2023
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Tennessee

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United Healthcare® Community Plan

Welcome

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

This provider manual supports TennCare, Tennessee's Medicaid program. It has been operating under a waiver from CMS since 1994 to offer coverage to the traditional Medicaid-eligible population as well as an expanded population (TennCare Standard). All TennCare members are enrolled into a managed care organization (MCO) within their geographic region.

We entered into a Contractor Risk Agreement (CRA) for each Grand Region with the State of Tennessee for provision of the TennCare benefits. The TennCare program in each Grand Region is governed by its CRA, the TennCare Rules and Regulations as well as the TennCare Policies. The Division of TennCare website contains links to all governing documents. These include:

- Contractor Risk Agreement: **tn.gov**
- TennCare Rules: **publications.tnsofiles.com**
- TennCare Policies: **tn.gov**

We administer the TennCare program as an MCO in all 3 geographic regions doing business as UnitedHealthcare Community Plan. We are a primary care practitioner (PCP)-driven HMO network focusing on PCPs providing appropriate care to covered persons based on established clinical guidelines. We operate in an integrated model where all physical, behavioral and long-term services and supports health care needs are assessed, coordinated and monitored. We offer our covered individuals and providers programs in medical management, quality improvement, education and development, as well as quality customer service.

Some TennCare enrollees are also eligible for enhanced services provided through CHOICES. CHOICES is the Long-Term Services and Supports (LTSS) program, which promotes quality and cost-effective care coordination for CHOICES enrollees with chronic, complex health care, social service and custodial needs. The CHOICES program includes both Nursing Facility and Home- and Community-Based (HCBS) care coordination. CHOICES care coordination operates based on our fully integrated model so the physical, behavioral and LTSS care health needs of the CHOICES enrollees are met. You may find detailed information on the CHOICES program in Chapter 6: Long Term Services and Supports Program (LTSS), and Chapter 7: Employment and Community First (ECF) CHOICES of this Manual.

Click the following links to access different manuals:

- Employment and Community First (ECF) CHOICES/ Intellectual and Developmental Disabilities (DIDD) Benefits Supplemental Guide **UHCprovider.com/ TNcommunityplan**
- **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 state Community Plan manual: go to UHCprovider.com > Resources > Care Provider Administrative Guides and Manuals > **Community Plan Care Provider Manuals for Medicaid Plans by State**.
- UnitedHealthcare Dual Complete: For information about UnitedHealthcare Dual Complete in Tennessee, go to UHCprovider.com > Resources > Health Plans choose state > Tennessee Medicare Advantage Health Plans > **Tennessee Dual Complete Special Needs Plans**.
- March Vision Routine Care provider reference guide: **marchvisioncare.com**. Ophthalmologists rendering medical services to TennCare enrollees should refer to this manual.

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 covered persons.

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

Using this manual

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

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

This manual will be amended as policies change.

Participation Agreement

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

The Division of TennCare requires specific language in TennCare Provider Agreements. As noted in the Modification Section of your Provider Agreement, Division of TennCare required language and State of Tennessee mandates about the TennCare program can be updated by inclusion in the care provider manual. For ease of your review, certain required language and TennCare program mandates are contained in a document titled “TennCare Program Regulatory Appendix Requirements Appendix. The Appendix is at UHCprovider.com.

The appendix is routinely appended to our TennCare Provider Agreements. The latest version of this Appendix is also appended to this care provider manual. When we amend your Agreement to comply with federal and state regulatory requirements, most of these changes may be made within the body of this care provider manual. However, those regulatory requirements may require us to make changes to confidential portions of your Agreement, such as the payment provisions. When this type of change is required, we may provide you a separate confidential notice of the regulatory changes to your Agreement. If the payment provisions are affected, we will send you a new fee schedule or payment appendix for your records. If we provide you notice of changes based on this paragraph, we will limit such changes to those required to comply with the change in regulatory requirements.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-800-690-1606
Training	UHCprovider.com/training	1-800-690-1606
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	1-800-690-1606
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	
Online Service Tools	UHCprovider.com > Resources > Resource Library > Online Service Tools	1-866-842-3278, option 1
Resource Library	UHCprovider.com > Resources > Resource Library	

Looking for something else?

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

TennCare is the Tennessee State Medicaid program TennCare offers traditional Medicaid to eligible populations (TennCare Medicaid) as well as an expanded population (TennCare Standard). All TennCare individuals are enrolled into an MCO.

UnitedHealthcare Plan of the River Valley has entered into a contractor risk agreement (CRA) with the State of Tennessee to provide TennCare benefits to qualifying residents. UnitedHealthcare Plan of the River Valley administers the TennCare program as UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan supports the Tennessee state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to eligible individuals:

- TennCare
- TennCare Kids
- TennCare Employment and Community First (ECF) CHOICES
- TennCare CHOICES Long-Term Services and Supports (LTSS) Program
- CoverKids

Tennessee has 3 geographic regions. All TennCare individuals are enrolled in an MCO within their geographic region. DHSS will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com/tncommunityplan or call Provider Services at 1-**800-690-1606**.

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 tools and other helpful information.

Our approach to health care

Care Model

The Care Model program seeks to empower covered persons enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting covered persons with chronic complex conditions who often use health care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns to help them get the right care from the right care provider in the right place and at the right time.

The program provides interventions to covered persons with complex medical, behavioral, social, pharmacy and specialty needs. This results in better quality of life, improved access to health care and lower expenses. Care Model provides a care management/coordination team that helps increase their engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach helps improve the health and well-being of the people and communities we serve. Care Model provides:

- An extended care team including primary care practitioner (PCP), pharmacist, medical and behavioral director, and peer specialist
- Interventions that engage individuals, 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 individuals to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs
- Education and support with complex conditions
- Tools for helping individuals engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage individuals

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 needs, measured by number of behavioral health 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 Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower covered persons to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care
- Engage community and care provider networks to help ensure access to affordable care and the appropriate use of services

Referring your patient

To refer your patient who is a UnitedHealthcare Community Plan covered person to the Care Model program, call Provider Services at **1-800-690-1606**.

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

Under state and federal law, all TennCare individuals have a right to receive free interpretation and translations as Limited English Proficiency (LEP) services. You must:

- Implement LEP policies and procedures for language assistance, interpretation, and translation services to individuals
- Provide similar services to hearing-impaired individuals
- Offer in-person interpreters, sign language or access to telephonic assistance (e.g., the ATT universal

line). This is a requirement for any care provider accepting TennCare funds.

To access these services, call the TennCare Foreign Language Line at **1-800-758-1638**. We do not reimburse for translation services offered to TennCare individuals in the care provider's office setting. Do not bill us or individuals for these services.

To help you meet patient needs, we have developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care. You must support UnitedHealthcare Community Plan's Cultural Competency Program. We offer the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, 7 days a week to individuals free of charge. More than 240 nonEnglish languages and hearing impaired services are available. If a covered person needs interpreter services, they can call the phone number on their ID card. If you need to call a professional interpreter during regular business hours, call the TennCare Foreign Language Line at **1-800-758-1638**.
- **Materials for limited English-speaking members:** We provide simplified materials for individuals with LEP and who speak languages other than English or Spanish. We also provide materials for visually impaired individuals.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses nationally recognized guidelines, including InterQual, MCG or CMS for care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide at UHCprovider.com > Resources > the UnitedHealthcare Provider Portal Resources > **Digital Solutions Comparison Guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

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' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/en/ resource-library/edi/edi-optimization.html**.

Getting started

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

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

UHCprovider.com

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

UnitedHealthcare Provider Portal

This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

To access the portal, go to UHCprovider.com/en/access.html to create or sign in using a One Healthcare ID. To use the portal:

If you already have a One Healthcare ID (formerly known as Optum ID), simply go to UHCprovider.com and click Sign In in the upper right corner to access the portal.

If you need to set up an account on the portal, follow these steps to register.

Here are the most frequently used tools 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 Library 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.

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

Direct Connect

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

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

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

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

Privileges

To help individuals access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable network facilities or arrangements with a 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 your primary contact for when you need help. It is staffed with representatives trained for UnitedHealthcare Community Plan. Provider Services works closely with all our departments.

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

How to contact us

Topic	Contact	Information
Benefits	tn.gov/tenncare > Members/Applicants > Covered Services UHCprovider.com/benefits 1-800-690-1606	Confirm a person'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 1-800-690-1606	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Claims	**EDI**: UHCprovider.com/edi > Companion Guides Payer ID 95378 **Provider Portal:** UHCprovider.com/claims **Online:** UHCprovider.com/claims (policies, instructions and tips) 1-877-842-3210 (follow the prompts for status information) Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5220 Kingston, NY 12402-5220 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.
Claim Overpayments	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 1-800-690-1606 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.

Topic	Contact	Information
Dental Services	DentaQuest dentaquest.com TennCare: 1-855-418-1622 CoverKids: 1-888-291-3766	DentaQuest providers dental coverage for TennCare covered persons younger than 21 years.
Electronic Data Intake Claim Issues	ac_edi_ops@uhc.com 1-800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	1-800-842-1109	Information is also available at UHCprovider.com/edi.
Eligibility	**EDI:** Transaction code 270 and response 271 **Online**: tn.gov/tenncare > Providers > Verify Eligibility To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to UHCprovider.com/eligibility **Phone:** Division of TennCare: 1-800-852-2683 UnitedHealthcare Community Plan voice portal: 1-800-690-1606 (follow the prompts)	Confirm covered persons' eligibility.
Enterprise Voice Portal	1-877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, Waste and Abuse (Payment Integrity)	**Online:** tn.gov/tenncare > Providers > Fraud and Abuse **Phone:** 1-800-690-1606 (UnitedHealthcare Community Plan tipline) 1-800-433-3982 (Division of TennCare & Office of Inspector General) **Payment Integrity Information:** website: UHCprovider.com/TNcommunityplan > Integrity of Claims, Reports, and Representations to the Government **Reporting:** uhc.com/fraud 1-800-455-4521 or 1-877-401-9430	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	1-800-599-5985	Refer high-risk OB individuals. Fax initial prenatal visit form.
Laboratory Services	LabCorp 1-800-833-3984	LabCorp is the preferred network laboratory.
Medicaid (TennCare Provider Services)	**tn.gov/tenncare/providers** TennCare Provider Services 1-800-852-2683 Family Assistance Service Center 1-866-311-4287 TennCare Solutions 1-800-878-3192 TennCare Advocacy Program 1-800-758-1638 Medicare/Medicaid Crossover Claims Unit 1-800-852-2683	Contact Medicaid directly.
Medical and Behavioral Claim, Reconsideration and Appeal	Sign in to the Provider Portal at **UHCprovider.com** or go to **UHCprovider.com/claims** for more information. 1-800-690-1606 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5220 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 5220 Kingston, NY 12402-5220	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	1-800-690-1606	Assist individuals with issues or concerns. Available 7 a.m.–5 p.m. Central Time, Monday through Friday.
Mental Health & Substance Abuse (Optum Behavioral Health)	Optum Behavioral Health: 1-800-690-1606	Refer individuals for behavioral health services. (A PCP referral is not required.)
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-758-1638 TDD 711	Available 8 a.m.–5 p.m. Central Time, Monday through Friday, except state-designated holidays.

Topic	Contact	Information
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Resource Team (NMRT)	1-877-842-3210 Networkhelp@uhc.com	Self-service functionality to update or check credentialing information.
NurseLine	1-800-690-1606 > Ask for NurseLine	Available 24 hours a day, 7 days a week.
Obstetrics and Baby Care	Healthy First Steps uhchealthyfirststeps.com 1-800-599-5985	Links for pregnant parents and newborn babies.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > Oncology Optum 1-888-397-8129 Monday -Friday 7am – 7pm CST	For current list of CPT codes that require prior authorization for oncology
Optum ID Support Center	email: ProviderTechSupport@uhc.com 1-855-819-5909	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	optumrx.com Prior Approval/Clinical 1-866-434-5524 Fax 1-866-434-5523 Pharmacy Help Desk 1-866-434-5520 Member inquiries 888-816-1680	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Advance Notification of Health Services (Intake)	**To notify us or request a medical prior authorization:** EDI: Transactions 278 and 278N Online Tool: UHCprovider.com/paan Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call 1-877-842-3210. UHCprovider.com/tncommunityplan > Prior Authorization and Notification Resources	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/ TNcommunityplan >Prior Authorization and Notification.

Topic	Contact	Information
Population Health	1-800-690-1606	Refer high-risk individuals (e.g., asthma, diabetes, obesity) and those who need private-duty nursing.
Provider Advocates	1-800-690-1606 Network providers, email **UHC_TN_Outreach@uhc.com** Out-of-network providers, email **UHCCP_TN_Outreach@uhc.com**	When calling, choose Provider option, enter Tax ID, enter specific Member ID or wait for provider services representative to request call from appropriate provider advocate.
Provider Services	**UHCprovider.com/tncommunityplan** 1-800-690-1606	Ask about behavioral health, benefits and eligibility, claims, medical management and prior authorizations. Representatives are available 8 a.m.–6 p.m. Eastern Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	UHCprovider.com > **Referrals** Provider Services 1-800-690-1606	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	UHCprovider.com/tncommunityplan > Policies and Clinical Guidelines > **Reimbursement Policies for Community Plan of Tennessee**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation (nonemergent)	Tennessee Carriers 1-866-405-0238	Call Tennessee Carriers to schedule nonemergent transportation or for transportation assistance. To arrange non-urgent transportation, please call 3 days in advance.
Utilization Management	1-877-842-3210	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.

Topic	Contact	Information
Vaccines for Children (VFC) program	Tennessee Department of Health (TDH) Immunization Program 1-615-741-1954	You must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Enroll as VFC providers with DHSS to bill for the administration of the vaccine. VFC does not apply to CoverKids.
Vision Services	March Vision marchvisioncare.com 1-844-966-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from March Vision Care.
Website for Tennessee Community Plan	UHCprovider.com/tncommunityplan	Access your state-specific Community Plan information on this website.
Website for TennCare	tn.gov/tenncare Provider Links Rules for Tennessee Department of Finance and Administration	Find phone numbers, policies, eligibility and other information. Helpful links to TennCare information TennCare rules for providers

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-800-690-1606
Enterprise Voice Portal		1-877-842-3210
Eligibility	UHCprovider.com/eligibility	1-800-690-1606
Referrals	UHCprovider.com > Referrals	
Provider Directory	UHCprovider.com > Our Network > Find a Provider	

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

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a covered person 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 person to another care provider type if that illness or condition may be better treated by someone else.

Post nondiscrimination notices where employees and individuals easily see them. You may be asked to show proof these notices are posted.

Any person who feels they have been discriminated against, or anyone who witnesses something discriminatory, may file a complaint. Complaint forms are available in English and Spanish on tn.gov/tenncare > Members/Applicants > Civil Rights Compliance.

