices. Copayments apply only when services are rendered by a specialist provider.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Autism Services	Covered.		Copays may apply to some services. No limit.
Ambulance Services (emergency)	Covered.		Covered.
Ambulatory Surgical Centers (ASCs)	Covered. May require prior authorization. Depends on service.		Covered. Some services may require prior authorization.
Birth Control Services	Covered.		Covered.
Blood & Blood Plasma	Covered.		Covered.
Bone Mass Measurement (bone density)	Covered.		Covered.
Chemotherapy	Covered.		Covered.
CRNP	Covered.		Covered.
Crisis Support	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Chiropractic Services	Covered.		Covered; limited to 20 visits per calendar year.
Colorectal Screening Exams	Covered.		Covered.
Cosmetic Services	Not covered.		Not covered.
Custodial Services	Not covered.		Not covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Dental Services	Covered. Prior authorization needed for some services.	Covered. Prior authorization needed for some services. Key Limitations: • Dentures: One per lifetime • Exams/prophylaxis: One per 180 days • Crowns, periodontics and endodontics: Only via approved benefit limit exception	No lifetime maximum. Requires prior authorization and proof of medical necessity to be covered. To find a dental provider, go to UHCprovider.com > **Find Dr** > Dental Providers by state.
Diabetic Education, Home Visits & Monitoring	Covered.		Covered.
Diabetic Supplies & Equipment	Covered.		Covered.
Durable Medical Equipment	Covered. Prior authorization needed if over $500.		Covered; some services may require prior authorization. No Limit.
Emergency Services	Covered.		Covered. Copays may apply to some services.
EPSDT/Bright Futures Services & Immunizations (younger than age 21)	Covered.	Not covered.	Covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Eyeglasses/Contact Lenses*	Daily-wear contacts of standard glasses (in-plan frames). **Frames and lenses:** Members under age 21 are covered for four lenses and two frames per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. **Contact lenses:** One pair soft daily wear contacts or medically necessary contact covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter. Medically necessary exceptions can be made for children under 21.	Daily-wear contacts or standard glasses (in-plan frames). **Frames and lenses:** Members age 21 and over are covered for two lenses and one frame per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered for adults who are blind in one eye and +/-6.00 prescription. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. **Contact lenses:** One pair soft daily wear contacts or medically necessary contacts covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter.	**Frames and lenses:** One set of eyeglass lenses may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items. **Frequency of eye exam:** One routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member In-Network. Out-of-Network – no coverage*. **Frequency of lens and frame replacement:** One pair of eyeglasses every 12 months, when medically necessary for vision correction. **Lenses:** In-Network — One pair covered in full every 12 months. Out-of-Network — no coverage.* **Frames:** In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of $130 allowance payable by member. Additionally, a discount of 20% is available for amounts over $130.** Out-of-Network — No coverage.* Replacement of lost, stolen, broken frames and lenses (one original and one replacement per calendar year, when deemed medically necessary).

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Eyeglasses/ Contact Lenses* (Continued)			**Contact lenses:** One prescription every 12 months — in lieu of eyeglasses when medically necessary for vision correction. Additionally, a discount of 15% is available for amounts over $130.** In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the $130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over $130. *Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement. Expenses in excess of $600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses. **Low Vision:** One comprehensive low-vision evaluation every five years, with a maximum charge of $300; maximum low-vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care — four visits in any five-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary pre-authorization for these services.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Federally Qualified Health Center/Rural Health Clinic	Covered.	Covered (except from dental services as defined above).	Covered.
Family Planning	Covered.		Covered.
Gender Confirmation Services	Covered; prior authorization needed for some services. Members under the age of 18 may not be eligible for some surgical treatments.	Covered; prior authorization needed for some services	Covered; prior authorization needed for some services.
Hearing Exams	Covered.		One routine hearing and audiometric examination per calendar year. Copayments apply when services are rendered by a specialist provider.
Hearing Aids & Batteries	Covered. Prior authorization needed.	Not covered.	One hearing aid or device per ear every two calendar years. No cost limit.
HIV/AIDS Testing	Covered.		Covered.
Home Assessment	Covered. Prior authorization needed.		Covered.
Home Adaptation	Not covered.		Not covered.
Home Delivered Meals	Not covered.		Not covered.
Home Health Care & Infusion Therapy	Covered. Prior authorization needed.	Unlimited first 28 days; 15 days per month following.	Covered. Some services may require prior authorization.
Hospice Care	Covered.	Covered. Respite care may not exceed a total of five days in a 60-day certification period.	Covered. Some services may require prior authorization.
Immunizations	Covered.		Covered.
Incontinence Supplies	Covered.		Covered.
Independent Clinic	Covered.		Covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Infertility	Not covered.		Not covered.
Inpatient Drug and Alcohol	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No Limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient Acute Hospital	Covered. Prior authorization needed for non-emergent admission.		Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient Rehabilitation Hospital	Covered. Prior authorization needed.		Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient Psychiatric Hospital	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Intermediate Care Facility (IID/ORC)	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Lab Tests & X-rays**	Covered.		Covered. Some services may require prior authorization.
Mammograms	Covered.		Covered.
Maternity Services	Covered.		Covered.
Mobile Mental Health Treatment	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Medical Supplies	Covered.		Covered.
Methadone Maintenance	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Non-Emergency Medical Transport	Covered. Some services provided by **Medical Assistance Transportation Program**.	Covered. Some services provided by **Medical Assistance Transportation Program**.	Not covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Nutritional Supplements	Covered.		Covered. Includes Medical Foods.
Optometrist services	Covered. Eyeglass or contact lens exams: two each year.		Covered. One every 12 months. Additional exams are covered if medically necessary.
Outpatient Drug and Alcohol Services	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No Limit.
Outpatient Hospital Clinic	Covered.		Covered.
Outpatient Psychiatric Clinic	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Organ Transplant Evaluation	Covered. Prior authorization needed.		Covered.
Orthodontia	Covered. Prior authorization needed.	Not covered.	Covered. No annual maximum. Some services will require prior authorization and proof of medical necessity in order to be covered. Some services may be limited based upon age or quantity.
Orthopedic Shoes	Covered.		Covered.
Pain Clinic Services	Covered. May require prior authorization. Depends on service.	Covered. May require prior authorization. Depends on service.	Covered.
Pap Smears & Pelvic Exams	Covered.		Covered.
Personal Emergency Response Systems	Not covered.		Not covered.
Peer Support	Please contact your Behavioral Health Managed Care Organization		Not covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Care Provider Office Visits (including medical/surgical services provided by a dentist)	Covered.		Covered. No limit.
Podiatrist Services: Medically Necessary, Routine & Preventive	Covered. May require prior authorization. Depends on service.		Excluded, except as necessary for the treatment of diabetes or medically necessary due to severe peripheral vascular disease.
Prescription Drugs	Covered.		Covered, copays may apply.
Primary Care Provider	Covered.		Covered. No copay required for Well Child visits.
Preventive Services	Covered.		Covered.
Private Duty Nursing	Covered. Prior authorization needed.	Not covered.	Not covered.
Prostate Cancer Screenings	Covered.		Covered.
Prosthetics and Orthotics	Covered. Prior authorization needed for items with a value greater than $500.00.	Covered. Prior authorization needed for items with a value greater than $500.00. Orthopedic Shoes and Hearing Aids are not covered. Coverage for low vision aids is limited to one per two calendar years. Coverage for an eye ocular is limited to one per calendar year.	Covered. Limits may apply.
Psychiatric Partial Hospital	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Radiation Therapy	Covered.		Covered.
Radiology Scans (PET, MRI, MRA, CT)	Covered. Prior authorization needed.		Covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Renal Dialysis (Kidney Treatment)	Covered.	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.	Covered.
Reproductive Health (Procedures & Devices)	Covered.		Covered.
Residential Treatment Facility (Non-Hospital Residential D&A)	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Second Opinions (Medical & Surgical)	Covered.		Covered.
Short Procedure Unit (SPU)	Covered. May require prior authorization. Depends on service.		Covered.
Skilled Nursing Care (Home Visits)	Covered. Prior authorization needed.	Covered. Prior authorization needed. Limits may apply.	Covered. Limits may apply.
Skilled Nursing Facility	Covered. Prior authorization needed.		Covered. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Targeted Case Management – Behavioral Health	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3). Limited to individuals identified in the target group.		Limited to individuals identified in the target group.
Targeted Case Management – Other than Behavioral Health	Covered. Limited to individuals identified in the target group.		Limited to individuals identified in the target group.
Transportation Help	Available to and from MA covered services. See information under **Medical Assistance Transportation Program in Appendix C**.		Not covered.
Tobacco cessation counseling	Covered.		Covered.