File a complaint through the following methods:

Mail: TennCare Office of Nondiscrimination
Contract Compliance
310 Great Circle Road, Floor 3W
Nashville, TN 37243

Email: hcfa.fairtreatment@tn.gov

Phone: 1-615-507-6474, **1-855-857-1673** (TTY 711)

Communication between care providers and covered persons

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

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

1. Educate covered persons 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 covered individuals (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 individuals 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 NPI information for care providers in your office. This form is located at the Provider Portal at **UHCprovider.com** then Sign In > Provider Practice Profile.

Transitioning care following termination of your participation

If your network participation ends, you must transition your covered persons to timely and useful care. This may include providing services for a reasonable time at our in-network rate. Provider Services can help with the transition.

If you decide to end your participation, submit a termination notification to us in the time frames stated in the Provider Agreement. All notices must be in writing and delivered either personally or by certified mail with prepaid postage. If mailed, the notice is considered delivered when deposited in the United States mail

Address notices to:
UnitedHealthcare Community Plan
Attn: Network Management
10 Cadillac Dr, Suite 200
Brentwood, TN 37027

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

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing covered persons with the information they need to take care of their health. To accurately list care providers who treat individuals, we:

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

Changing an existing TIN or adding a 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 Care 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 Care Provider Demographic Change Form and emailing it to the appropriate number listed on the bottom of the form
- Calling our Enterprise Voice Portal

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 an individual calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, individual 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 12 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 covered persons within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, an individual's grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

View protocols at UHCprovider.com/policies.

Office hours

You must provide the same office hours of operation to covered persons as those offered to commercial members.

Protect confidentiality of covered persons' data

Covered persons 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 individuals' health care experience. We require our associates to protect privacy and abide by privacy law. If a covered person requests specific medical record information, we will refer them 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 individuals' 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 11 for Medical Record Standards.

Inform covered persons 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 individuals on state laws about advance treatment directives, their right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform covered persons 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 an individual asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in their benefit contract or handbook. Locate the Member Handbook at UHCCommunityPlan.com/tn/medicaid/community-plan > Member Resources > View Available Resources > Member Handbook.

Also reference Chapter 14 of this manual for information on provider claim reconsiderations, appeals, and grievances.

Reporting abuse and neglect

You must identify and report suspected cases of abuse, neglect, or exploitation. Not reporting child abuse or neglect is a violation of Tennessee law. See TCA 71-6-101 et seq., TCA 37-1-401 et seq., and TCA 37-1-601 et seq. All abuse reports are confidential.

- Reporting Child Abuse: Call Child Protective Services at **1-877-237-0004**. You can also go to tn.gov/dcs > Program Areas > Child Safety to report instances of abuse or neglect that do not require an emergency response.
- Reporting Abuse of Adults: Call Adult Protective Services at **1-888-277-8366**. You can report suspected or confirmed cases of abuse or neglect after hours by fax at **1-866-294-3961**.
- Emergency Reporting: If the individual is at immediate risk, please call 911. For more information, go to the Tennessee Department of Human Services website at tn.gov.

Appointment standards (TennCare 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, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment in the office: within 48 hours or phone follow-up with referral for urgent care
- Routine care appointment: within 3 weeks
- Physical exam: within 3 weeks
- EPSDT appointments: within 3 weeks
- New individual appointment: within 3 weeks
- In-office waiting for appointments: not to exceed 45 minutes of the scheduled appointment time

- Phone calls:
  - After-hours calls to the answering service for urgent problems: within 15 minutes or as soon as possible
  - Urgent phone calls during regular office hours: the same day. The office staff should set an expectation with the caller as to when the call will be returned
  - Nonurgent phone calls during regular office hours: as soon as possible

Specialty care

Specialists should arrange appointments for:

- Routine appointment type: within 30 working days of request/referral
- Urgent appointments: within 48 hours
- In-office waiting for appointments: within 45 minutes of the scheduled appointment time
- Optometry: within 3 weeks for a regular appointment, 48 hours for an urgent appointment Do not exceed 45 minutes for office wait time

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within 15 calendar days of request
- Third trimester: within 3 days of request
- High-risk: within 3 calendar days of identification of high risk

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.

For more information about Behavioral Health Access and Availability Standards, please see Chapter 9.

Provider Directory

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a covered person, or potential covered person, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for help finding a care provider.

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

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 nonresponsive we will remove you from our care provider directory after 10 business days.

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

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

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

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

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

Provider attestation

Confirm your provider data every quarter through the Provider Portal 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.

Referral provider lists

You can find a current list of referral care providers, including behavioral health care providers, as well as download and print contact information at any time. Access the Referral Provider Lists on our Provider Portal at **UHCprovider.com/TNcommunityplan** > Member Information > Referral Provider Listings by Region.

We send PCPs a quarterly postcard about Referral Provider Lists updates. Request a printed version of the list by calling Provider Services at **1-800-690-1606**.

Prior authorization request

Prior authorization requests may include procedures, services, and/or medication.

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

Take the following steps before providing medical services and/or medication to covered persons:

- 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 individual's ID card each time they visit. Verify against photo ID 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

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m.–9 p.m. Central Time, Monday through Friday.

Timeliness standards for notifying individuals of test results

After receiving results, notify individuals within:

- Urgent: 24 hours
- Nonurgent: 10 business days

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 TennCare covered persons may seek services from any participating care provider. The TennCare program requires covered persons be assigned to PCPs. We encourage individuals 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 individual a "medical home."

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

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

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

Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot; they must be part of a group practice.

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

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

Pregnant persons have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any nonwomen's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP. This is in addition to the enrollee's designated PCP.

UnitedHealthcare Community Plan works with covered persons and care providers to help ensure all individuals understand, support and benefit from the primary care case management system. The coverage includes availability of 24 hours a day, 7 days a week. During nonoffice 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 covered persons with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying individuals 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 covered person's overall course of care
- Accept covered persons at your primary office location at least 20 hours a week for a 1-MD practice and at least 30 hours per week for a 2- or more MD practice
- Be available to individuals by phone any time
- Tell individuals about appropriate use of emergency services
- Discuss available treatment options with covered persons

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, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the covered person's first appointment
- Treat individuals' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, Provider Services, UnitedHealthcare Community Plan Clinical, or TennCare's pharmacy benefits manager, as appropriate
- Admit covered persons to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect individuals' advance directives. Document in a prominent place in the medical record whether a covered person has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and based on UnitedHealthcare Community Plan standards. Document procedures for monitoring individuals' missed appointments as well as outreach attempts to reschedule them.
- Transfer medical records upon request. Provide copies of medical records to individuals upon request at no charge.
- Allow timely access to covered persons' medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Comply with the TennCare Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in Chapter 2 of this manual.

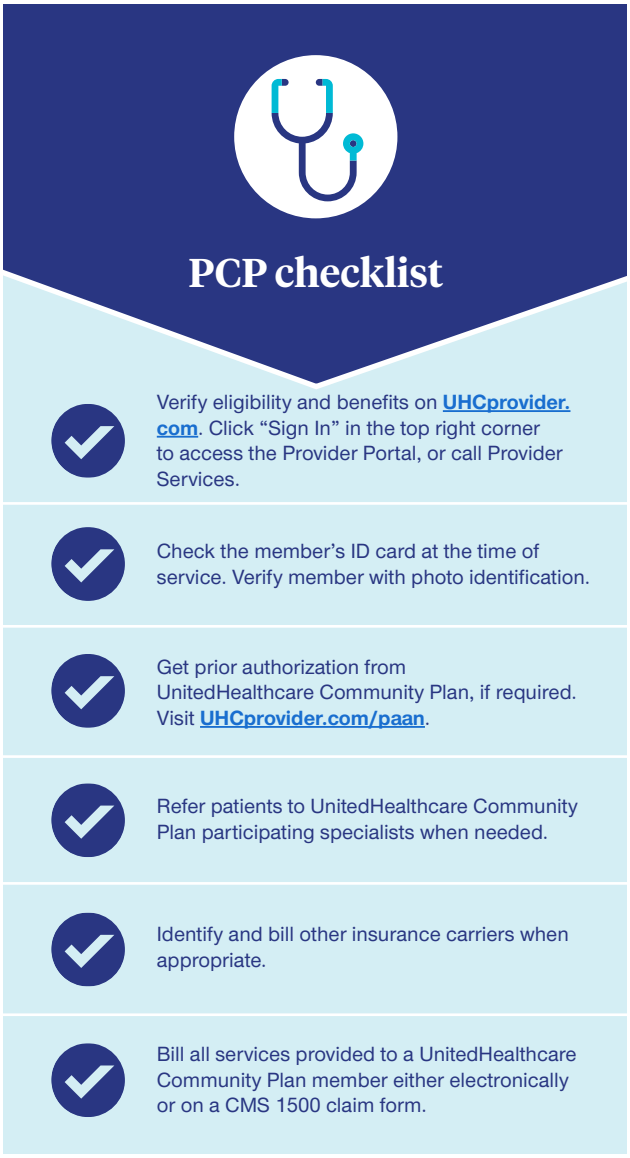
RHC, FQHC or PCC

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

- **RHC:** RHCs help increase access to primary care services for Medicaid and Medicare individuals in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural,

underserved areas.

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



Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to covered persons recommended by their PCP or who self-refer
- Verify the eligibility of the individual 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 individual's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the TennCare 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 role must be available to individuals by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary provider responsibilities

Ancillary providers include:

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

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

Ancillary provider checklist

- Verify the member's enrollment before rendering services. Sign in to the Provider Portal at UHCprovider.com or contact Provider Services.
- Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- Identify and bill other insurance carriers when appropriate.

Chapter 3: Care Provider Office Procedures and Individual Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/tn	1-800-690-1606
Member Handbook	UHCCommunityPlan.com/tn > Go to Plan Details, then Member Resources, View Available Resources	
Provider Services	UHCprovider.com	
Prior Authorization	UHCprovider.com/paan	

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

Benefit information

Review the following benefits chart. You may also see individual benefit coverage information at tn.gov/tenncare > Members/Applicants > Covered Services.

Physical health benefits (Contract Risk Agreement [CRA] Section 2.6.1.3)

Service	Benefit Limit
Inpatient Hospital Services	Medicaid/Standard eligible, age 21 and older: As medically necessary Inpatient rehabilitation hospital facility services are not covered for adults unless we determine it is a cost-effective alternative. Medicaid/Standard eligible, younger than 21: As medically necessary, including rehabilitation hospital facility
Outpatient Hospital Services	As medically necessary
Physician Inpatient Services	As medically necessary
Physician Outpatient Services/ Community Health Clinic Services/ Other Clinic Services	As medically necessary
Prenatal, Maternity, and Postpartum Care (delivered based on standards the American College of Obstetrics and Gynecology endorses)	As medically necessary

Service	Benefit Limit
TennCare Kids Services	Medicaid/Standard eligible, birth through 20 years: Covered as medically necessary, except that screenings do not have to be medically necessary. Children may also receive screenings between regular checkups. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary based on federal and state requirements. See Section 2.7.6 of the CRA for further details.
CoverKids	CoverKids is available to children: • Younger than 19 years who are not eligible for TennCare Medicaid • Whose household income must be at or below 250% of the federal poverty level (FPL) based on Eligibility Determination Group (EDG) size • Who meet all non-financial eligibility requirements CoverKids is available to unborn babies of pregnant persons: • Not eligible for TennCare Medicaid • Whose household income is at or below 250% of FPL based on EDG size • Who meet all non-financial eligibility requirements
Preventive Care Services	We provide preventive services, including initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations based on TennCare rules and regulations, as described in Section 2.7.5.
Lab and X-Ray Services	As medically necessary
Hospice Care	As medically necessary when provided by a Medicare-certified hospice
Dental Services	Dental services shall be provided by DentaQuest We cover the facility, medical and anesthesia services related to medical services not provided by a dentist or in a dentist's office when DentaQuest covers the dental service. This requirement only applies to Medicaid/ Standard eligibles younger than age 21.

Service	Benefit Limit
Vision Services	TennCare Medicaid: As medically necessary for those younger than 21 years old: Preventive, diagnostic, and treatment services (including eyeglasses) based on TennCare Kids requirements. As medically necessary for those 21 years and older: • Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye • 1 pair of cataract glasses or lenses following cataract surgery CoverKids children younger than 19 years old: • Annual vision exam, including refractive exam and glaucoma screening • Prescription eyeglass lenses: 1 pair per calendar year with $85 maximum benefit per pair • Eyeglass frames: replacement frames limited to once every 2 calendar years with $150 maximum benefit per pair • Prescription contact lenses in lieu of eyeglasses limited to 1 pair per calendar year with $150 maximum benefit per pair CoverKids birth parents (age 19 and older) of eligible unboard children: • Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye. • 1 pair of cataract glasses or lenses following cataract surgery.
Home Health Care	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary and based on the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on the definition of Home Health Care Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). Benefit limits for skilled nursing for CoverKids (125 visits per year)
Pharmacy Services	OptumRx covers pharmacy services except in the following cases. We reimburse for injectable drugs obtained in an office/clinic setting and for care providers providing both home infusion services and the drugs and biologics. We require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services we reimburse are not included in any pharmacy benefit limits TennCare establishes for pharmacy services (see CRA Section 2.6.2.2)
Durable Medical Equipment (DME)	As medically necessary Specified DME services are covered/noncovered based on TennCare rules and regulations
Medical Supplies	As medically necessary Specified DME services are covered/noncovered based on TennCare rules and regulations

Service	Benefit Limit
Emergency Air And Ground Ambulance Transportation	As medically necessary
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Covered nonemergency medical transportation (NEMT) services are necessary nonemergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI of the CRA). NEMT services are provided based on federal law and TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI of the CRA) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third-party resource (see definition in Section 1 of the CRA). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only 1 escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, we do not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is younger than age 18. Except for fixed route and commercial carrier transport, we do not make separate or additional payment to a NEMT provider for an adult accompanying a member younger than 18 years. We are not responsible for providing NEMT to home- and community-based services (HCBS) provided through a 1915(c) waiver program for persons with intellectual disabilities and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event we cannot meet the access standard for adult day care (see Attachment III of the CRA), we shall provide and pay for the cost of transportation for the member to the adult day care facility until we have sufficient provider capacity. If the member is a child, transportation shall be provided based on TennCare Kids requirements (see CRA Section 2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages. (Does not include CoverKids)
Renal Dialysis Services	As medically necessary

Service	Benefit Limit
Private Duty Nursing	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary based on the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a registered nurse or a licensed practical nurse who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse or a licensed practical nurse, who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-04 (for TennCare Standard). (Does not include CoverKids)
Speech Therapy	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on TennCare Kids requirements CoverKids: Limited to 52 treatments
Occupational Therapy	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions. Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on TennCare Kids requirements CoverKids: Limited to 52 treatments
Physical Therapy	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions. Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on TennCare Kids requirements CoverKids: Limited to 52 treatments
Chiropractic Services (defined at 42 C.F.R. § 440.60(b))	Medicaid/Standard eligible, age 21 and older: Not covered unless we determine them to be a cost-effective alternative based on the CRA at 2.6.5 Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on Tenncare Kids requirements CoverKids: Chiropractic care is covered for children younger than age 19. CoverKids does not pay for any chiropractic care for pregnant persons 19 and older.

Service	Benefit Limit
Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services (defined as the transfer of an organ or tissue from individual to a TennCare enrollee)	Medicaid/Standard eligible, age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: • Bone marrow/stem cell • Cornea • Heart • Kidney • Liver • Pancreas • Small bowel/multi-visceral Medicaid/Standard eligible, younger than age 21: Covered as medically necessary based on TennCare Kids requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery (defined in accordance with Tenn. Code Ann. § 56-7-2507)	Medicaid/Standard eligible, age 21 and older: Covered based on Tenn. Code Ann. § 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the nondiseased breast deemed necessary to establish symmetry between the 2 breasts. The surgical procedure performed on a nondiseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a nondiseased breast occurs within 5 years of the date the reconstructive breast surgery was performed on a diseased breast. Medicaid/Standard eligible, younger than age 21: Covered based on Tenn. Code Ann. § 56-7-2507. This rule requires coverage of all stages of re-constructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the nondiseased breast deemed necessary to establish symmetry between the 2 breasts. The surgical procedure performed on a nondiseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within 5 years of the date the re-constructive breast surgery was performed on a diseased breast.

Additional physical health benefits

Service	Benefit Limit
Mammography Screening	We provide mammography screenings a minimum of: once for ages 35-40; every 2 years or more frequently on physician recommendation for ages 40-50; and annually for ages 50 and older. The facility where the mammogram was performed shall provide the patient notice as required by The Breast Cancer Prevention Act (TCA 63-6-2) Not applicable to CoverKids
Phenylketonuria (PKU) Treatment	We provide coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.

Service	Benefit Limit
Diabetic Services	We provide coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary. Not applicable to CoverKids
Chlamydia Screenings	TennCare Medicaid: We provide for 1 annual chlamydia screening test in conjunction with an annual Pap smear for members younger than 29 years old, if deemed medically necessary. Not covered for CoverKids

Behavioral health benefits (CRA Section 2.6.1.4)

Service	Benefit Limit
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary
24-hour Psychiatric Residential Treatment	Medicaid/Standard eligible, age 21 and older: As medically necessary Medicaid/Standard eligible, younger than age 21: Covered as medically necessary
Behavioral Health Intensive Community Based Treatment	As medically necessary
Outpatient Mental Health Services (including physician services)	As medically necessary
Inpatient, Residential & Outpatient Substance Abuse Benefits	Medicaid/Standard eligible, age 21 and older: Covered as medically necessary Medicaid/Standard eligible, younger than age 21: Covered as medically necessary When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. CoverKids: Coverage as medically necessary for inpatient and outpatient substance abuse services
Birth through age 20 years	As medically necessary
Psychiatric-Rehabilitation Services	As medically necessary
Behavioral Health Crisis Services	As necessary
Lab and X-ray Services	As medically necessary

Service	Benefit Limit
Nonemergency Medical Transportation (including Nonemergency Ambulance Transportation)	Covered NEMT services are necessary NEMT services provided to convey members to and from TennCare covered services. NEMT services is provided based on federal law and the Division of TennCare's rules and policies and procedures. TennCare-covered services include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver; (b) the provider could be a TennCare provider for that service; and (c) the service is covered by a third party. If a member needs help, 1 escort (as defined in TennCare rules and regulations) may accompany the member. Except for fixed route and commercial carrier transport, we will not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if they are younger than 18 years. UnitedHealthcare Community Plan does not provide NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities and HCBS provided through the CHOICES program. However, if we cannot meet the access standard for adult day care, we will provide and pay for the member's transportation to the adult day care facility until our network can support the request. UnitedHealthcare Community Plan provides NEMT to dental services for ECF CHOICES members, including medical and dental services related to such dental services. Mileage reimbursement, car rental fees, or other reimbursement for use of a private car is not a covered NEMT service, unless otherwise allowed or required by TennCare as a pilot project or a cost-effective alternative service. If the member is a child, transportation is provided based on TennCare Kids requirements.

UnitedHealthcare Dual Complete (HMO D-SNP)

D-SNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid. For general information about D-SNP, go to: **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For Tennessee-specific information, go to UHCprovider.com > Resources > Health Plans > Tennessee > Tennessee Medicare Advantage Health Plans > **Tennessee UnitedHealthcare Dual Complete® Special Needs Plans**.

Assignment to PCP panel roster

Once an individual 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 individual 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.

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

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

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

Choosing a PCP

Each enrolled UnitedHealthcare Community Plan person 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 individuals. UnitedHealthcare Community Plan assigns them to the closest and appropriate PCP.

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

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

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

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

Individual assignment

Assignment to UnitedHealthcare Community Plan

The Division of TennCare assigns eligible individuals to UnitedHealthcare Community Plan daily. We manage the person's care on the date the person is enrolled until the person is disenrolled from UnitedHealthcare Community Plan. The Division of TennCare 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 individual receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the individual's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook at UHCCommunityPlan.com/TN by calling Provider Services.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for individuals, 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 covered persons to notify TennCare when they know they are expecting. TennCare notifies us daily of an unborn child when TennCare learns a member we cover is expecting. We or you may use the online change report through the TennCare website to report the baby's birth. With that information, TennCare verifies the birth through the pregnant member. Our and/or your information is taken as a lead. To help speed up the process, the member should notify TennCare 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 parent has enrolled the baby in a managed care plan.

PCP selection

Although unborn children cannot be enrolled with us until birth, have the covered person 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.

Covered persons can go to myuhc.com/communityplan to look up a care provider.

Individual eligibility

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

Eligibility categories include:

- TennCare Medicaid
- TennCare Standard
- Presumptive Eligibility for Breast/Cervical Cancer Group
- Presumptive Eligibility for Maternity

Individual ID card

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

If a fraud, waste and abuse event arises from a care provider or an individual, go to uhc.com/fraud. Or you may call the Fraud, Waste, and Abuse Hotline at 800-433-3982.

The PCP assignment is shown on the front of the card. If a person does not bring their card, call Provider Services. Also document the call in their chart.

Individual identification numbers

Each covered person receives a 9-digit UnitedHealthcare Community Plan identification number. Use it to communicate with us about a specific covered person.

PCP-initiated transfers

A PCP may transfer a TennCare covered person due to an inability to start or maintain a professional relationship or if the individual is noncompliant. The PCP must provide care for them until a transfer is complete.

1. Send a letter saying you are requesting the members be removed from your panels. The letter must include specific documentation of the events that occurred. Include the following:
   - Copy of the letter you sent to the member notifying of termination
   - Dates of failed appointments or a detailed account of the reason for termination request
   - Charts/medical records supporting the decision
   - Name, date of birth, address, Medicaid number and telephone number of the patient
   - PCP name

- Member name
- Mail to –

  UnitedHealthcare Community Plan
  10 Cadillac Dr., Ste 200
  Brentwood, TN 37027

2. We will review the request for removal, considering both the provider and member rights. If the member's removal/transfer is approved, we will reach out to the member explaining why and providing help with choosing a new PCP. If the member's removal/transfer is not approved, the provider advocate will contact the PCP with an explanation. The PCP must continue to provide care to the members as necessary for up to 30 days unless some extenuating circumstances are present (e.g., danger to office staff, member is threatening, etc.).
3. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the individual and resolve the issue to develop a satisfactory relationship.
4. If the individual and UnitedHealthcare Community Plan cannot resolve the issue, we work with the individual to find another PCP. We refer them to care management, if necessary.
5. If UnitedHealthcare Community Plan cannot reach the covered person by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we choose one for them. A new ID card is sent to the person with the new PCP information.

Sample individual ID card

See Chapter 8 for a sample CoverKids ID card.

Verifying enrollment

Verify eligibility before providing services. Determine eligibility in the following ways:

- EDI: Transaction 270 and response 271
- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7 a.m.-5 p.m. local time, Monday through Friday
- tn.gov/tenncare > Providers > **Verify Eligibility**

Effective dates are frequently revised as individuals re-verify with TennCare.

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	1-800-690-1606
Prior Authorization	UHCprovider.com/paan	1-877-842-3210
Pharmacy	professionals.optumrx.com	Prior Approval/Clinical: 1-866-434-5524
Dental	dentaquest.com	TennCare: 1-855-418-1622 CoverKids: 1-888-291-3766

Looking for something else?

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

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

Ambulance services

Air ambulance

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

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

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

Emergency ambulance transportation

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

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

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

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport, but Tennessee Carriers, Inc. has authorized it. Find more detail in the Nonemergent ambulance transportation section.

Nonemergent ambulance transportation

(Does not apply to CoverKids)

Individuals may get nonemergent transportation services through Tennessee Carriers, Inc. for covered services. Individuals may get ambulance transportation when:

- A care provider has completed a certificate of medical necessity and submitted it to TCI
- They are bed-confined before, during and after transport

Call Tennessee Carriers to request a copy of the Certificate Of Medical Necessity form. With prior approval, hotel stays may also be made available to eligible individuals for trips that require an overnight stay.

For non-urgent appointments, individuals must call **1-866-405-0238** for transportation at least 3 days before their appointment.

One escort (of the person's choice) may accompany the person. Exceptions can be made if childcare keeps person from using health care services. Individuals may request car seats when scheduling the trip.

To ask about claims, email billing@tenncarriers.com. You may also call **1-901-795-7055**. View the UnitedHealthcare Community Plan NEMT Broker Provider Manual at tennesseecarriers.com/nemt.

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 performi ng 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. Select the Go to Prior Authorization and Notification Tool
- **Phone**: **1-866-889-8054** Monday through Friday

Make sure the medical record is available.

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

Dentaquest dental services

A dental provider manual is available for detailed coverage information at dentaquest.com. For information about exclusions, limitations and covered services, visit dentaquest.com.

Durable medical equipment

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

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

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

Emergency/urgent care services

Emergency services do not require prior authorization. They are available 24 hours per day, 7 days per week. This includes outside the usual service area.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell individuals about appropriate ER use. A PCP should treat non-emergencies such as sprains/strains, stomachaches, earaches, fevers, coughs, 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 and air transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal

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

Emergency room care

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

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

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-599-5985**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the individual's care
2. A plan care provider takes over the covered person's care by sending them to another place of service
3. A UnitedHealthcare Community Plan representative and the treating care provider agree about the person's care
4. The individual is released

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

Urgent care (nonemergent)

Urgent care services are covered.

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

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

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

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.)

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

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

If a covered person 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 individuals manage their fertility and achieve the best reproductive and general health. Covered persons 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, including 1 annual chlamydia screening test for women younger than 29 years, if deemed medically necessary

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

Noncovered items include:

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

Parenting/child birth education programs

Parenting education is not covered.

Voluntary sterilization

In-network treatment is covered when the required consent form is completed. The covered person 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 TennCare regulations for more information on sterilization at **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html**.

ER services filed with observation

ER services (RC 0450) and observation charges (RC 0762) are both part of the observation room charge. They are not reimbursed separately. File ancillary charges with the appropriate CPT® or HCPCS code.

Services filed with observation and outpatient surgery

ER services (RC 0450) and observation services filed with outpatient surgery services are considered all-inclusive in the outpatient surgery reimbursement. They are not reimbursed separately. The observation services will reimburse separately after the first 6 hours. Ancillary services are considered all-inclusive in the OSF reimbursement.

Care coordination/health education

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

The program goals are to:

- Provide covered persons with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of covered persons
- 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 covered persons' outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support covered person 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 covered persons that address topics that help them manage their condition. Our program provides personalized support to individuals in case management. The case manager collaborates with them to identify educational opportunities, provides the appropriate health education and monitors the covered person's progress toward management of the condition targeted by the care coordination 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.

Health Home program

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of the state's highest-need individuals. Health Home helps improve coordination of care, quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable emergency room visits, inpatient psychiatric admissions, and the need for nursing home admissions. We work with area hospitals in providing transitional care services to individuals enrolled in Health Home. Hospitals and care providers may refer individuals to us for potential Health Home enrollment. Health Home eligibility is determined by Medicaid. The program provides services beyond those typically offered by care providers, including, but not limited to:

- Comprehensive care management
- Care coordination and health promotion,
- Individual and family support
- Referral to community services

For more information about Health Home, call your contract manager.

Hearing services

UnitedHealthcare Community Plan provides hearing aids, batteries, or cochlear implants. They are available when medically necessary to individuals age 20 and younger. These services require prior authorization.

Hospice

Hospice services require prior authorization.

Laboratory

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

Use a network laboratory when referring individuals 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.

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

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

Maternity/pregnancy/ well-child care

Pregnancy notification 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 at **UHCprovider.com**. Call Healthy First Steps at 1-800-599-5985.

HFS-Maternal care model

The HFS-Maternal care model strives to:

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

Program staff act as a liaison between members, care providers, and United Healthcare Community Plan for care coordination.

Pregnancy/maternity

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk individuals. High-risk claims must include the corresponding diagnosis code.

Pregnant covered persons should receive care from UnitedHealthcare Community Plan care providers only.

We must approve all out-of-plan maternity care. Call Provider Services to get prior approval for continuity of care.

Notify UnitedHealthcare Community Plan immediately of a covered person's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. Call Healthy First Steps at **1-800-599-5985.**

A covered person does not need a referral from their PCP for OB/GYN care. They may use perinatal home care services 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**.

To notify UnitedHealthcare Community Plan of deliveries, call Provider Services. Provide the following information within 1 business day of the admission:

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

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

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

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner. 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.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the parent and the newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 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 covered person's discharge date. Prior authorization is required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital notifies the county of all deliveries, including covered persons (provided the parent was admitted using their UnitedHealthcare Community Plan ID card).

The hospital provides enrollment support by providing required birth data during admission.

Bright Futures assessment

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

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

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

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

Hysterectomies

Hysterectomies cannot be reimbursed if performed solely for sterilization. Individuals 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 the Federal Acknowledgment of Hysterectomy Information form, per TennCare requirement. The covered person should sign and date the form stating they were informed prior to the surgery that the procedure will result in permanent sterility.

The federal form is on tn.gov/tenncare > Providers > **Miscellaneous Provider Forms**.

A signature is not required from the covered individual in the following cases:

- Retroactive-eligible individual only: The member must be retroactive per the state enrollment
- The covered person is already sterile – medical records showing this are required
- The hysterectomy was performed under a life-threatening emergency, and the information about sterility could not be given before the hysterectomy

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

Pregnancy termination services

Pregnancy termination services are not covered except:

- To preserve the life of the parent
- Credible evidence exists to show the pregnancy is the result of rape or incest

In these cases, follow the TennCare consent procedures for abortion. Find the form and more details at tn.gov/tenncare > Providers > **Miscellaneous Provider Forms**.