	Community Plan for Families Medical Assistance		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program
Services	**Children**	**Adults**	**CHIP Plan**
Therapy (physical, occupational, speech (PT, OT, ST)) (includes rehabilitative and habilitative)	Covered.	Covered. Only when provided by a hospital, outpatient clinic, or home health provider.	Covered. **Physical Therapy** — limited to 30 visits per year combined rehabilitative and habilitative. **Speech Therapy** — limited to 30 visits per year combined rehabilitative and habilitative. **Occupational Therapy** — limited to 30 visits per year combined rehabilitative and habilitative.
Urgent Care	Covered.		Covered. Copays may vary depending on the facility where services are provided.

Exceptions to the medical assistance adult benefit limits

Exceptions can be granted if:

- The member has a serious chronic illness or health condition and without the additional service, their life would be in danger; or
- The member has a serious chronic illness or health condition and without the additional service, their health would get much worse; or
- The member would need more expensive services if the exception was not granted; or,
- It would be against the law to deny the service.

For details on submitting benefit limit exception requests for dental benefits, please call **800-508-4876**.

Assignment to PCP panel roster

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

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

Go to UHCprovider.com > Select Sign In on the top right. Log in > Click on Document Library. You may also find the "Document Library" Quick Reference Guide at UHCprovider.com > Menu > Resource Library > UnitedHealthcare Provider Portal > Document Libraryt > Reference Guides, Training and Other Resources.

Choosing a PCP

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

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

Copayments

Copayments do not apply to members:

- Younger than 18
- Pregnant or in a nursing home
- Women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) coverage group
- Terminally ill individuals who are receiving hospice care
- Individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance

Also, most Medicaid limits do not apply to pregnant women, residents of nursing homes or intermediate care facilities.

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

Obtain copies of the Member Handbook online at **UHCCommunityPlan.com** 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 Provider Services.

Unborn enrollment changes

Encourage your members to notify the PA DHS when they know they are expecting. DHS notifies Managed Care Organizations (MCOs) daily of an unborn when PA Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the PA website to report the baby's birth. With that information, DHS verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify DHS when the baby is born.

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.

PCP selection

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

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

Member eligibility

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

Member ID card

The member should present their member ID card whenever seeking UnitedHealthcare Community Plan covered services. Medicaid members should also present their Pennsylvania ACCESS card. No member should be denied services because of failure to have a member ID card at the time of service. 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, file a report at **uhc.com/fraud**. Or you may call the **Fraud, Waste, and Abuse Hotline**.

The member ID card displays the UnitedHealthcare Community Plan logo and the UnitedHealthcare Community Plan Member Services number.

The member ID card also displays:

- The member's PCP name and telephone number
- The member's name and UnitedHealthcare Community Plan ID number
- Copayment requirements, if applicable

The back of the member ID card has the:

- Telephone number for you to verify eligibility and obtain prior authorization
- Mailing address for claims
- Pharmacy Help Desk phone number for pharmacy claim issues

If a member does not bring their card, verify eligibility:

- Online at **UHCprovider.com**
- By calling **800-600-9007**.

Also document the call in the member's chart.

Member ID numbers

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

PCP-initiated transfers

A PCP may wish to transfer a member after not being able to create or maintain a professional relationship with them To do so, the PCP must send a written request to the medical director or their designee noting the member's name and the circumstances supporting the request. Do not request a transfer unless you have attempted and documented interventions. This includes contacting the PCP office and UnitedHealthcare Community Plan to educate the member about their rights and responsibilities. A PCP may not request a change because of the member's condition or needed services unless the PCP cannot deliver quality care to the member. If the medical director or their designee approves the transfer, the PCP must provide services to the member for 30 days from the date of the letter. For more information, contact your provider advocate or call Provider Services at 800-600-9007.

Verifying member enrollment

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

- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7 a.m. - 5 p.m. Central Time, Monday through Friday.
- Eligibility Verification System (EVS): For Medicaid members, obtain eligibility status information through the Pennsylvania's EVS.

EVS

You can access EVS through:

- Telephone at 800-766-5387
- Point of Sale (POS) Device
- Personal Computer (PC)
- Mainframe Computer

To request EVS software, call **800-248-2152**. There is a shipping and handling charge. Specifications for customizing a computer system to access EVS is available at **dhs.pa.gov**.

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 > Insurance Plans > Medicaid > **Dual Eligible Special Needs Plans (D-SNP)**.

For information regarding UnitedHealthcare Dual Complete, please see the Administrative Guide for Commercial, Medicare Advantage and DSNP at **UHCprovider.com/guides**. For Pennsylvania-specific DSNP information, go to **UHCprovider.com/health-plans-by-state/pa/medicare-plans/dual-complete-snp-plans.html**.

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Menu > Referrals	800-600-9007
Prior Authorization	UHCprovider.com/paan	800-600-9007
Pharmacy	professionals.optumrx.com	800-600-9007

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

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. Or
- Dysfunction of a bodily organ or part.

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

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

Non-emergent air ambulance requires prior authorization.