Allowable pregnancy termination services do not require a referral from the individual's PCP. Individuals must use the UnitedHealthcare Community Plan care provider network. Please provide any documentation (medical records, police reports, etc.) that substantiates the covered person's life is in danger or the abortion is the result of rape or incest. If supporting documentation is not submitted, the claim will not be paid.

Sterilization

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

The covered person must not be mentally incompetent or live in a facility treating mental disorders. In the case of premature delivery or emergency abdominal surgery, the care provider may perform a sterilization procedure if the Sterilization Consent Form was signed at least 72 hours prior to the sterilization procedure. In the case of premature delivery, the recipient must sign the Sterilization Consent Form at least 30 days before the estimated due date.

Informed consent may not be obtained while members are in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent forms

Use the consent form for sterilization:

- Complete all applicable sections of the federal consent form before submitting it with the billing form. The TennCare Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- The physician statement section should be completed after the procedure, along with their signature and the date. This may be the same date of the sterilization or a date afterward. If they sign the consent form before the sterilization is performed, the form is invalid.

You may also find the form on tn.gov/tenncare > Providers > TennCare Provider News, Notices & Forms > **Miscellaneous Provider Forms**. You can also find information there about how to complete the form.

Have 3 copies of the consent form:

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

Effective July 1, 2023, UnitedHealthcare Community Plan of Tennessee requires medical records on all termination, sterilization and hysterectomy claims billed with certain CPT® codes, in addition to the completed federal notification form on **tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html**, if applicable.

The applicable medical record is the minimum requirement if your claim contains at least one of the following CPT® codes:

- 55250
- 58600
- 58605
- 58661
- 58700
- 58720

NICU case management

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

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

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

Inhaled nitric oxide

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

Oncology

Prior authorization

To help ensure our member benefit coverage is medically appropriate, we regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence, published clinical guidelines and specialty society guidance.

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

Radiology

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting.

The following images do not require prior authorization:

- Ordered through ER visit
- While in an observation unit
- When performed at an urgent care facility
- During an inpatient stay

Not getting this prior authorization approval results in an administrative denial. Claims denied for this reason may not be balance-billed.

To get or verify prior authorization:

- 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. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use the Provider Portal or the search option at **UHCprovider.com**.

SBIRT services

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

- Provided by, or under the supervision of, a certified care provider or other certified licensed health care professional within the scope of their practice
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

What is included in SBIRT?

Screening – With just a few questions on a questionnaire or in an interview, you can identify covered persons 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 covered persons 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 (SUD). **This includes coordinating with the Alcohol and Drug Program in the County where the individual 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 4 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.

MAT

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 the number on the back of the covered person's health plan ID card or search for a behavioral health professional on liveandworkwell.com.

To find a medical MAT provider in Tennessee:

1. Go to UHCprovider.com
2. Go to Our Network > Find a Provider
3. Select the care provider information
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

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

Substance Use Disorder Helpline — **855-780-5955**. This anytime service helps:
- Identify local MAT and behavioral health treatment providers and provide targeted referrals for evidence-based care
- Educate individuals and their families about substance use
- Find individuals community support services

TB screening and treatment; direct observation therapy

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

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

TB screening, diagnosis, treatment, compliance, and follow-up of covered persons. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Waiver programs

Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) HCBS waiver program

The HIV/AIDS in-home waiver services program is available to covered persons who would otherwise require long-term institutional services.

Identification – Individuals with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify those potentially eligible for the waiver program. They may also inform the individual of the waiver program services.

Referral – If the covered person agrees to participation, provide the waiver agency with supportive documentation including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of Care – The HIV/AIDS waiver program will coordinate in-home HCBS services in collaboration with the PCP and care coordinator. If the individual does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support them.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for covered persons who may benefit from HCBS services. We refer these individuals to the Long Term Care Division/HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will cover all medically necessary covered services for the individual unless/until they are disenrolled from the Medicaid Program.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please contact Optum Behavior Health at **800-690-1606**.

If you have questions, go to Tennessee's prior authorization page: UHCprovider.com/ TNcommunityplan > **Prior Authorization and Notification**.

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

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ individual notification of denial
Non-urgent Pre-service	Within 5 working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 3 days of request receipt	Within 3 days of the request	Within 3 days of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and individual notification within 2 business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and individual notification within 2 business days

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities (SNF), home health care and ambulatory facilities. We conduct reviews for each day's stay using nationally recognized guidelines – including InterQual, MCG and/or CMS – to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a covered person'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

We use clinical information to make determinations for continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or on-site.

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, covered person 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 covered persons directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within 4 hours of receipt of our

request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

UnitedHealthcare Community Plan uses nationally recognized guidelines – including InterQual, MCG and/or CMS – 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.

Retrospective review process

A retrospective review occurs when you request authorization after a service has been delivered. For all retrospective reviews, we issue a determination within 30 calendar days of request receipt after receiving all pertinent clinical information. We deny retrospective review requests received 120 calendar days from the initial date of service based on timely filing rules.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We do not consider experimental treatments medically necessary.

Determination process

Benefit coverage for health services is determined by the individual-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 individuals 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/policies > **Clinical Guidelines**.

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

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

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

- Continuity of care issues

- Necessary services are not available within network

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

Reimbursement

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

- Determine if the covered person is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, contacting Provider Services or the Tennessee 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 covered person has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Noncovered services. Additional information on exclusions may be found in TennCare Rules at **publications.tnsosfiles.com**. Information begins on page 66 under 1200-13-13-.10.
- Services provided to individuals not enrolled on the dates of service

Second opinion benefit

If a covered person 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 TennCare 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 individual's PCP refers them to an in-network care provider for a second opinion. Care providers forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion then forwards their report to the individual's PCP and treating care provider, if different. The individual may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan arrange for a consultation with a non-participating care provider. The participating provider should contact UnitedHealthcare Community Plan at **1-800-690-1606**.
- Once the second opinion has been given, the covered person and the PCP discuss information from both evaluations
- If follow-up care is recommended, the individual meets with the PCP before receiving treatment

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by TennCare but not through UnitedHealthcare Community Plan
- Mental health and substance abuse care. This service is covered by Optum Behavioral Health.
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

View TennCare's benefit exclusions in the Exclusions section of the TennCare Rules on **publications.tnsosfiles.com**. Find 1200-13-13-10, beginning on page 6. The services, products and supplies listed in the exclusion rules apply to all covered persons unless the rules require a medical necessity review for persons younger than 21 years.

Services requiring prior authorization

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

Seek prior authorization within the following time frames

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

Utilization management guidelines

Call **1-866-815-5334** to discuss the guidelines and utilization management.

Utilization management (UM) is based on a covered person's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service basis. The plan's UM staff works with care providers to help ensure covered persons 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.

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 noncovered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

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

Key contacts

Topic	Link	Phone Number
EPSDT	tn.gov/tenncare/tenncare-kids.html	1-800-342-3145
Vaccines for Children	tn.gov/health/cedep/immunization-program/ip/vfc.html	1-800-219-3224

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

The **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid. EPSDT does not apply to CoverKids. We do not require prior authorization for periodic and interperiodic screens PCPs conduct.

Follow the EPSDT schedule for all eligible covered individuals to age 21, including pregnant women. EPSDT screening includes a comprehensive health history, complete unclothed/suitably draped physical exam, lab tests, vision screening, hearing screening, immunizations, anticipatory guidance and a developmental/behavioral screening.

For complete details about diagnoses codes, go to tnaap.org/programs > EPSDT & Coding.

For more information about screening requirements, go to aap.org > Professional Resources > Engaging Patients and Families > Periodicity Schedule, and cdc.gov > Healthy Living > Vaccines and Immunizations.

To find the Well Child/Age Specific Encounter forms, go to tnaap.org.

Find details on how to fill out the Well-Child/Age-Specific Encounter form at: tnapp.org > Programs > EPSDT & Coding > EPSDT & Well Child Visits > EPSDT Manual.

Department of intellectual and developmental disabilities

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

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

Continuity of Care – The RC will determine the most appropriate setting for eligible home- and community-based services (HCBS) and will coordinate these services for the covered person 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 individual does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the covered person's screening, preventive, medically necessary, and therapeutic covered services.

Full screening

Perform a full screen. Include:

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

Without all these components, you cannot bill for a full screen. You may only bill for a partial screen. If the screening reveals the need for other health care services, and you cannot make an appropriate referral for those services, please contact the health plan.

Head start

Head Start and Early Head Start are federally funded programs that promote school readiness for children ages 0-5 from eligible families. They offer educational, health, social and other supports and services. These programs support partnerships with various entities, including Tennessee's pre-K program.

Head Start classrooms are operated by government, private, faith-based and community-based organizations directly or through child care partnerships or other collaborative arrangements. For more information, go to tn.gov > Education > Early Learning > **Head Start**.

Interperiodic screens

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

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

Lead screening/treatment

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

School-based services

For medically necessary services provided in a school setting, TennCare requires an Individual Education Plan (IEP). The IEP must state the service provided and note a parental consent form was obtained. Each school must prepare and maintain updated IEPs for each eligible student. It must then provide any IEP to UnitedHealthcare Community Plan upon request. Document all referrals in the individual's chart.

We do regular post payment audits on school-based services we reimburse, such as Individualized Education Plans (IEP). When we request a copy of the IEP, please include a copy of the parental consent and physician's order.

We conduct regular post-payment sample audits of IEPs and all other documentation to support the medical necessity of the school-based services we reimburse.

When we request a copy of an IEP, you must also include a copy of the appropriate parental consent.

The school may coordinate with UnitedHealthcare Community Plan to arrange for services. The services may be provided during school or outside of a school setting through the IEP process. We cover medically necessary covered services in the school or out of school when the service is documented in the current IEP, performed by the appropriate practitioner and parental consent has been obtained. TennCare has updated the authorization forms for school-based

services, on tn.gov.

If a school does not follow these requirements, they may be subject to recoupments and other penalties. UnitedHealthcare Community Plan may choose to require schools to submit IEPs before reimbursing for covered medically necessary services.

If you need help arranging transportation, referrals, or have other questions about IEPs or other children's services, call Case Management at **800-690-1606**. Document all referrals in the child's chart.

TennCare school nursing guidelines

Providing and billing covered medicaid services provided by the school nurse

The Individualized Education Program (IEP) is the document developed by the school for a school child who is eligible for special education. This document is created by a multidisciplinary team that includes, but is not limited to, the parent, the child's PCP, special education professionals, the child's teacher(s) and other school system team members. This planning is done at least annually but more frequently if needed.

The IEP documents the plan to meet the child's educational needs and supports. This includes an evaluation of the child's present educational performance, educational goals, supports and strategies. In addition to the educational components, the plan may include any medical or behavioral supports needed. Once the plan is completed and parental permission is obtained, the plan is put into action. Medically necessary services (medical or behavioral) may be covered services and eligible for reimbursement by the child's TennCare Medicaid plan.

The following describes the guidelines for obtaining TennCare Medicaid reimbursement for medically necessary covered school nursing services as required by the IEP and as allowable by TennCare through the Individual Health Plan (IHP):

1. The billable services in the following table are performed by the school nurse and shall be ordered by the PCP or the child's treating provider. In addition to the supervision required for the performing school nurse, as described in section 4a (ii), the school nursing program shall have a physician to clinically supervise the physician assistant (PA) or nurse practitioner (NP) in accordance with the Tennessee Board of Nursing Rules and Regulations and T.C.A., Title 63
2. The school nurse will meet the clinical and licensing requirements, as required by the Tennessee Department of Health, as well as the training required to perform these services in the school setting
3. The school will maintain policies and procedures for the provision and documentation of the services listed in the following table
4. The following are the guidelines for billing:
   - Use 99211 with POS 03 as the daily billable CPT code, to include a global fee.
     i. School nursing services eligible for reimbursement, as denoted by (Y) in the following table, are restricted to medically necessary covered services included in the IEP or IHP, as applicable
     ii. Medically necessary covered services in the IEP or IHP that are ordered by the PCP or treating provider may be reimbursed. The IEP or IHP alone does not satisfy requirements for Medicaid reimbursement. Services are performed by the school nurse, under the clinical supervision of an in-network physician, PA or NP licensed through the Tennessee Department of Health. Clinical supervision does not require the continuous and constant presence of the clinical supervisor; however, the clinical supervisor must always be available for consultation or shall arrange for a substitute provider to be available. Services are performed pursuant to the student's PCP's or the child's treating provider's order.
     iii. The supervising physician, PA or NP shall serve as the rendering provider on the claim, as the school nurse is not credentialed and cannot contract with us as a network provider
     iv. Administrative services are not billable services
   - The billable items in the following table include the code to be used for the services
   - We will contract with any school district(s) that seek(s) to contract with us, based on our standard reimbursement rates, to receive reimbursement for medically necessary covered services in the IEP or IHP that are ordered by the PCP or treating provider and provided in a school setting

- We will monitor claims and will retrospectively audit claims for appropriate claims billing and the presence of a valid care provider order to ensure school-based providers are submitting claims appropriately.
- We will document these guidelines in our provider manual

Timely filing for IEP and IHP services

School districts must submit claims with place of service code 3 and any required documentation within 365 days of the date of service. Any claims submitted outside of the 365-day timeframe will be denied for timely filing. Corrected claims must be submitted within 60 days from the date of denial or 365 days from the date of service, whichever is later.

Service	If Billable, use corresponding CPT Code: 99211, POS 03 Note: This code is a global encounter code, billable once per day and includes ALL services received Billable (Y) / Nonbillable (N)
Assessment and Treatment treatment of acute and chronic illnesses	Y
Blood glucose monitoring and testing	Y
Vital sign monitoring	N
Tracheostomy care and suctioning	Y
Colostomy care	Y
Catherization	Y
Administration of oral medication – per tube	Y
O2 saturation monitoring (pulmonary and/or cardiac disease)	Y
G-Tube feeding	Y
Wound care	Y
Nebulizer treatment	Y
Postural drainage	N
Medication administration for medically fragile students as identified in IEP or IHP	Y
Development, /implementation of Individual Health Plan (IHP)	N
Evaluation of Nursing nursing service in the Individualized Education Program (IEP)	N

VFC

The Vaccines for Children (VFC) 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.

VFC providers are required to record administered vaccinations in the Tennessee Immunization Information System (TennIIS).

You must record every vaccine administered to all individuals younger than 19 years, regardless of VFC status, within 2 weeks of the administration date.

Contact VFC if you have questions.

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (These children have health insurance, but the benefit plan does not cover immunizations.)
  - A child who has health insurance, but the coverage does not include vaccines
  - A child whose insurance does not cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. The child may receive from VFC only those vaccines not covered by the insurance, or
  - A child whose insurance caps its payment for vaccine coverage. The child may receive the VFC vaccine after the insurance cap has been reached. If the cap is expected to be reached as a result of the cost of all the services provided at the visit, the VFC vaccine may be used.

Children in this category may not only receive vaccinations from a FQHC or RHC.

For more information about TennCare Kids, go to the following websites:

- UHCprovider.com/tncommunityplan > Provider Forms, Resources and References > TennCare Kids Resources
- TennCare Kids: tn.gov/tenncare/section/tenncare-kids
- Tennessee Chapter of the American Academy of Pediatrics: tnaap.org

VFC does not apply to CoverKids.

Referral provider listing

We provide all PCPs participating in EPSDT with a current listing of TennCare participating referral care providers, including behavioral health providers.

Go to UHCprovider.com > Member Information: Current Medical Plans, ID Cards, Provider Directories, Dental & Vision Plans > Referral Provider Listings by Region

You also have the right to request a hard copy at least 30 calendar days prior to your start date of participation by contacting Customer Service at 800-690-1606. Thereafter, we provide quarterly notification to PCPs regarding how to access and request a hard copy of an updated version of the listing.

Chapter 6: Long-Term Services and Supports (LTSS)

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

The TennCare CHOICES Long-Term Services and Supports (LTSS) Program is a Medicaid care delivery system that balances LTSS and facility-based nursing services with home- and community-based services (HCBS). The CHOICES LTSS program aims to:

- Improve access to cost-effective HCBS services
- Raise accountability by helping members with functional needs access to LTSS/HCBS services

With CHOICES, persons receive acute and chronic physical health care, behavioral health care, and LTSS/HCBS in a collaborative way. A care coordinator helps them schedule appointments and learn about their options. That way, they can make informed decisions about their health care and custodial needs.

CHOICES eligibility and enrollment

Recipients new to TennCare and CHOICES

The Tennessee Area Agencies on Aging and Disability (AAAD) is the Division of TennCare's Single Point of Entry (SPOE) for recipients new to both TennCare and CHOICES. The AAAD intake staff checks whether CHOICES can meet a person's medical, behavioral and LTSS/HCBS needs where they live. If the individual does not qualify for CHOICES, the person may appeal based on TennCare Rule 1200-13-13-.11.

Refer an individual for the CHOICES Program by calling the AAAD in the individual's area. AAAD offices are listed on tn.gov > Residents > Children and Families > TennCare > Long-Term Services & Supports > **CHOICES**.

If the person is already covered by TennCare and assigned an MCO, contact the assigned MCO to request assessment for CHOICES.

Individuals new to CHOICES

Refer individuals for CHOICES screening by calling the Case Management Assistant (CMA) unit at **1-800-690-1606**. If the person is not eligible for CHOICES, the CMA tells the individual about their right to appeal based on TennCare Rule 1200-13-13-.11.

If the person passes the screening, the CMA makes a referral to a care coordinator. This coordinator completes a comprehensive assessment, Person-Centered Support Plan (PCSP) and risk assessment. The care coordinator submits the request to the Division of TennCare and DHS for enrollment into CHOICES.

CHOICES groups

CHOICES has 3 groups. Each has its own eligibility requirements, enrollment process and benefits. CHOICES individuals qualify for only 1 group:

- Group 1: Medicaid members of all ages who receive Medicaid-reimbursed care in a nursing facility
- Group 2: Persons age 21 and older with physical disabilities and those age 65 and older who:
  - Meet the nursing facility level of care (LOC)
  - Quality for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group
  - Need and are receiving CHOICES HCBS as an alternative to nursing facility care
- Group 3: Persons age 65 and older and adults age 21 and older with physical disabilities who:
  - Qualify for TennCare as SSI recipients
  - Do not meet the nursing LOC but are at risk for NF care without CHOICES HCBS as defined by the state

Find more information at tn.gov > Long-Term Services and Supports > CHOICES > **To Qualify for CHOICES**.

CHOICES benefits

Choices individuals receive the same benefits as all other TennCare-covered persons. For a list of TennCare benefits, see Chapter 3 in this manual. The following LTSS are available to CHOICES persons when medically necessary.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care (Group 1 covered persons, who are residents in a NF, may receive skilled and/or custodial services as provided by the facility, without requirement for additional authorization.)	X	short-term only - up to 90 days	short-term only - up to 90 days
Community-based residential alternatives		X	Specified CBRA services and levels of reimbursement only.[1]
Personal care (up to 2 visits per day at intervals of no less than 4 hours between visits)		X	X
Attendant care (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2,080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
Inpatient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

The Division of TennCare is solely responsible for the addition or deletion of any service or supply.

[1] CBRAs for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)

CHOICES consumer direction

A CHOICES-covered person may hire someone to provide one or more eligible HCBS. A consumer-directed worker cannot include an agency employee we pay to provide HCBS to the person. The worker may provide attendant care, personal care, in-home respite, companion care and/or other services specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) the provision of such services (i.e., the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed services). Call **1-877-224-0219** for more information.

CHOICES cost neutrality cap

The cost of providing care to a CHOICES Group 2 person cannot be more than nursing facility services. The level of services provided is based on the person's needs as well as whether family and other caregivers can meet those needs. The cost neutrality cap is the maximum level of service that can be provided in the community to those with high levels of need and little support.

The person may not exceed the cap and remain in Group 2. If the person's needs cannot be safely met without exceeding the cap, a care coordinator helps the individual transition to Group 1 for nursing home placement.

Expenditure cap

For CHOICES Group 3 persons, the annual limit on expenditures for HCBS is $18,000. This does not count home modifications, home health and private-duty nursing services.

Community living supports models

Community Living Supports (CLS) is a community-based residential alternative (CBRA) service for adults 65 and older and adults 21 and older with a physical disability enrolled in CHOICES. Two models are available: CLS and CLS Family Model.

CLS model

For up to 3 individuals living in a home of trained caregivers (other than the individual's family) who own or lease the home and who live onsite and support each resident's independence and integration into the community:

- CLS 1: For CHOICES persons who are mostly independent or who have family members and supports. They need limited intermittent CLS supports, less than 21 hours per week. The support staff must be on-call on 24 hours per day.
- CLS 2: For CHOICES persons who need minimal to moderate ongoing support. A primary staff member or other support staff must be on-call 24 hours per day.
- CLS 3: For persons who require support and supervision 24 hours per day

CLS family model

For up to 3 individuals living in a home trained caregivers own or lease who live onsite and support each resident's independence and integration into the community.

- CLS-FM1: For independent persons who need periodic CLS. A CLS family staff member must be on-call 24 hours a day if the caregiver is not on site for part of the day.
- CLS-FM2: For persons who require minimal to moderate ongoing support. A CLS staff member must be on-call 24 hours a day to assist, if needed.
- CLS-FM3: For persons who require constant support and supervision. The PCSP shows the number of hours the staff is required to care for the person.

The PCSP supports each person's choices and rights. Persons are responsible for room, transportation, and other community living expenses, similar to other CBRAs. For more information, call your provider advocate.

CHOICES assessment

Level of care assessment

For Group 1 persons:

- TennCare determines LOC for nursing facility (NF) services. This is based on the PAE submitted by the NF, AAAD or us, as applicable.
- We must authorize NF services based on LOC established by TennCare
- Submit any LOC changes to TennCare. LOC must be reassessed at least annually and with any change in functional status.

For Group 2 and 3 persons:

- TennCare determines initial LOC for CHOICES HCBS. This is based on the Pre-Admission Evaluation (PAE) submitted by AAAD or by us, as applicable.
- LOC must be reassessed by us at least yearly and with any change in functional status

Reassessment plan of care process

Each CHOICES person's care coordinator annually reassesses services provided to persons in the community home receiving HCBS Groups 2 and 3 and for NF residents (Group 1). They review the PCSP at least one time every quarter for persons receiving services in Group 2 and semi-annually for persons in Group 3 and Group 1.

CHOICES care planning process

Each CHOICES person's PCSP details the amount, frequency, length, and scope of each service needed to support the person in the least restrictive LOC possible. When developing the PCSP, the care coordinator considers needs identified during the face-to-face visit and the assessments, the care plan to address those needs, the execution of the plan, and advocacy for the person.

For persons in CHOICES Group 1, the person's care coordinator may:

- Use the plan of care the NF created
- Based on person's needs, supplement the plan of care by developing and implementing strategies to improve health, increase and/or maintain functional abilities to improve quality of life.

For CHOICES Groups 2 and 3, the care coordinator facilitates a care planning team. The care coordinator seeks input from the individual, their representative or other individuals the person says may help with needs assessment and care planning. The care coordinator also consults with the person's PCP and other care providers as needed and documents the results in the PCSP. They also help ensure the person or their representative reviews, signs and dates the plan and any future updates.

Contacting the CHOICES care coordinator

Changes in condition for Group 1 include:

- Recurring falls
- Incident, injury, or complaint
- Report of abuse or neglect
- Reportable event
- Frequent emergency department use and hospitalizations
- Any physical, medical, functional or behavioral change that results in a needed reassessment of the person served

For Groups 2 and 3:

- Change of residence or primary caregiver
- Significant change in health and/or functional status
- Loss of mobility
- An event that significantly increases the perceived risk to a person.
- Individual has been referred to Adult Protective Services (APS) because of abuse, neglect, or exploitation
- Any physical/medical/functional/behavioral change or circumstance that results in reassessment

Also contact care coordinators about:

- Skin integrity issues
- Behavioral health issues
- Hospice election
- Outpatient therapies including PT/OT/SP/RT

Contacting the CMA

Contact a care management associate (CMA) if any of the following occur:

- Inability to contact person
- Person unexpectedly leaves their residence
- Person is admitted to the hospital
- Therapeutic leave requests (NFs only)
- Death of a person served
- Electronic Visit Verification (EVV)-related issues or questions, such as manual confirmations, timesheets, schedule deviations, demographic updates (address/phone number)

Reach a CMA by calling **1-800-690-1606**.

Service authorizations

We do not require a treating physician to order HCBS. However, the care coordinator may consult with the treating physician regarding the person's physical health, behavioral health, and LTSS needs. For questions about authorizations, call CMA at 800-690-1606.

CHOICES patient liability

Patient liability is a monthly amount that persons receiving Medicaid LTSS services (NFs or HCBS) must pay toward the cost of their care. We deduct patient liability for Group 2 and Group 3 individuals living in a CBRA. We pay the facility net of this total. We collect patient liability from CHOICES Group 2 and Group 3 persons who receive CHOICES HCBS in their home. This includes persons receiving short-term NF care, adult day care services, and those from Group 2 receiving companion care.

LTSS care provider responsibility

Service requirements for HCBS providers

- Offer services based on the PCSP. This includes the amount, frequency, duration and scope of each service in accordance with the PCSP service schedule
- Use the EVV Tablet assigned to the individual. If the EVV Tablet is unavailable, you may use a Bring Your Own Device (BYOD – SMART Device with the HealthStar EVV App) or Telephony (using the individual's phone).
- If you use EVV, monitor and immediately address service gaps. This includes personal care, attendant care, in-home respite, and home-delivered meals. All other HCBS providers should file claims electronically on a UB-04 form.
- Help ensure the number of monthly late and missed visits are not more than 10% of total scheduled visits for that month. We pursue corrective action if the result is greater.
- Help ensure monthly manual confirmations are not more than 10% of the number of total scheduled visits for a month. We pursue corrective action if the result is greater.
- Include the following if you have to enter a manual sign-in confirmation as well as a timesheet:
  - Name of the member receiving services
  - Signature of the member or authorized representative
  - Type of service rendered
  - Time services were rendered/duration of care, including AM/PM designation
  - Date services were rendered
  - Tasks performed: if a number is used, include a key
  - Name of caregiver performing services
  - Signature of caregiver performing services
  - Name or logo of provider submitting timesheet
- Manage and monitor late and missed visits by addressing care provider-initiated late or missed visits. Late and missed visits due to provider-initiated reasons should be worked on the Late/Missed Appointments Dashboard in EVV within 7 days.
  - For example, if a visit is late due to scheduling issues, please select Staff Scheduling Issue from the Reason Code drop-down menu.
  - If a visit is missed due to insufficient staff, please select Insufficient Staff to Provide Service.
  - For all missed visits, please select a Resolution Status from the drop-down menu to notify us the visit was or was not made up, or if a back-up plan was Initiated.
  - Schedule deviations – when the member requests to reschedule a visit either later in the

day or another day in the same week (as long as the visit does not overlap with another visit already scheduled), please submit a Schedule Deviation Request using an appropriate Member Rescheduled Reason from the drop down menu.
  - When the member requests to cancel a visit or is unavailable at the time of the visit, please submit a Schedule Deviation Request using an appropriate Member Canceled Reason from the drop down menu.
- Do not ask persons to receive services. This includes:
  - Referring an individual for CHOICES screening with the expectation that the care provider will be selected by the person as the CHOICES service provider
  - Asking the CHOICES persons by phone, in person, or written communication to change CHOICES providers
- If a person is admitted to the hospital, notify us using fax forms. NFs should use the Nursing Facility Discharge/Transfer/Hospice form. HCBS providers should use the Nursing Facility Discharge/Transfer/Hospice form.
- Comply with critical incident reporting and management requirements. Comply with Reportable Events Management (REM) when that method is implemented.
- Work with the person's care coordination team to provide a copy of the PCSP. Each care provider must sign the PCSP and agree to provide the services as described. We accept electronic signatures.
- When recredentialing, include verification of continued licensure and/or certification as well as compliance with policies and procedures identified during credentialing. This includes:
  - Background checks and training requirements
  - Critical incident reporting and management
  - EVV use
  - Compliance with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5). We verify compliance
- For new care providers, complete the HCBS self-assessment with necessary policies, procedures and transition plans. The credentialing process will not proceed until the self-assessment has been submitted and approved by us.
- Provider advocates conduct onsite assessments with each HCBS provider. They also request copies of the documents submitted to satisfy the HCBS self-assessment. If changes are needed after the documents are submitted, the HCBS provider must disclose them.

Service authorization requirements and processes

We authorize NF services based on approved PAE based on TennCare standards. NFs receiving an individual transferred from another facility must complete a Nursing Facility Discharge/Transfer/Hospice Form and fax it to us. HCBS providers may review authorizations using the EVV System.

NFs send us the authorization request for ventilator weaning, chronic ventilator care, sub-acute tracheal suctioning or tracheal suctioning secretion management. They must indicate whether the ERC service is in addition to standard NF services.

If we submit an LOC application to TennCare for a person in a NF, the care coordinator notifies the NF within 2 business days. They provide a copy of the application to the NF.

Enhanced respiratory care oversight

We contract with Eventa, LLC to provide quality oversight for enhanced respiratory care (ERC). ERC refers to enhanced levels of care in a NF. This includes chronic ventilator care, ventilator liberation and weaning and tracheal suctioning.