For authorization, go to UHCprovider.com/paan or call Provider Services.

Non-emergent transportation

UnitedHealthcare Community Plan Medicaid members who need to be monitored may get non-emergent ambulance transportation. Members may get transportation when they are bed-confined before, during and after transport.

For non-urgent appointments, members must call for transportation at least three days before their appointment. Appendix C lists contact phone numbers by county.

Non-emergency medical transportation (NEMT)

NEMT must be requested at least three business days in advance. Schedule NEMT up to two weeks in advance.

Contact Medical Assistance Transportation Program (MATP) for non-emergency transports. Refer to the appendix for phone numbers based on county.

Requesting services

Non-emergency medical transportation services are available through MATP. 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.

Abuse reporting

You are required by law to report suspected abuse.

- For suspected child abuse or neglect, call ChildLine at **800-932-0313**. You can also report electronically at **compass.state.pa.us/cwis**.
- For suspected adult abuse or neglect, visit dhs.pa.gov > **Adult Protective Services**.
- For suspected abuse or neglect of individuals ages 60 and older, visit aging.pa.gov > **Protective Services**.

Resources and information

- Pennsylvania Code Suspected Child Abuse Mandated Reporting Requirements: **pacode.com**
- Child protection in Pennsylvania: **KeepKidsSafe.pa.gov**
- Identification of child abuse and neglect: **childwelfare.gov/topics/can/identifying/**
- Call **800-490-8505** if you are concerned about individuals ages 18-59 with disabilities, or individuals older than 60.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

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

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

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

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

Request prior authorization online or by phone:

- Online: **UHCprovider.com/cardiology** > Go to Prior Authorization and Notification Tool
- Phone: **866-889-8054** from 7 a.m. - 7 p.m., Monday through Friday.

Make sure the medical record is available.

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

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

We now cover Home Accessibility DME. Covered items may include stair glides, wheelchair ramps and vertical lifts. This does not cover structural home modifications. For more information, call the Special Needs Unit at **877-844-8844**.

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

Emergency/urgent care services

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

Covered services include:

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

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

Prior notification is not required for emergency services.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

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.

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 on the Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services**.

Nurses review emergency admissions within one business day of notification.

UnitedHealthcare Community Plan makes UM determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize 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 > **Policies and Protocols, Community Plan Policies**.

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

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

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

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 (i.e., Plan B One Step, EContra EZ). These are covered under the member's pharmacy benefit and do not require prior authorization.

Fertility treatment

We do not cover any costs, drugs, procedures or devices associated with fertility treatment or reversal of sterilization procedures.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHS Regulations for more information on sterilization.

Health education

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

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

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 restricted to 10 days per month.

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

Laboratory

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

For more information on our in-network labs, go to UHCprovider.com > Find Dr > **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 Encounters chapter for more information.

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

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.

Access the digital Notification of Pregnancy form through the Provider Portal at **UHCprovider.com**.

The Obstetrical Needs Assessment Form (ONAF) is a state-required item. Submit this form at the first prenatal visit so we can identify any potential health risks that can contribute to poor birth outcomes and intervene. Find the ONAF at **UHCprovider.com/PAcommunityplan** > Provider Forms.

HFS-maternal care model

The HFS-Maternal care model strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment. Make every effort to have pregnant members come in during the first trimester.
- 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. Help ensure members get timely prenatal care in the first trimester.
- 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. We offer our Family Visiting Program to any pregnant woman as well as families with a child younger than 18 months old. This program provides support to build strong healthy families. For more information, call our Special Needs Unit at **877-844-8844**.
- Act as a liaison between members, care providers, and United Healthcare for care coordination.

Pregnancy/maternity

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

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

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

UnitedHealthcare Community Plan must approve all out-of-plan maternity care and continuity of care. Call **800-366-7304** or go to **UHCprovider/paan**. For more information about prior authorization requirements, go to UHCprovider.com/PAcommunityplan > **Prior Authorization and Notification**.

Members do not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for 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.

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

Provide the following information within 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 for referral and consultation if complications arise. The CNM may furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through an NP, PA or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

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

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

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is not 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. The hospital provides significant support to the enrollment process by providing required birth data at the time of admission.

EPSDT/Bright Futures assessment

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

The primary goal of EPSDT/Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to *EPSDT/Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Settings for EPSDT/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 child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of EPSDT/ 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.

Other women's health services

Covered services include:

- Post-partum care visit between the 7th and 84th day after delivery
- Birth control services and counseling
- Annual pap smear beginning at the age of 21 or at the onset of sexual intercourse
- Annual pelvic exam beginning at age of 18 or earlier if sexually active
- Sexually transmitted disease testing beginning at age 16, or at the onset of sexual intercourse
- Mammogram screening
- Family planning services
- Birth control

Women being discharged from a hospital postpartum may have two home nursing visits with a physician's order. Additional visits require prior authorization.

Hysterectomies

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

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

Find the form on **UHCCommunityPlan.com**.

See "Sterilization consent form" section for more information.

Exception: PA DHS does not require informed consent if:

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

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

Pregnancy termination services

Termination of pregnancy is a covered benefit when the abortion is necessary to preserve the woman's life or when the result from rape or incest.

You must complete the Medical Assistance Physician Certification for an Abortion Consent Form (MA3) prior to performing the procedure. This form must be completed for both Medical Assistance and CHIP Program members.

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

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

A member has only given informed consent if the PA Department of Social Services Medical Assistance Consent Form for sterilization (MA 31) is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The PA Medical Assistance Program 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 UHCCommunityPlan.com.

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 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 > Policies and Protocols > For Community Plans > Clinical Guidelines.

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to UHCprovider.com > Prior Authorization > Oncology or call Optum at 888-397-8129 Monday -Friday 7am – 7pm CT.

Radiology

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

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

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

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- Online: UHCprovider.com/radiology > Prior Authorization and Notification Tool
- Phone: **866-889-8054** from 8 a.m. - 5 p.m. Central Time, Monday through Friday.

Make sure the medical record is available.

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

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

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- An Evaluation and Management (E/M) exam occurs, which 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 to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the county where the member resides for treatment.**

SBIRT services will be covered when all of the following are met:

- The billing provider and servicing provider are SBIRT certified.

- The billing provider has an appropriate taxonomy to bill for SBIRT.
- The diagnosis code is V65.42.
- The treatment or brief intervention does not exceed the limit of 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 mental health center
- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter

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

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (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 contact the county behavioral health managed care organization at **healthchoices.pa.gov**.

To find a medical MAT provider in Pennsylvania:

1. Go to **UHCprovider.com**
2. Select either "Find Dr" or "Find a Provider" from the menu on the home page
3. Select the care provider information
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on Pennsylvania
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

For more SAMHSA waiver information:

Physicians — **samhsa.gov**

NPs and PAs — **samhsa.gov**

If you have questions about MAT, call Provider Services, and enter your TIN. Say "representative," then "representative" again. Say "something else" to speak to a representative.