Eventa conducts on-site reviews with respiratory care practitioners to monitor the quality of care provided to each person receiving services at a facility. They also provide training at the facilities licensed by Tennessee Department of Health, Health Care Facilities.

CHOICES critical incident reporting

We require participating CHOICES providers to report all critical incidents that occur in a home and community-

based LTSS delivery setting. Settings include assisted-living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a person's home (if the incident is related to HCBS). Critical incidents for a CHOICES person include:

- Unexpected death
- Suspected physical, sexual or mental abuse or neglect
- Theft
- Severe injury
- Financial exploitation
- Medication error

You must contact a regional Clinical Quality Analyst (CQA) with a verbal report within 24 hours of their knowledge of the incident. The report must include:

- The person's name and date of birth
- Date and time of incident
- A brief description of the incident, person's current condition
- Actions taken to mitigate risk to the person

If the incident involves abuse, neglect, or financial exploitation, report the incident to APS. A Critical Incident Reporting Form must be submitted to us, by fax or secure email no later than 48 hours following the discovery of the incident.

You must cooperate fully in the investigation of CHOICES critical incidents, including submitting all requested documentation. If the incident involves an employee of an HCBS provider, also submit a written report including actions taken within 20 calendar days of the incident. To protect the person's safety, also immediately take the following actions:

- Remove accused worker from servicing all TennCare CHOICES persons until the investigation is complete. The investigation may take up to 30 calendar days.
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview involved employees as soon as possible following the incident. Have the employee submit a written account of the events. Fax these written accounts to us along with documentation to support completion of pre-employment screenings (i.e., background checks, drug screening, and a statement that the employee did not begin to perform services for CHOICES persons until all required pre-employment screenings were completed and verified).

Based on how severe the incident is, any identified trend or failure on the part of the care provider to cooperate with the investigation requires them to submit a written plan of correction to address/correct any problem or deficiency. Not submitting a written plan of corrections within the time frame requested and subsequent problems or deficiencies surrounding critical incident reporting, investigations or cooperation of the care provider can and will result in further actions. This includes closed panels and contract termination. The CHOICES Critical Incident Reporting Form is on UHCprovider.com/tncommunityplan > Provider Forms, Resources and References > **CHOICES Critical Incident Reporting Form**.

We provide 2 training videos that give an overview of critical incident reporting and investigation on vtsinxpo.com (video **1**, video **2**). HCBS providers must view the videos at least annually.

HCBS

We require the following from HCBS providers:

- Sign the PCSP. The person's care coordination team must provide a copy of the person's completed PCSP. This includes any updates to the person, their representative, the person's community-based residential alternative provider and other providers authorized to deliver their care. Electronic signatures cannot be accepted.
- Complete the credentialing process. We recredential HCBS providers by verifying continued licensure and/or certification. We check for compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, use of the EVV, and compliance with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5).

We require that all CHOICES HCBS providers comply with the HCBS Settings Rule and complete the HCBS self-assessment with accompanying policies, procedures and transition plans. These items are on **tn.gov**. The credentialing process is not complete until we approve the full self-assessment. If you have already submitted a completed HCBS self-assessment, we will request a copy.

Provider advocates will conduct onsite assessments with each HCBS provider and request copies of the documents submitted. The HCBS provider must notify us of any changes following submission.

CHOICES claims filing tips

Billing for nursing facility room and board services

For non-EVV services, submit an electronic or paper claim. You may send UB-04 claims through your EDI vendor. You may also use Office Ally. Learn more at cms.officeally.com.

HCBS claims submissions

EVV:

- Attendant care
- Home-delivered meals
- In-home respite
- Personal care

Usage and dedicated resources

You must have at least 2 staff members trained on the EVV system who can train caregivers to use the device in a person's home. You must have at least 1 staff person monitoring caregiver activity. Monitoring needs to include ensuring caregivers are in the person's home providing services at the scheduled time agreed upon when the referral was accepted.

You must comply with these standards to help ensure persons receive timely services. Not complying will result in disciplinary action, which may include termination from the network.

Claims for group transitions

- If a transitioning person is enrolled in CHOICES Group 1, they must complete CHOICES HCBS before they move from a NF to the community. CHOICES HCBS is billed as Group 2 services once the person is enrolled into that group, with the date of service as the effective date of enrollment in CHOICES Group 2.
- If a transitioning person is enrolled in CHOICES Group 2 or 3 but is receiving short-term NF care, they must complete CHOICES HCBS before they move from an NF to the community. CHOICES HCBS are billed as a Group 2 or Group 3 service, as applicable. However, a person shall not be transitioned from CHOICES Group 1 into Group 2 or 3 for receipt of short-term NF services to provide them. Short-term NF care is available only to a CHOICES 2 or CHOICES 3 persons receiving home and community-based services upon admission to the short-term NF stay.

Corrected claims

When altering claims for resubmission, use a "7" frequency in the appropriate bill type. Also indicate the claim number you are correcting in FL 64.

EVV registration

The EVV system was developed with providers who deliver services to CHOICES members in mind. It features:

- Flexible schedule deviation
- Electronic schedule requests
- Managed care organization communication within the EVV system
- Auto assignment of a worker at a visit
- An actionable dashboard

The new EVV process was created as a result of new requirements:

- The ability to log the arrival and departure of a provider's staff person through a static GPS device provided to the member for this program
- The ability to capture the arrival and departure of a provider's staff person through the member's phone number if a GPS device fails
- The ability to verify based on business rules that services are delivered in the correct location (e.g., the member's home)
- The ability to verify the identity of the individual provider staff person or worker providing the service to the member

Flexible scheduling for TennCare's CHOICES and ECF CHOICES

All CHOICES and Employment and Community First (ECF) CHOICES persons may schedule services on a flexible plan. TennCare uses the flexible scheduling option to give persons access to services at their convenience.

We encourage individuals to work with care providers to schedule services 2 weeks before the time that works best for the person. The person's care or coordinator adds the appointments to the PCSP.

Care providers who don't have appointments scheduled 2 weeks in advance should contact the person.

A flexible schedule might not be appropriate for members who require services at consistent times and days.

Enter the appointments into the HealthStar EVV system as usual. You may not be able to enter the appointments as early when a person is using a flexible schedule. They may enter the appointment schedule into the Healthstar EVV portal before the shift is worked so staff can check in and out.

We offer training and more information at UHCprovider.com/tncommunityplan > **Training and Education**.

Discharge guidelines

Nursing home/LTSS facilities

LTSS facilities participating in Medicaid must comply with the following guidelines for transfers, discharges, and/or readmissions.

A LTSS facility must permit each resident to remain in the facility. They must not transfer or discharge the resident from the facility unless:

- Resident's needs can no longer be met in the facility. Those needs are necessary to resident's well-being.
- Through the Nursing Facility Diversion Plan, eligible persons are transitioned from an NF to the community when the resident's health and well-being has drastically improved and the level of services provided is no longer needed.
- The resident's safety and health is endangered at a facility
- The resident cannot meet their financial responsibilities for the facility
- Facility is no longer operational

The order must come directly from a physician. If a resident becomes eligible for assistance under Title XIX after admission to the facility, only the charges which may be applicable under Title XIX are covered.

When a patient is transferred, the care coordinator provides a summary of treatment given at the facility. The summary lists the condition of the patient at time of transfer, and date and place to which transferred. If an emergency caused the transfer, this information is recorded within 48 hours. Otherwise, it will slow the transport.

When the facility transfers a person, it sends a copy of the clinical summary to the care coordinator and to the LTSS facility that will continue their care.

Before transferring or discharging a resident, a LTSS facility must:

- Notify the resident (and their representative, if needed) of the transfer or discharge and the reasons
- Record the reasons in the resident's clinical record (including any documentation) and include in the notice the items described
- Notify the Department of Health Division of Health Care Facilities and the long-term care ombudsman
- Wait to transfer or discharge a resident until the agencies have designated their intention to intervene and until any appeal process is complete, if needed
- Discharge a person from your services if you cannot meet the person's needs and/or preferences. Send a certified letter to the person, or the person's power of attorney, directing them to contact their care coordinator for help selecting a new care provider. You must continue providing care for at least 30 business days or until the person is assigned to the new care provider.

  Mail to:
  UnitedHealthcare Community Care
  Attn: LTSS Provider Relations Team
  10 Cadillac Drive, Ste #200
  Brentwood, TN 37027

You must contact the care coordinator as quickly as possible to advise them when the dismissal starts.

The notice must be provided at least 30 calendar days before the resident's transfer or discharge except if:

- Resident's safety and health is in danger
- Resident's health or needs have improved and through the Nursing Facility Diversion Plan. The resident will transition from the NF to the community.
- Resident's medical needs require an immediate transfer
- Resident has not resided in the facility for more than 30 calendar days

With these exceptions, notice must be given in as soon as possible before the date of transfer or discharge. Include the following in the pre-transfer and pre-discharge notice:

- Notice of the resident's right to appeal the transfer or discharge if transfers or discharges were affected on or after Oct. 1, 1990
- The name, mailing address and phone number of the long-term care ombudsman
- In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals
- In the case of mentally ill residents, the mailing address and phone number of the agency responsible for the protection and advocacy system for mentally ill individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
- A LTSS facility must provide sufficient preparation and orientation to residents to help ensure safe and orderly transfer or discharge from the facility

HCBS

Reasons for discharge from HCBS:

- Plan of care change
- Person or family request that services stop
- Transitioned to Group 1
- Loss of eligibility in the CHOICES Program
- Person is not receiving ongoing monthly HCBS service In these cases, we:
  - Fax notification of stopping services to the HCBS provider
  - Mail a letter notifying the person of service changes if required by the Grier Consent Decree

Notify the person in writing by certified mail 60 days prior to discharge. Also submit the notice to us at tn_ltc_choices_cma@uhc.com or fax to **1-888-582-1963**. Include the reason for discharge, such as:

- Environment not safe for you to provide services
- You cannot meet the person's level of service
- Person or family request you stop services

TennCare regulatory requirements appendix

Find more requirements in the TennCare Regulatory Requirements Appendix on **UHCprovider.com**.

Reportable events management for CHOICES

CHOICES providers will follow the Critical Incidents process for reporting all reportable events as outlined below.

Critical incidents for CHOICES are defined as such if after the investigation of an allegation of abuse, neglect or exploitation, the allegation is substantiated for a specific staff worker; and/or after investigation or review (as applicable) of a reportable event other than an allegation of abuse, neglect or exploitation, there is a determination that the CHOICES provider, provider staff, and/or MCO/MCO staff could have and should have done something differently in order to prevent the reportable event or reduce the negative consequences of that event on the member and/or others involved.

Reportable event management (REM) is an important component of an overall approach for assuring the health, safety and welfare of members participating in. REM in CHOICES has been designed in partnership with TennCare, the Department of Intellectual and Developmental Disabilities (DIDD) and managed care organizations, and with input from HCBS providers.

There are important differences between the REM system for CHOICES and the Protection from Harm system in place for current HCBS waivers for individuals with intellectual and/or developmental disabilities. One notable difference is that consistent with expectations set forth in the HCBS Settings Rule, person-centered planning in CHOICES is intended to identify and mitigate risk of harm, while not placing unnecessary restrictions on the freedom and choices of members, nor preventing opportunities for members to achieve increased independence and autonomy as they participate fully in community life.

Staff providing HCBS supports in CHOICES are accountable for ensuring the supports are provided in accordance with each member's person-centered support plan (including the implementation of strategies identified to help mitigate risk), but should not be held responsible if, in spite of appropriate supports

and implementation of appropriate and reasonable risk mitigation strategies, an untoward event occurs. This distinction supports the CHOICES programmatic commitment to embrace dignity of risk and recognizes that the normal risk-taking in life is essential for personal growth and development, and for maximizing quality of life. CHOICES is designed to balance health and safety with happiness, to ensure members achieve the best possible employment and community living outcomes and overcome low expectations through opportunities to develop and use the gifts, skills and capacities they have to achieve unique and fulfilling lives.

Reportable events and requirements

In CHOICES, there are 3 tiers of reportable events. The type of reportable event dictates the reporting requirements and process that must be followed by the provider, MCO and DIDD (if applicable).

The following table identifies the 3 tiers of reportable events as well as nonreportable events:

Tier 1 Reportable Events	Tier 2 Reportable Events	Tier 3 Reportable Medical Events	Tier 3 Reportable Behavioral Events	Nonreportable Events
• Any incident involving allegations, suspicions, or evidence of any form of Abuse, Neglect or Exploitation including Misappropriation of Property. For purposes of this section, abuse, neglect, and exploitation will be defined as in TCA 33-2-402 and implemented as specified in TennCare protocol. • Sexual abuse includes sexual battery by an authority figure as defined in TCA 39-13- 527; • All unexpected or unexplained deaths, including suicide. • A suspicious injury where abuse or neglect is suspected, or the nature of the injury does not coincide with explanation of how the injury was sustained; • Serious injury, including serious injury of unknown cause; For purposes of this section, serious injury is any injury requiring medical treatment beyond first aid by a lay person, and includes, but is not limited to: fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples, or dermabond; torn igaments (e.g., a severe sprain) or torn muscles or tendons (e.g., a severe strain) requiring surgical repair, second and third degree burns, and loss of consciousness.	• Allegations that provider personnel (employees, volunteers) engaged in disrespectful or inappropriate communication about a member e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) , or any other similar acts that do not meet the definition of emotional or psychological abuse, and which are directed to or within eyesight or audible range of the member (we will include such complaints in our nondiscrimination reporting pursuant to A.2.30.22.3.2.1). • Member whose whereabouts are unknown and could likely place him/her in a dangerous situation for self or others. This event is reportable if the whereabouts of the member are unknown for 60 minutes or more if the absence is unusual, unless a shorter time is specified in the member's PCSP or Behavior Support Plan (BSP), or the absence is a known risk as specified in the member's PCSP or the BSP. Reporting that a member's whereabouts are unknown is in addition to, and not a substitute for or priority over, actively looking for the member and contacting law enforcement if necessary.	• Deaths (other than those that are unexpected or unexplained) • ER visits • Any inpatient observation or admission (acute care, long-term acute care, skilled nursing facility/ nursing facility) • Use of CPR or an automated external defibrillator • Choking episode requiring physical intervention (e.g., use of abdominal thrust or Heimlich maneuver) • Fall with injury (including minor or serious) • Insect or animal bite requiring treatment by a medical professional • Stage II and above pressure ulcer • Staph infection • Fecal impaction • Severe dehydration requiring medical attention • Seizure progressing to status epilepticus • Pneumonia • Severe allergic reaction requiring medical attention • Victim of natural disaster (Natural disasters affecting multiple members do not require multiple individual reports.)	• Criminal conduct or incarceration • Engagement of law enforcement • Sexual aggression if not specifically being addressed through a BSP or if being addressed in BSP but instance of sexual aggression is considered new or unusual for the member • Physical aggression if not being addressed through a BSP or if being addressed in BSP but instance of physical aggression is considered new or unusual for the member • Injury to another person because of a behavioral incident of a member • Suicide attempt • Self-injurious behavior if not specifically being addressed through a BSP or if being addressed in BSP but instance of self- injurious behavior is considered new or unusual for the member • Property destruction greater than $100 • Swallowing inedible/ harmful matter if not specifically being addressed through a BSP or if being addressed in BSP but instance of swallowing inedible/harmful matter is considered new or unusual for the member	• Minor injury, not previously identified and not requiring medical treatment • Staff misconduct that falls outside the definitions for tier 1, 2 or 3 reportable medical and behavioral events, and does not result in serious injury or probable risk of serious injury (e.g., not following the PCSP/BSP/dinin g plan when such action or inaction would not pose a probable risk of serious injury, staff convenience or minor traffic violation while transporting member) • Failure to provide goods or services when such failure does not result in injury or probable risk of serious harm (i.e., does not meet neglect threshold) • Allegations that provider personnel (employees, volunteers) engaged in disrespectful or inappropriate communication (e.g., humiliation, harassment, threats of punishment or deprivation, intimidation, or demeaning or derogatory communication vocal, written, gestures , or any other similar acts that do not meet the definition of emotional or psychological abuse and which are not directed to or within eyesight or audible range about a member)