Pharmacy

Preferred Drug List

UnitedHealthcare Community Plan uses the Statewide Preferred Drug List (PDL) and determines and maintains its Supplemental PDL of covered medications. These lists apply to all UnitedHealthcare Community Plan of Pennsylvania members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe Medicaid members drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at **800-310-6826**. You may also use the online Prior Authorization and Notification tool on the Provider Portal.

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 a 72-hour supply for new medications when drug therapy must start before a prior authorization is secured. A 15-day supply is provided if the prescription qualifies as an ongoing medication. The rules apply to non-preferred PDL drugs and to those affected by a clinical prior authorization edit.

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

Specialty pharmacy medications

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

Outpatient specialty pharmacy medications are covered under the member's benefit and are available through our specialty pharmacy network. The contracted specialty pharmacy or home infusion care providers fulfill and dispense these medications. They have an agreement that identifies their full program participation requirements.

For a list of the covered medications and participating specialty pharmacy care providers, go to UHCprovider.com/PAcommunityplan > **Pharmacy Resources and Physician Administered Drugs** > Additional Pharmacy Resources > UnitedHealthcare Community Plan - Care Provider Manual Specialty Pharmacy Requirements for Certain Specialty Medications.

This procedure does not apply to:

- Network hospitals that are exempt because medication pricing is the same as or less than the specialty pharmacy. Exemption status is communicated to you by mail through the Network contracting team.
- Members who have Medicare or another health benefit plan as the primary payer and UnitedHealthcare Community Plan as the secondary payer.

For more information about specialty pharmacy medications, go to UHCprovider.com/pacommunityplan > **Pharmacy Resources and Physician Administered Drugs**.

Using non-network specialty pharmacies

We may deny, in whole or in part, any claim when you use a non-participating specialty pharmacy, wholesaler, or direct purchase from the manufacturers without prior approval from us. Hospitals may also be subject to other administrative actions based on their Agreement.

To join our specialty pharmacy network, or to be considered for listing as a designated supplier for the affected products, email NationalAncillaryStrategy_DL@ds.uhc.com to discuss their participation in our Medication Sourcing Expansion. Contact your provider advocate if you have questions.

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

PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional 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.

If you have questions, go to your state's prior auth page: UHCprovider.com/PAcommunityplan > **Prior Authorization and Notification Resources**.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within 24 hours	Within 24 hours of the decision	Within two business days of the decision
Urgent/Expedited Pre-service	Within 24 hours	Within three days of the request	Within three days of the request
Concurrent Review	Within 24 hours	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 24 hours	Within 24 hours of determination	Within 24 hours of determination and member notification within two business days

Medicaid recipient restriction program

If you suspect a member is misusing or abusing the Medicaid benefit by obtaining prescriptions from multiple care providers or requesting controlled substances for questionable indications, you should call the Fraud and Abuse Hotline at **844-347-8477** (844-DHS-TIPS).

We monitor non-compliant members through the Recipient Restriction Program. This program makes members go to a single pharmacy and/or care provider when obtaining prescriptions.

If you notice that a member has stolen a prescription pad or has forged a prescription, report it immediately to the Fraud and Abuse Hotline.

We investigate issues involving potential misuse or abuse of prescription drugs, including:

1. Informing the Department of Human Services of member's activity.
2. Informing the appropriate care provider network of the member's activity.
3. Enrolling the member in the UnitedHealthcare Community Plan Pharmacy Recipient Restriction Program, upon approval from Department of Human Services.

Peer-to-peer

We have a reconsideration line as a place for professional clinical discussions. It is dedicated to care providers to discuss a determination that was not approved at the level of care requested. Call **800-955-7615**.

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling the Special Needs Unit at **877-844-8844**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk pregnancies.

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, acute rehabilitation, skilled nursing facilities (SNFs), home health care and ambulatory facilities. We perform a record review or phone review for each day's stay using Interqual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in 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. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning 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, (We previously used MCG.) 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:

1. Prevent the onset of an illness, condition, or disability.
2. Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability.
3. Assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for a member of the same age.

The determination is based on medical information provided by the care provider who evaluated the member. We make determinations on a timely basis, as required by the urgency of the situation.

An UnitedHealthcare Community Plan care manager can authorize, but not deny, a service or supply. If the care manager cannot determine the need based on the information given, the case is referred to the medical director.

If the medical director determines the service or supply is medically necessary, the care manager calls you, assigns an authorization number, and sets the next review date.

If the medical director denies or limits the request, we call you. Our employees are not compensated for denial of services. Information on how to obtain criteria used to make the decision is included in all denial letters.

You may contact the medical director to have the decision reconsidered, based on medical information. You may make a written request for a copy of the criteria applied and a description of the process for denial. The medical director can help immediately in urgent or emergency cases and on a timely basis for all other cases.

If, after discussion with you, the attending physician or designee, the medical director or their designee determines the service or supply is reasonable, the case manager is notified. They call the facility's utilization review department.

We will not retroactively deny reimbursement for a provided covered service if you relied upon the written or oral authorization of UnitedHealthcare Community Plan prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

For members younger than 21, we complete a medical necessity review for all requested services and items.

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**.

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

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

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

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

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

Continuity of care when the care provider leaves the network

Continue to provide services to members who are under your care at the time of termination. A member may continue an ongoing course of treatment with you for a transitional period of up to 90 days from the date the member was notified of your participation termination. We can extend this, if clinically appropriate.

During Pregnancy: Services can extend through post-partum for care related to delivery. Services during this period are covered under the same terms and conditions applicable to participating care providers.

Primary Care Providers: Provide services to the members assigned to you through the end of the month in which termination is effective. If we end your agreement for cause, we are not responsible for services provided to members after the date of termination.

Reimbursement

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

- Determine if the member is eligible on the date of service by using the Provider Portal on UHCprovider.com, contacting UnitedHealthcare Community Plan's Provider Services, or the PA Medicaid Eligibility System.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

If a 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 PA DHS. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **800-366-7304**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services requiring prior authorization

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

All care providers, facilities, and agencies providing services that require prior authorization should call the Provider Services Monday through Friday, 8 a.m. to 5 p.m. Eastern Time at **800-366-7304** or enter request into I-Exchange®, a web-based authorization system. For any discharge or urgent needs, call **800-366-7304**.

Clinical review for all inpatient admissions must be provided within two business days of the admission.

Authorization of care for new members

For adult members (ages 21 or older), we honor plans of care (including DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) started prior to a new member's enrollment for a period of up to 60 days, or until the primary care provider evaluates the member and establishes a new plan of care.

For any member younger than the age of 21, information on ongoing courses of treatment when transferring enrollment is found in Medical Assistance Bulletins 99-96-01 and 99-03-13.

Medical Assistance Bulletins may be viewed at: **dhs.pa.gov**.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** one business day.
- **Inpatient Admissions; After Ambulatory Surgery:** one business day.
- **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 **800-600-9007** to discuss the guidelines and utilization management.

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

Hospital UM

Prior authorization for an inpatient stay is not a guarantee of approval. We conduct concurrent reviews to confirm prior requested procedure/service was performed and was the reason for the admission.

We approve or deny inpatient stays per our clinical guidelines.

If clinical information does not support the level of care requested, the case is sent to the Medical Director for a Medical Necessity determination.

All initial clinical reviews must be received within one business day of notification of the admission. Failure to provide clinical review within one business day of notification may result in an administrative denial.

In the case of a denial, we tell the facility by phone within one business day after we received all the clinical information. A written notification of the denial is sent within two business days of the final determination.

You may request a Peer to Peer review by calling **800-514-4910** within two business days of the decision or within two business days of discharge.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in **Chapter 12** for more details.

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Bright Futures/ Prevention

Key contacts

Topic	Link	Phone Number
EPSDT – American Academy of Pediatrics	brightfutures.aap.org	866-843-2271
Vaccines for Children	health.pa.gov	888-646-6864

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.

The **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Bright Futures** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the EPSDT/Bright Futures schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. EPSDT/Bright Futures screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule. Also review the AAP/Bright Futures Periodicity website at aap.org.

Developmental disability services and coordination with county intellectual disability office

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment.

The Office of Developmental Programs (ODP) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

Referral – If you determine supportive services would benefit the member, refer the member to ODP for approval and assignment of a County Supports Coordinator who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the County Intellectual Disability Office Interdisciplinary Team. While the County Intellectual Disability Office does not provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of Care – The County Intellectual Disability Office will determine the most appropriate setting for eligible HCBS services and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

Early Intervention program

Pennsylvania's CONNECT early intervention program provides support and services to families with children, from birth to age 5, with developmental delays and disabilities. CONNECT builds on the natural learning opportunities that occur within the daily routines of a child and their family.

Parents who have questions about their child's development may contact the **CONNECT Helpline at 800-692-7288**. The CONNECT Helpline assists families in locating resources and providing information about child development for children ages birth to age 5.

Full screening

Perform a full screen. Include:

1. Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders
2. Comprehensive, unclothed physical examination
3. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
4. Laboratory testing (including blood lead screening appropriate for age and risk factors)
5. Health education and anticipatory guidance for both the child and caregiver
6. Hearing, vision, and dental screenings and testing

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. Use this screen to start expanded HCY services. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

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

Lead screening/treatment

UnitedHealthcare Community Plan reminds care providers that the EPSDT/Bright Futures members are required to have a venous blood lead screening by 12 months and again at 24 months. If lead levels are determined to be elevated (>5 micrograms per deciliter), you can refer for an Environmental Lead Investigation. UnitedHealthcare is contracted, statewide, with Accredited Environmental Technologies (AET). Physicians can make direct referrals to AET by calling **800-969-6238**. You can also go to UHCprovider.com/pacommunityplan > **Bulletins and Newsletters**.

Physicians can also refer to CONNECT for Early Intervention services at **800-692-7288**.

Safe/Care Examinations

UnitedHealthcare Community Plan helps ensure members seen for physical examinations for determination of abuse or neglect are able to receive such services. These services are performed by a trained examiner in a timely manner in accordance with the Child Protective Services Law. See **keepkidssafe.pa.gov** website for additional follow-up information.

Targeted case management

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

Identification – The five target populations include:

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

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

Vaccines for Children program (VFC) (Medicaid only)

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.

For more information, call Vaccines for Children program at **888-646-6864**. Information can also be accessed at the Pennsylvania Department of Health website at **health.pa.gov**.

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).

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	800-600-9007
Healthy First Steps Rewards	uhchealthyfirststeps.com	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.

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

Chronic condition management

We use educational materials and newsletters to remind members to follow positive health actions such as immunizations, wellness, and EPSDT/Bright Futures 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.

Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

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

Referral – PCPs may make referrals to support practice-based interventions by contacting the Special Needs Unit at **877-844-8844**.

Doctor Chat— virtual visits

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

Healthy First Steps Rewards

Members are incentivized for seeing their pregnancy care provider for prenatal and postpartum care as well as for well-child visits and screenings for their baby. Members can earn up to 10 rewards in all and get a $50 gift card just for signing up.

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

Mobile apps

Our apps are available at no charge to our members. For example, **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.

NurseLine

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

- **844-222-7341** (HealthChoices)
- **877-440-0253** (CHIP)
- **877-440-9407** (DSNP)

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.

Pediatric asthma care

We recognize the challenge of managing pediatric members with asthma diagnoses. There are resources for specialized programs to provide remediation in the home. These services also provides education on triggers, environmental remediation, and medications.

School-based services

School districts sometimes provide basic health services or offer programs to promote healthy behaviors. These programs vary from district to district. Contact our Special Needs Unit (SNU) at 877-844-8844 to locate these services.

State-funded program

The Women, Infants and Children supplemental nutrition program (WIC) provides federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age 5 who are at nutritional risk.

To learn more about WIC, call **800-WIC-WINS**. Or go to **pawic.com.**

SUD behavioral health advocate

Our SUD behavioral health advocate (BHA) works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

Tobacco cessation

Nicotine replacement products (medicine, patches, and gum) are a covered benefit for members. None of these medications need a prior-authorization. Members can also have up to 70 tobacco cessation counseling visits per year. You can refer members to the PA Quit Line at **1-800-QUIT-NOW** or **https://pa.quitlogix.org**.

Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	800-888-2998
Provider Services	UHCprovider.com	800-600-9007

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.

All Medicaid members receive their mental health and substance abuse services through a contracted behavioral health managed care organization for their county. See How To Contact Us. CHIP members receive mental health and substance abuse services through Optum Behavioral Health.

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

The 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.

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

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

Covered services

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

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

For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient

  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- Prevention:
  - Prevent OUDs before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community partnerships 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 be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com**. Then click “Drug Lists and Pharmacy”. Click Resource Library to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain.

Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

Supply limit on long-acting opioids

We have a 90 morphine equivalent doses (MED) supply limit for the long-acting opioid class. Prior authorization is required for greater than or equal to 50 MME per day.

Our prior authorization criteria matches the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at **cdc.gov** > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain. For more information, access our website at **liveandworkwell.com**.

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.

Expanding Medication Assisted Treatment (MAT) access & 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.

To find a MAT provider in Pennsylvania:

1. Go to **UHCprovider.com**,
2. Select either "Find Dr" or "Find a Care Provider" from the menu on the home page
3. Select the care provider information
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "(state)" for options
6. 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.

Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/PA	800-414-9025
Member Handbook	UHCComunityPlan.com/PA > Community Plan > Member benefits	800-414-9025

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.