Tier 1 Reportable Events	Tier 2 Reportable Events	Tier 3 Reportable Medical Events	Tier 3 Reportable Behavioral Events	Nonreportable Events
• Theft by provider personnel (employees or volunteers) of more than $1,000 (Class E felony). • A serious traffic violation with significant risk of harm (e.g., reckless, careless, or imprudent driving; driving under the influence, speeding in excess of fifteen (15) miles per hour over the speed limit). • Medication error, which results in the need for face-to-face medical treatment based on injury or probable risk of serious harm, including physician services, emergency assistance, or transfer to an acute care facility for stabilization. Such errors will include: (1) medication omission; (2) administering the wrong drug; (3) administering the wrong drug dosage; (4) administering the drug to the wrong member; (5) administering the drug at the wrong time; (6) administering the drug at the wrong rate; (7) administering the drug following improper or inadequate preparation; or (8) administering the drug via the incorrect route	• Member will have the freedom to come and go without staff supervision, except when such restrictions are necessary to ensure their health and safety or the safety of others, which must be documented in the PCSP. • Minor vehicle accident resulting in an injury that does not require face-to-face medical treatment by someone other than a lay person. • Victim of fire. • Medication variance resulting in the need for observation, but which does not require any face-to- face medical treatment (including treatment by provider's trained medical staff, physician services, emergency assistance or transfer to an acute inpatient facility for stabilization) because there is no injury or probable risk of serious harm Such variances will include: (1) medication omission; (2) administering the wrong drug; (3) administering the wrong drug dosage; (4) administering the drug to the wrong person; (5) administering the drug at the wrong time; (6) administering the drug at the wrong rate; (7) administering the drug following improper or inadequate preparation; or (8) administering the drug via the incorrect route.		• Behavioral crisis requiring protective equipment, manual or mechanical restraints, regardless of type or time used or approved by PCSP (all take-downs and prone restraints are prohibited) • Behavioral crisis requiring as needed psychotropic medication • Behavioral crisis requiring crisis intervention/ call • Behavioral crisis requiring in-home stabilization (SOS participants only) • Behavioral crisis requiring out-of- home therapeutic respite • Psychiatric admission (or observation), including an acute care hospital	

Tier 1 Reportable Events	Tier 2 Reportable Events	Tier 3 Reportable Medical Events	Tier 3 Reportable Behavioral Events	Nonreportable Events
	• Unsafe environment (cleanliness/ hazardous conditions not otherwise expected to normally exists in the environment). • The use of manual or mechanical restraint or protective equipment approved for use in the member's PCSP or BSP, but used incorrectly or in a manner other than intended. Reportable Events determined to be outside of an approved PCSP or BSP or intentionally inappropriate or in violation of guidelines specified in the member's PCSP or BSP will be referred to DIDD as a Tier 1 Reportable Event. • The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of belongings or money valued between $250 and $1,000 (i.e., less than the threshold for misappropriation).			

Both you and we will be responsible for tracking and trending all reportable events and for evaluating the nature, frequency, and circumstances of reported events to determine how to prevent or reduce similar occurrences in the future when possible. Such efforts may be targeted to an individual person, a particular service setting or location or a particular type of event; for us this can be targeted to a particular provider or system wide.

Nonreportable events include circumstances which do not rise to the level of a reportable event, but which you are expected to document, address, track and trend because of the potential to impact safety and quality of care and will be reviewed as part of ongoing quality monitoring efforts by the DIDD and/or UnitedHealthcare Community Plan, as applicable.

UnitedHealthcare Community Plan, Fiscal Employer Agent (FEA) and your staff must immediately report all instances of suspected abuse, neglect and exploitation of members who are adults in accordance with the applicable federal and state laws, including Tenn. Code Ann. § 71-6-103. Suspected brutality, abuse or neglect of members who are children must be immediately reported in accordance with the applicable federal and state laws, including Tenn. Code Ann.§ 37-1-605 and§ 37-1-401-414.

The following are additional reportable event reporting requirements:

All reportable events witnessed or discovered by CHOICES providers/staff, will be reported by your event management coordinator (EMC) or designee to DIDD and us via data exchange within the required time frame

All reportable events involving CHOICES members occurring within HCBS settings are reportable when the

member supported is receiving any CHOICES benefit in the setting in which the event occurred - regardless of whether the event occurs during the provision of services.

All reportable events, provider oversight and documented occurrences reported to DIDD/ UnitedHealthcare Community Plan by the member, caregiver, family member or citizen/friend will be documented by DIDD or UnitedHealthcare Community Plan, as applicable. A CHOICES Reportable Event Report Form will be generated within suggested timeframe of the event type (Tier 1 and Tier 2 REF should be generated within 1 business day, and Tier 3 REF will be generated within 2 business days) and will follow the process for investigations. The receiving entity (DIDD or UnitedHealthcare Community Plan) will be responsible for submitting the completed CHOICES Reportable Event Report Form to the other entity. The provider Incident Management Coordinator (IMC) or designee will be notified of the reported event by close of the next business day via data exchange.

Tier 1 reportable events

- Tier 1 reportable events must initially be reported to DIDD via telephone within 4 hours of witness or discovery of the event
- The CHOICES provider and the UnitedHealthcare Community Plan SC will not move forward with an internal review if a Tier 1 reportable event has been reported
- The CHOICES provider's IMC or designee will submit a written CHOICES Reportable Event Report Form via data exchange to both DIDD and UnitedHealthcare Community Plan by close of the next business day of witness or discovery
- All Tier 1 reportable events will be reported to TennCare by DIDD within 24 hours of receipt via data exchange
- DIDD is the entity for investigating all Tier 1 reportable events
- DIDD will notify you of its intent to investigate, and instructions for removing staff within 24 hours of receipt of the reportable event
- DIDD will communicate with you to obtain any additional information needed to support a Tier 1 reportable event
- DIDD will notify UnitedHealthcare Community Plan via data exchange by close of the next business day of its occurrence that the event appears to meet Tier 1 criteria, as well as its decision on whether to investigate due to the evidence obtained.
  If DIDD determines that the reportable event is not Tier 1:
  - DIDD will amend the CHOICES Reportable Event Report Form and send it to the you and us via data exchange by the close of the next business day
  - DIDO will send any supporting documentation to us via data exchange
  - We will follow established processes for Tier 2 reportable events. Our timeliness will begin the day we receive the amended CHOICES Reportable Event Report Form and supporting documentation.
- DIDO will complete its investigation within 30 days of notification of the event. If the investigation is not completed within 30 days due to uncontrollable circumstances (e.g., a law enforcement investigation is ongoing or there are difficulties obtaining medical documentation) and not solely for staff convenience, DIDD may utilize an extension period of up to 30 additional days for completion of the investigation. DIDD will notify us via data exchange of the extended period.
- DIDD provides their reportable event investigation report within no more than 7 days of completion of the investigation via data exchange. DIDD will simultaneously submit notification of a referral to the Abuse Registry Referral Committee, if substantiated.

We will review all Tier 1 reportable events investigations for potential quality of care issues and subsequent action will be taken by us per established policy.

Tier 2 reportable events

- CHOICES provider's IMC or designee will submit a written CHOICES Reportable Event Report Form via data exchange to both DIDD and us by close of the next business day of witness or discovery
- UnitedHealthcare Community Plan will be responsible for reviewing all Tier 2 reports for completeness and to ensure the event has been appropriately identified as a Tier 2 event and doesn't need to be escalated to Tier 1. Any necessary follow-up with the CHOICES provider will be completed.

- CHOICES providers are responsible for conducting investigations of Tier 2 events
  - The completed investigation must be submitted to us within 14 calendar days of written notification of the Tier 2 reportable event
  - If there are extenuating circumstances beyond your control, you may submit one 7-day extension request to us. If the request is granted, the investigation will be completed and submitted to us within 21 calendar days of written notification of the Tier 2 reportable event.
- We will review the investigation report, and by no more than the 30th calendar day following written notification of the Tier 2 reportable event, will advise the provider if the investigation is accepted or if we will conduct additional review
  - If additional review is needed, we will complete the review in no more than 14 calendar days following written notification. We may request from TennCare 1 7-day extension only upon extenuating circumstances beyond the health plan's control, and will issue its findings to the provider no later than 30 calendar days following such written notification, including any actions that will be taken by us pertaining to the reportable event or the provider's investigation. This may include, but is not limited to, sanctions (e.g., a corrective action plan) and/or referral to the UnitedHealthcare Community Plan quality management review committee.
- We must submit all reportable data including actions taken for Tier 2 reportable events to DIDD within 7 days of notification to the provider, for purposes of tracking and trending
- If at any time during the review the information obtained by UnitedHealthcare Community Plan supports a Tier 1 (rather than Tier 2), we will:
  - Notify DIDD immediately (notification should be made to DIDD via telephone to the appropriate hotline number in the corresponding region)
  - Amend the CHOICES Reportable Event Report Form and send any supporting documentation to DIDD by the close of next business day

DIDD timeliness for completing the investigation will begin the day DIDD receives the amended CHOICES Reportable Event Report Form and supporting documentation.

Tier 3 reportable medical and behavioral events

The CHOICES provider's IMC or designee will submit a written CHOICES Reportable Event Report Form to UnitedHealthcare Community Plan within 2 business days of witness or discovery.

All subsequent processes, including investigation, review, etc., will proceed as outlined herein.

CHOICES providers are required to immediately remove an employee or volunteer implicated in Tier 1 allegations of physical or sexual abuse from direct support to all CHOICES members until DIDD has completed their investigation, either by placing such alleged perpetrator on administrative leave or in another position in which they do not have direct contact with, or supervisory responsibility for, a member.

- Providers (i.e., the IMC or agency management, and not the alleged perpetrator) may request an exception to this requirement if:
  - They furnish evidence of consent from the legal representative of the alleged victim
  - The alleged perpetrator will not come into unsupervised contact with other members, and
  - Other conditions, such as increased supervision and unannounced visits to the home by provider management are undertaken. Such requests are reviewed and approved or denied expeditiously by DIDD director of investigations.
- DIDD investigator may also notify the provider that the alleged perpetrator may return to work or volunteer status, as applicable, based on a preliminary determination of false or frivolous allegation
- DIDD investigator will notify the provider that the alleged perpetrator may return to work or volunteer status, as applicable, as soon as possible upon determination that the allegation will not be substantiated (i.e., before the investigation report is completed)
- CHOICES agencies will determine, at their discretion and in accordance with their agency's policy whether to remove an employee or volunteer implicated in Tier 1 reportable events other than alleged physical or sexual abuse or Tier 2 reportable events from any or all direct support to CHOICES members until the agency has completed their

investigation and the completion of any corrective action (e.g., training) deemed appropriate, or whether modified assignment or increased supervision is needed during the investigation and corrective action period. The agency is expected to ensure that adequate steps are taken for the protection and safety of the victim and other members during the investigation process.

The following outlines the responsibilities and timeliness:

- Adult Protective Services (APS) –
  - Phone: **1-888-277-8366**
  - Fax: **1-866-294-3961**
  - **reportadultabuse.dhs.tn.gov**
- Child Protective Services (CPS) – **1-877-237-0004**
- DIDD 24/7 Investigations – **1-888-633-1313** for tier 1 reportable events only

DIDD will maintain a statewide system for tracking and trending all reported Tier 1 and Tier 2 reportable event data on at least a quarterly basis. Trending will include evaluating the nature, frequency, and circumstances of reported events in order to determine how to prevent or reduce similar occurrences in the future.

- All Tier 1, Tier 2 Tier 3 (and reportable medical and behavioral) events will be tracked and trended by us on at least a quarterly basis
- All Tier 1, Tier 2, Tier 3 (reportable medical and behavioral) events and nonreportable events will be tracked and trended by the CHOICES provider on at least a quarterly basis

CHOICES providers must cooperate with any investigation conducted by us or outside agencies (e.g., TennCare, DIDD, Adult Protective Services, Child Protective Services and law enforcement).

Abuse registry process

- An employee or volunteer for whom abuse, neglect or misappropriation of property regarding a member in CHOICES has been substantiated will be considered for placement on the state's Abuse Registry
- Such consideration will be performed by DIDD's existing Abuse Registry Review Committee (ARRC). (TennCare is a participating member of the ARRC.) DIDD will notify us when such consideration involves abuse, neglect or misappropriation of property of a UnitedHealthcare Community Plan CHOICES member.
- A UnitedHealthcare Community Plan representative will participate in the ARRC as appropriate
- Recommendation for placement of an employee on the Abuse Registry requires consensus between DIDD, TennCare and UnitedHealthcare Community Plan
- ARRC meeting minutes are maintained and will be provided to TennCare after each meeting
- DIDD will notify us of all administrative determinations regarding placement on the Abuse Registry

Our CHOICES Reportable Event Report Form and Tier 2 Provider Investigation Form can be found on our provider website at **UHCprovider.com/en/health-plans-by-state/tennessee-health-plans/tn-comm-plan-home/tn-cp-forms-refs.html.**

Chapter 7: CoverKids

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

CoverKids is a CHIP program authorized by Title XXI of the Social Security Act. Similar to Medicaid, CHIP is administered by the federal and state governments

CoverKids provides free, comprehensive health coverage for qualifying children younger than 19 years and for pregnant persons. Coverage includes:

- Preventive health services
- Provider services
- Hospital visits
- Vaccinations
- Well-child visits
- Developmental screenings
- Behavioral health care services
- Pharmacy
- Prenatal and postpartum care
- Vision
- Dental care

CoverKids does not cover any chiropractic, routine vision and dental care for pregnant persons 19 years and older. There are low co-pays for medical services, though well-child visits and immunizations are covered at 100%.