Privacy regulations

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

Access to protected health information

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

Amendment of 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, during 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

Right to request restrictions

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

Right to request confidential communications

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

Member rights and responsibilities

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

Member rights

Members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers at any time for any reason.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.
- Get emergency services when you need them from any provider without our approval.
- Ask for a DSH Fair Hearing.
- Get information about services that we or a care provider does not cover because of moral or religious objections and about how to get those services.

Member responsibilities

Members should:

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

- Give you and us information that could help improve their health.
- Make a good-faith effort to pay your copayments.
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

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 of Quality Assurance (NCQA) are to:

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

Chapter 9: Medical Records

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.

You must maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, and dated.

You must maintain medical records in paper form for at least two years before they are converted to any other form, and all forms must be readily available for review. You must maintain and preserve medical records for a minimum of 10 years from the termination of the provider agreement.

You will make medical records or copies of medical records available to UnitedHealthcare Community Plan, agents of the Pennsylvania Department of Human Services, the CMS, and any external quality review organization for purposes of assessing the quality of care rendered.

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

The following are basic requirements for an acceptable medical records system:

- Records are stored in a central file in locked, fireproof cabinets.
- If a computerized medical records system is utilized, the provider has established and enforces policies and procedures for saving, storing, securing, protecting, and retrieving medical records.
- Records are organized in a logical manner, by individual patient or family, or other acceptable medical records filing system.

We adopted the medical record keeping and documentation standards of the National Committee for Quality Assurance. You must comply with these standards.

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 80% 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:
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
- 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.
- 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 primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Medical record documentation standards

If a care provider scores less than 80%, review five more charts. Only review those elements the care provider received a “NO” on in the initial phase of the review. Upon secondary review, if a data element scores at 80% or above, that data element is recalculated as a “YES” in the initial scoring. If upon secondary review, a data element scores below 80%, the original calculation remains.

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 Chiropractic: myoptumphysicalhealth.com	800-600-9007
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 HEDIS® record review.
- Providing requested medical records for quality activities 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).

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 chief 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.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you based on applicable Pennsylvania statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

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

Credentialing and recredentialing process

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.

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 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. You can find applications on the Council for Affordable Quality Healthcare (CAQH) website.

Go to **UHCprovider.com/join** to submit a participation request. 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 Network Resource Management Team 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 provided.

You also have the right to receive the status of your credentialing application, please 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.

Resolving disputes

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

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

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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 and Abuse line or go to uhc.com/fraud.

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

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the State of Pennsylvania 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 PA Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the PA 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 PA program standards.

You must cooperate with the state or any of its authorized representatives, the Pennsylvania Department of Health and Human Services, the 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 (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

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

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

Criteria for site visits

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

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	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

Chapter 11: Billing and Submission

Key contacts

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

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 Chapter 10 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 a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call Provider Services.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the 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.

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

Use the 02/12 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. Claims must be submitted within 180 days of the date of service (or discharge) or in accordance with your provider agreement. 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.

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'.

Electronic claims submission and billing

You should submit all your claims electronically, unless the claim requires invoice documentation. You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

For more information, contact **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 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, use our Electronic Data Exchange (EDI) at UHCprovider.com/edi > **EDI Clearinghouse Options**.

e-Business support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), 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**. Click Menu then Resource Library to find Electronic Data Interchange.

Electronic payment solutions

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/healthcare 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/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.
- 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 United HealthCare 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**. Click Menu then Resource Library to find the EDI section.

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

Completing the UB-04 form

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

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

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

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

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

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

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

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

Form reminders

- Note the attending provider's name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the referring provider's NPI and name on outpatient claims when this care provider is not the attending 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 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 > Menu > Policies and Protocols > 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.

National Drug Code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Service 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

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 One Healthcare 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 and paperwork.

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

Find training on UHCprovider.com > Menu > Resource Library > Training.

Provider Portal training course is available using the Community Care Provider Portal User Guide.

Resolving claim issues

To resolve claim issues, contact Provider Services, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

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

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

For paper claims

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

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

Timely filing

Timely filing issues may occur if members give the wrong insurance information 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 clam is considered late billed. It will be denied timely filing.

Timely Filing Limits	
Initial Claims	180 days
Resubmissions/ Corrections	365 days
COB Submissions After Primary Payment	365 days
COB Resubmissions	365 days

Balance billing

UnitedHealthcare Community Plan members must NEVER receive a bill or a balance bill for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Pennsylvania State law and regulation.

If you don't know who your provider advocate is, email UHC-PA-ProviderRelations@uhc.com A provider advocate will get back to you.

Chapter 12: Claim 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 contract. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

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	UHC provider.com/claims	800-600-9007	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.	Within 60 days of remittance	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402	N/A	800-600-9007	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.	Time frame listed in your contract	30 calendar days

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 (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan ATTN: Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131	N/A	800-600-9007	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.	Time frame listed in your contract	30 to 60 calendar days

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

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

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 the Provider Portal, sign in to UHCprovider.com using your One Healthcare 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 common causes of claim rejections happen due to:

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

How to use:

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

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

Claim reconsideration (step 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.

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 **800-600-9007** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail**: Submit the Claim Reconsideration Request Form to:

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

  This form is available at UHCprovider.com/claims.

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

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.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

- A denial or rejection letter from another insurance carrier.
- Another insurance carrier's explanation of benefits.

- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

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

How to use:

Submit a reconsideration request electronically, 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.

Appeals (step two of dispute)

What is it?

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

When to use/file:

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

How to use:

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

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

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

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

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.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

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

Instructions and forms are on UHCprovider.com/claims.

If you do not agree with the overpayment findings, submit a dispute within the required 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.

Sample overpayment report

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

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	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

Member grievances and complaints procedures

What is a grievance?

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.

Pennsylvania Act 68 allows you, with written permission from the member, to act on their behalf to file a grievance. A form the member can use to give consent is available in Appendix A. The form, or a document containing the same information the form provides, signed by the member, must be sent with the grievance. If you are appealing on behalf of the member, you may not bill them for those denied services. Information on member complaints, grievances, and state fair hearings can be found in section 8 of the UnitedHealthcare Community Plan for Families Member Handbook. A copy of the handbook can be found at UHCCommunityPlan.com.

Fraud, waste and abuse

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

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to 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 the PA DHS information on Fraud, Waste and Abuse at dhs.pa.gov or call **844-347-8477**.Also find out how we follow federal and state regulations around false claims at UHCprovider.com/PAcommunityplan > Integrity of Claims, Reports, and Representations to the Government.

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

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

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates.

Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

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

In accordance with 42 CFR § 455.436, Federal and State databases are checked upon enrollment and re-enrollment on providers against the LEIE, SAM, NPPES, SSA DMF and Pennsylvania Medicheck List. Ongoing monitoring of Medicare/Medicaid sanctions and license actions are conducted using State and Federal databases such as the LEIE, SAM, Pennsylvania Medicheck List and state licensing boards.

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.

Pennsylvania medical assistance hotline to report fraud and abuse

DHS has a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is **844-347-8477** and (844-DHS-TIPS). It is available 8:30 a.m. to 3:30 p.m., Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous.

Provider fraud includes:

- Billing services not rendered.
- Billing separately for services instead of an available combination code.
- Misrepresenting the service or supplies rendered (e.g., billing brand-named for generic drugs).
- Upcoding to more expensive service than was rendered.
- Billing more time or units of service than provided.
- Billing incorrect provider or service location.
- Altering claims.
- Submitting false data on claims, such as date of service or care provider.
- Billing services provided by unlicensed or unqualified persons.
- Billing used items as new.

Pennsylvania medical assistance provider self-audit protocol

The Pennsylvania Medical Assistance Provider Self Audit Protocol allows you to disclose overpayments or improper payments of MA funds. This is done through the reporting fraud website.

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Menu > Resource Library	800-600-9007
News and Bulletins	UHCprovider.com > News and Network Bulletin	800-600-9007
Provider Manuals	UHCprovider.com/guides	800-600-9007

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:

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Pennsylvania's managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (e.g., PreCheck MyScript)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is UHCCommunityPlan.com > select Member.

Care provider websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The UHCprovider.com portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on UHCprovider.com. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual

Care provider office visits

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

Care provider newsletters and network bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire PA network at least three

times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

Network Bulletins

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources.

View the latest news or sign up to receive the monthly bulletin at UHCprovider.com > News and Network Bulletin.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide 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.

Glossary

AABD
Assistance to the aged, blind and disabled

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.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

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

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

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

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

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

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

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

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

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's Primary Care Provider (PCP).

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.

CHIP
Children's Health Insurance Program.

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.

Contracted Health Professionals
Primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

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

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

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

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a 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.

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

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)/Bright Futures
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, mental 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.

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

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

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

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

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

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

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.

FHC
Family Health Center

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

Grievance
A request to have a PH-MCO or utilization review entity consider an adverse benefit determination concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding a PH-MCO decision to:

1. deny, in whole or in part, payment for a service/item;
2. deny or issue a limited authorization of a requested service/item, including the type or level of service/item;
3. reduce, suspend, or terminate a previously authorized service/item;
4. deny the requested service/item but approve an alternative service/item;
5. deny a request for a BLE.

This term does not include a complaint without an adverse benefit determination.

Health Plan Employer 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.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

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

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
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.

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

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by PA DHS.

Specialist
A care provider licensed in the state of PA 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.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. 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.

Appendix

Appendix A: Consent for Provider to File a Grievance for Member

CONSENT FOR PROVIDER TO FILE A GRIEVANCE FOR MEMBER

Provider Name	**Provider Plan ID Number**
Provider Address	
Description of Specific Service or Item for which I agree the Provider Can File a Grievance	**Name and Address of PH-MCO Where Grievance Will Be Filed** UnitedHealthcare Community Plan Grievance and Appeal Department P.O. Box 31364, Salt Lake City, UT 84131-0364

Name of Member	**Member's Date of Birth**
Member ID No.	
Member Mailing Address	
Member Daytime Telephone Number	**Member Evening Telephone Number**

I, **[Name of Member]**, agree that **[Name of Provider]** can file a Grievance for me with **UnitedHealthcare Community Plan** about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a Grievance about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the Grievance process by telling **UnitedHealthcare Community Plan** and PROVIDER NAME in writing that I do not want PROVIDER NAME to continue the Grievance process for me.

2. My consent to have the Provider file the Grievance for me will automatically no longer be in effect if the Provider does not file a Grievance or does not continue with the Grievance through the end of the Grievance review process.

3. I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

_____ _____

Signature of Member or Representative **Date**

_____ _____

Witness Signature **Date**

_____

Print Witness Name

If the Member is unable to sign this Consent Form because the Member is legally incompetent:

_____

Name of Person Signing on Behalf of Member

_____

Address of Person Signing on Behalf of Member

_____

Relationship of Person Signing to Member

Appendix B: Form — Authorization to Appoint a Personal Representative

Authorization to Appoint a Personal Representative

A personal representative is a person authorized to represent you through the complaint and grievance process.

Instructions: Please complete and sign this form to appoint a personal representative. A separate form is required for each member. Return in the self-addressed, stamped envelope.

UnitedHealthcare of Pennsylvania, Inc., will provide your appointed personal representative the same rights to your protected health information (PHI) that is provided to you.

Member Information: (individual whose information will be released)

Name (Last, First, MI) _____

Identification Number _____

Social Security Number _____ Date of Birth _____

Telephone Number _____

Street Address _____

AUTHORIZATION:

I hereby authorize the request and release of my PHI, held by UnitedHealthcare, to my personal representative. By appointing the person named on this form as my personal representative, I understand that I am authorizing UnitedHealthcare to give this person access to my PHI and medical records and the right to talk to UnitedHealthcare about my account.

I understand that my authorization will remain in effect of the length of time specified below.

I have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the request and release of my PHI, as described in this form.

I _____ appoint _____ to be my personal
(Member) **(Personal Representative)** representative.

Time Period for Representation: **From:** ____/____/____ **To:** ____/____/____

NOTE: If no time period is provided, this request will remain in effect until the member or his/her legal representative notifies UnitedHealthcare, in writing, requesting a change.

YOUR RIGHT TO REVOKE: You may revoke this authorization, at any time, by giving written notice to UnitedHealthcare. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact UnitedHealthcare for more information if you desire to cancel this authorization.

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI) _____

Social Security Number (last 4 digits) _____ Date of Birth _____

Telephone Number _____

Address _____

Relationship to Member _____

IMPORTANT: Guardians, court-appointed representatives or other responsible parties must send a copy of legal documents. If you have questions or need help, call Member Services at the number listed on the back of the member card.

Signature of Member/Requestor: _____ **Date:** _____

Printed Name: _____

Appendix C: Medical Assistance Transportation Program (MATP) Phone Numbers

Transportation is available for Medical Assistance (MA) members to use for medical appointments.

Non-emergency medical transportation services are provided through the Medical Assistance – Transportation Program (MATP).

Medical Assistance Transportation Program (MATP)

Each county has a program to help with transportation. If the member needs transportation to their appointments, have them call the phone number for their county.

County	Telephone number	Toll-free number
Adams	717-846-7433	800-632-9063
Allegheny	412-350-4476	888-547-6287
Armstrong	724-548-3408	800-468-7771
Beaver	724-375-2895	800-262-0343
Bedford	814-623-9129	800-323-9997
Berks	610-921-2361	800-383-2278
Blair	814-946-1235	800-458-5552
Bradford	570-888-7330	800-242-3484
Bucks	215-794-5554	888-795-0740
Butler	724-431-3663	866-638-0598
Cambria	814-535-4630	888-647-4814
Cameron	866-282-4968	866-282-4968
Carbon	610-253-8333	800-990-4287
Centre	814-355-6807	814-355-6807
Chester	484-696-3854	877-873-8415
Clarion	814-226-7012	800-672-7116
Clearfield	814-765-1551	800-822-2610
Clinton	570-323-7575	800-222-2468
Columbia	717-846-7433	800-632-9063
Crawford	814-333-7090	800-210-6226
Cumberland	717-846-7433	800-632-9063
Dauphin	717-232-7009	800-309-8905

County	Telephone number	Toll-free number
Delaware	610-490-3960	610-490-3960
Elk	866-282-4968	866-282-4968
Erie	814-456-2299	800-323-5579
Fayette	724-628-7433	800-321-7433
Forest	814-927-8266	800-222-1706
Franklin	717-846-7433	800-632-9063
Fulton	717-485-6767	888-329-2376
Greene	724-627-6778	877-360-7433
Huntingdon	814-641-6408	800-817-3383
Indiana	724-801-8857	724-801-8857
Jefferson	814-938-3302	800-648-3381
Juniata	717-242-2277	800-348-2277
Lackawanna	570-963-6482	570-963-6482
Lancaster	717-291-1243	800-892-1122
Lawrence	724-652-5588	888-252-5104
Lebanon	717-273-9328	717-273-9328
Lehigh	610-253-8333	888-253-8333
Luzerne	570-288-8420	800-679-4135
Lycoming	570-323-7575	800-222-2468
McKean	866-282-4968	866-282-4968
Mercer	724-662-6222	800-570-6222
Mifflin	717-242-2277	800-348-2277
Monroe	570-839-8210	888-955-6282
Montgomery	215-542-7433	215-542-7433
Montour	717-846-7433	800-632-7433
Northampton	610-253-8333	888-253-8333
Northumberland	717-846-7433	800-632-9063
Perry	717-846-7433	800-632-9063
Philadelphia	877-835-7412	877-835-7412
Pike	570-296-3408	866-681-4947

County	Telephone number	Toll-free number
Potter	814-544-7315	800-800-2560
Schuylkill	570-628-1425	866-656-0700
Snyder	717-846-7433	800-632-9063
Somerset	814-701-3691	800-452-0241
Sullivan	570-888-7330	800-242-3484
Susquehanna	570-278-6140	866-278-9332
Tioga	570-888-7330	800-242-3484
Union	717-846-7433	800-632-9063
Venango	814-432-9767	877-836-4699
Warren	814-723-1874	877-723-9456
Washington	724-223-8747	800-331-5058
Wayne	570-253-4280	800-662-0780
Westmoreland	724-832-2706	800-242-2706
Wyoming	570-278-6140	866-278-9332
York	717-846-7433	800-632-9063

Appendix D: Medical Record Charting Standards

- All pages of the record must contain patient identification (name and identifying number).
- The record must contain biographical/personal data, such as age, date of birth, sex, race/ethnicity, and marital status/social supports as well as a notation of cultural/linguistic needs.
- Each entry must have provider name, initials, or other identification (even for solo practitioner sites).
- Each entry must be dated and signed.
- The record must be legible, as judged by the auditor (illegibility of records may result in the need for provider assistance in completing the audit).
- The record must contain a completed, up-to-date, problem list and a list of all prescribed medications.
- Allergies and adverse reactions to medications must be prominently displayed for patients of all ages. Document even if no allergies exist.
- The record must contain an appropriate and organized medical history and physical exam.
- Preventive services/risk screenings must be appropriately used and documented.
- Pediatric charting must contain a completed immunization record and BMI charting.
- Adolescents should be screened for and counseled on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition.
- The record must document smoking habits and history of alcohol and substance use: negative histories also must be noted. If the history is positive for any of these habits, document advice to quit.
- Lab and other studies must be signed and documented
- Notes must be appropriate in presenting a problem or complaint.
- Working diagnosis(es) must be documented and must be consistent with findings.
- Plans of action/treatment must be consistent with diagnosis(es).
- Episodes of emergency care, hospitalizations and discharge summaries must be documented, including follow-up care, such as home health visits, physical therapy reports, etc.
- Each encounter must include documentation of clinical findings and evaluation, as well as a follow-up plan, such as date for return visit
- Each encounter must present evidence that unresolved problems from previous visits have been addressed.
- Consultations documented in the record must be appropriate given patient characteristics, history, and presenting problems.
- The record must document appropriate coordination of care between the Primary Care Provider and authorized specialty care providers.
- Consultant summaries, lab reports, imaging study reports, operative procedures, and tissue excisions must be noted in the chart or otherwise reflect care provider's review.
- Care must be medically appropriate.
- The record must document efforts to educate patients, including lifestyle counseling, and disease specific education.
- Records should reflect the patient's advance directives.
- Providers are to maintain an organized medical record keeping system and standards for the availability of medical records and medical record retention.
- Providers are to maintain the confidentiality of all medical records in accordance with any applicable statutes and regulations.
- All medical records are to be stored securely. Only authorized personnel are to have access to the records and all staff should receive periodic training on maintaining confidentiality of member information.

Appendix E: Civil Rights

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

UnitedHealthcare Community Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact UnitedHealthcare Community Plan at **800-414-9025, TTY/PA RELAY 711.**

If you believe that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364
800-414-9025, TTY/PA RELAY 711

The Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: **717-787-1127, TTY/PA Relay 711**
Fax: **717-772-4366**, or
Email: **RA-PWBEOAO@pa.gov**

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, UnitedHealthcare Community Plan and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov**.

Language Assistance Service

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: **1-800-414-9025**, **TTY/PA RELAY: 711**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-414-9025, TTY/PA RELAY: 711**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по телефону **1-800-414-9025, TTY/PA RELAY: 711.**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-414-9025**, **TTY/PA RELAY: 711** 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-414-9025, TTY/PA RELAY: 711.**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-414-9025**، **TTY/PA RELAY: 711.**

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-800-414-9025, TTY/PA RELAY: 711** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-414-9025, TTY/PA RELAY: 711** 번으로 전화해 주십시오.

ស្មូមចាប់អារម្មណ៍ ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាឥតគិតថ្លៃ គឺអាចមានសម្រាប់បំរើជូនអ្នក ។ ចូរទូរស័ព្ទទៅលេខ **1-800-414-9025, TTY/PA RELAY: 711**។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-414-9025, TTY/PA RELAY: 711.**

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-414-9025, TTY/PA RELAY: 711** သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-414-9025, TTY/PA RELAY: 711.**

ATENÇÃO: se fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para **1-800-414-9025, TTY/PA RELAY: 711.**

লক্ষ্য করুন: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য বিনা খরচে ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। **1-800-414-9025, TTY/PA RELAY: 711** নম্বরে ফোন করুন।

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime falas të ndihmës gjuhësore. Telefononi në **1-800-414-9025, TTY/PA RELAY: 711.**

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૉલ કરો **1-800-414-9025, TTY/PA RELAY: 711.**