CoverKids covered persons may obtain a second opinion prior to undergoing an elective medical service. The second opinion is covered as long as the covered person sees a participating CoverKids network provider. If a network provider is not available, contact your provider advocate.

Coverage period

Children younger than 19 years determined eligible for CoverKids receive coverage for 12 continuous months except in the following cases:

- The child turns 19
- Coverage is voluntarily terminated
- The child is no longer a resident of Tennessee
- The State determines that eligibility wasn’t granted correctly at the most recent eligibility determination or renewal of eligibility because of either state error, fraud, abuse, or perjury attributed
- Death
- The child is determined eligible in a TennCare Medicaid category

Pregnant persons stay eligible for CoverKids benefits through a 60-day postpartum period. This period begins the last day of the pregnancy and ends on the last day of the month in which the 60-day period ends. This postpartum period is automatic and applicable to all pregnant persons who have applied, been determined eligible for and received CoverKids benefits with an effective date on or before the end of the pregnancy. The coverage period applies regardless of any change in household income and how the pregnancy ends.

Newborns

CoverKids benefits apply to infants not eligible for TennCare Medicaid when the TennCare Medicaid benefits apply to infants born to a CoverKids enrollee with household income at or below 195% of the FPL. Eligibility begins the date of birth.

Cost-sharing

CoverKids enrollees may be required to pay copays for covered services and pharmacy benefits.

Individuals with verified American Indian/Alaskan Native status receive additional cost-sharing benefits.

Please refer to the Contractor Risk Agreement, Attachment II at tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf for the non-pharmacy copayment schedule that applies to the following services:

- Hospital ER
- PCP and community mental health agency services for services other than preventive care
- Physician specialists
- Inpatient hospital admissions

Nonfinancial eligibility requirements

Individuals eligible for CoverKids must meet all nonfinancial eligibility requirements.

- A child must be younger than 19 years
- A child must be a U.S. citizen, U.S. national or eligible noncitizen. The unborn child of a pregnant person is presumed to be a U.S. citizen, regardless of the citizenship or immigration status of the parent.
- An individual eligible to receive a Social Security Number (SSN) must have and provide a valid SSN or proof of application for an SSN, unless they meet an exception. The individual must be a resident of Tennessee.
- TennCare accepts self-attestation of pregnancy at application or as a reported change, unless TennCare has information that doesn't match such attestation. In this case, TennCare will contact the individual. They may request written medical verification of the pregnancy.

Financial eligibility requirements

The Eligibility Determination Group (EDG) for CoverKids uses Modified Adjusted Gross Income (MAGI) to determine whether to cover individuals. Household members may have different household sizes when determining eligibility. When determining EDG size for a pregnant person, the pregnant person counts as themselves plus the number of children they are expected to deliver. When determining EDG size for other applicants in the household, the pregnant person is counted as 1 person.

Income standard

Individuals must have income at or below 250% FPL.

Sample determination

Ms. Wilson applied for medical assistance for her 10-year-old son. Ms. Wilson is employed with a net countable earned income of $3,000. Her before/pre-tax contributions total $150. The example budget is based on an EDG size of 2 and determines eligibility for the child with CoverKids Benefits Limits (effective Jan. 1 2021, as described in Contractor Risk Agreement on tn.gov).

Primary health insurance

CoverKids must be the individual's only health insurance plan. Health insurance plans include:

- Employer sponsored insurance
- COBRA
- Medicare
- TRICARE
- Peace Corps
- Other comprehensive medical coverage.

Individuals enrolled in a limited benefit policy will not be considered as enrolled in other insurance. A limited benefit policy is health coverage for a specific disease (e.g., cancer), an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

If the applicant is a pregnant person with health insurance, they may be eligible for pregnancy benefits if their health insurance does not cover pregnancy-related care.

Sample ID cards

Covered services and limits

Service	Benefit Limits
Ambulance Services, Air and Ground	As medically necessary.
Chiropractic Care	Children younger than 19 years: Maintenance visits not covered when no additional progress is apparent or expected to occur. Pregnant persons (age 10 and over) of eligible unborn children: not covered.
Clinic Services and other Ambulatory Health Care Services	As medically necessary.
Dental Services	Provided by the dental benefits manager (DBM). However, we cover the facility, medical and anesthesia services related to the dental service not provided by a dentist or in a dentist's office when the DBM covers the dental service.
Disposable Medical Supplies	As medically necessary. Specified medical supplies are covered/non-covered based on TennCare Division rules and regulations.

Service	Benefit Limits
Durable Medical Equipment (DME)	Must be medically necessary. DME and other medically related or remedial devices are limited to most basic equipment that will provide the needed care. Hearing aids are limited to 1 per ear per calendar year up to age 5; limited to 1 per ear every 2 years thereafter. Specified DME services are covered/non-covered based on TennCare Division rules and regulations.
Home Health Services	Prior approval required. Limited to 125 visits per enrollee per calendar year.
Hospice Care	As medically necessary. Provided by a Medicare-certified hospice.
Inpatient Hospital Services	As medically necessary, including rehabilitation hospital facility.
Inpatient Mental Health and Substance Abuse Services	As medically necessary
Lab and X-ray Services	As medically necessary
Outpatient Mental Health and Substance Abuse Services	As medically necessary
Outpatient Hospital Services	As medically necessary
Pharmacy Services	Pharmacy services are provided by the pharmacy benefits manager (PBM) unless otherwise described. We reimburse injectable drugs obtained in an office/clinic setting and to care providers providing both home infusion services and the drugs and biologics. All home infusion claims must contain National Drug Code (NDC) coding and unit information to be paid. Services we reimburse are not be included in any pharmacy benefit limits established by TennCare for pharmacy services (as described in Contractor Risk Agreement, A.2.6.2.2).
Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders	Limited to 52 visits per calendar year per therapy type
Physician Inpatient Services	As medically necessary
Physician Outpatient Services/ Community Health Clinic Services/ Other Clinic Services	As medically necessary
Prenatal care and pre-pregnancy family services and supplies	As medically necessary
Preventive Care Services	As described in Contractor Risk Section A.2.7.5
Skilled Nursing Facility services	Limited to 100 days per calendar year following an approved hospitalization
Surgical Services	As medically necessary

Service	Benefit Limits
Vision Services	Children younger than 19 years: Annual vision exam including refractive exam and glaucoma screening Prescription eyeglass lenses. Limited to 1 pair per calendar year. $85 maximum benefit per pair Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair. Prescription contact lenses in lieu of eyeglasses. Limited to 1 pair per calendar year. $150 maximum benefit per pair. Pregnant persons (age 19 and older) of eligible unborn children: medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

The plan will pay the allowable charge, per the contract, for medically necessary and appropriate services and supplies described below and provided in accordance with the reimbursement schedules. Charges in excess of the reimbursement rates set forth in your contract are not eligible for reimbursement or payment by us or by the enrolled person.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with our policies and medical management procedures.

Referrals are not required for specialty care, including well-woman care.

Chapter 8: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-800-690-1606
Healthy First Steps	uhchealthyfirststeps.com	1-800-219-3224
Value Add services	UHCCommunityPlan.com/tn View plan details	1-800-690-1606

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 covered persons. If you have questions or need to refer an individual, call Provider Services at **1-800-690-1606** unless otherwise noted.

Adult pain management/ chiropractic services

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

We provide individuals older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

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

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

Chronic condition management

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

Individuals at highest risk with conditions such as asthma, CHF, diabetes, COPD and CAD receive more intense health coaching. Resources and tools are available to support covered persons and caregivers with conditions common to children with special health care needs and help them manage their illness.

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

Healthy First Steps Rewards

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

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

How it works

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

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

How you can help

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

MTM pilot program

TennCare has a pilot program authorizing qualified Tennessee-licensed pharmacists to provide medication therapy management (MTM) services to eligible TennCare individuals. Participating pharmacists provide MTM under a collaborative practice agreement (CPA) with a TennCare Patient Centered Medical Home (PCMH) or Tennessee Health Link (THL).

Learn more about the MTM program at:

- tn.gov/tenncare > Providers > Pharmacy > Medication Therapy Management
- Care Coordination Tool at tn.gov/tenncare > Health Care Innovation > Primary Care Transformation > Care Coordination Tool. Care providers participating in PCMH and THL programs can use the tool to identify care opportunities linked to quality measures.

Reimbursement guidelines are in the provider manual posted to the TennCare MTM website. Email questions to the pilot team at TennCareMTMpilot@tn.gov.

Mobile apps

Available apps for covered persons include **Health4Me**. It enables users to review health benefits, access claims information and locate in-network providers.

NurseLine

NurseLine is available at no cost to our covered persons 24 hours a day, 7 days a week. Individuals 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 individuals about staying healthy. Call **1-866-600-4985** to reach a nurse.

Optum OB homecare

Optum OB home care program for 17P/ Makena®

17P/Makena® Administration Nursing and Care Management service helps improve weekly injection adherence and reduce preterm delivery. The person must meet criteria for 17P/Makena during current pregnancy.

17P/Makena requires prior authorization except for home services. To request prior authorization, use our Prior Authorization and Advance Notification tool at UHCprovider.com/paan. For more information, go to UHCprovider.com/policies > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > 17-Alpha-Hydroxyprgesterone Caproate (Makena and 17P) – Community Plan Medical Benefit Drug Policy.

Peer recovery coaching

Our peer support specialists (PSS) work with individuals to support recovery from behavioral health and/or substance use disorders (SUD). The PSS uses a strengths-based approach to help individuals develop a recovery plan. They help identify triggers and develop action plans to help individuals take responsibility for their recovery. Our clinical team identifies eligible individuals through inpatient behavioral health or SUD admissions.

The program has no age limitation. It works with the guardian if the person is a minor.

Teen resources

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.

Peer support specialist

We have a peer support specialist working with youth and their families. The specialist works with the person and the family to define the covered person's recovery goals.

The specialist helps the person develop life skills and provides phone and/or face-to-face communications to covered persons. The individual and family receive support and help improve the person's overall physical and behavioral health. This benefit can also help to reduce hospitalizations and ER visits related to behavioral conditions in youth.

Tennessee Tobacco QuitLine

The Tennessee Tobacco QuitLine is a free smoking and/or tobacco cessation program for state residents. Services include:

- Personalized, toll-free phone services
- Master's-level counselors specially trained in tobacco cessation who help individuals make healthy lifestyle changes, learn new skills and behavior, and choose the way they want to quit
- Online resources to help develop a convenient plan that fits individual needs
- Community support with online forums
- 24/7 Educational QuitKit with logs and activities to help individuals stay on track

Additional services are available in Spanish and for the Deaf or hard of hearing. Text message support is also available.

For more information, call 1-800-748-8669 or go to tnquitline.org.

UHC Doctor Chat— virtual visits

Members will have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for 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.

Chapter 9: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	1-800-888-2998
Provider Services	UHCprovider.com	1-800-690-1606

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 provides covered individuals with mental health and substance use disorder (SUD) benefits.

Credentialing

For credentialing information, call the National Credentialing Center at **1-877-842-3210**.

Covered services

We offer covered behavioral health services and care management for mental, emotional and SUDs. We also provide tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources at UHCprovider.com and liveandworkwell.com. Accessed through myuhc.com, Live and Work Well houses mental health and well-being information and articles on health conditions, addictions and coping. It also lets individuals to take self-assessments and find community resources.

For more resources, go to Tennessee Department of Mental Health and Substance Abuse Services at tn.gov.

Benefits include:

- Inpatient facility services (substance abuse)
- 24-hour residential treatment services (substance abuse)
- Outpatient treatment services (substance abuse)
- Intensive community-based treatment (CCFT, CTT, etc.)
- Tennessee Health Link Services
- Psychosocial rehabilitation
- Supported employment
- Illness management and recovery
- Peer support services and family support services
- Supported housing
- Crisis services (mobile)
- Crisis stabilization

Find more information at UHCprovider.com/tncommunityplan > Behavioral Health or tn.gov/behavioral-health/mental-health > Mental Health Services.

Behavioral health access and availability standards

NCQA® standards require routine behavioral health office visits to be available within 10 business days. UnitedHealthcare Community Plan is required to adhere to the most stringent access and availability standards.

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Psychiatric Inpatient Hospital Services	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all members	Emergency/involuntary, within 4 hours Involuntary, within 24 hours Voluntary, within 24 hours
24-Hour Psychiatric Residential Treatment	Not subject to geographic access standards	Within 30 calendar days
Outpatient Non-MD Services	Transport access ≤ 30 miles travel distance and ≤ 45 minutes travel time for at least 75% of children and adult members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for all children and adult members	Within 10 business days Urgent, within 48 hours
Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance ≤ 90 miles and 90 minutes travel time for 75% of children and adult members and ≤ 120 miles and 120 minutes travel time for all children and adult members	Within 10 business days Urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all children and adult members	Detoxification, within 2 calendar days Emergency, within 4 hours Non-emergency, within 24 hours
24-Hour Residential Treatment Services (Substance Abuse)	Not subject to geographic access standards	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Transport access ≤ 30 miles travel distance and ≤ 30 minutes travel time for 75% of members and ≤ 45 miles travel distance and ≤ 45 minutes travel time for all members	Within 10 business days Detoxification, within 24 hours
Intensive Community-Based Treatment (CCFT, CTT, etc.)	Not subject to geographic access standards	Within 7 calendar days
Tennessee Health Link Services	Not subject to geographic access standards	Within 30 calendar days
Psychosocial Rehabilitation	Not subject to geographic access standards	Within 10 business days
Supported Employment	Not subject to geographic access standards	Within 10 business days
Illness Management & Recovery	Not subject to geographic access standards	Within 10 business days
Peer Support Services and Family Support Services	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within: • 2 hours for emergencies • 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

Service Type	Geographic Access Requirement	Maximum Time for Admission/ Appointment
Opioid Use Disorder Treatment	Travel distance ≤ 45 miles and ≤ 45 minutes travel time for 75% of non-dual members and ≤ 60 miles and 60 minutes travel time for all non-dual members.	

Tennessee crisis services statewide map

Statewide crisis line: 1-855-274-7471 (1-855-CRISIS-1)

Travel distance ≤ 45 miles and 45 minutes travel time for 75% of non-dual members and ≤ 60 miles and 60 minutes travel time for all non-dual members.

Youth Villages

- 1-866-791-9221 (North Middle TN)
- 1-866-791-9222 (South Middle TN)
- 1-866-791-9227 (Rural West TN)
- 1-866-791-9226 (Memphis Region)
- 1-866-791-9224 (East Region)
- 1-866-791-9225 (South East Region)

Mental Health Cooperative

- 1-615-726-0125 (Davidson County)

Frontier Health

- 1-877-928-9062 (Upper East TN)

Helen Ross McNabb

- 1-865-539-2409 (East TN)

To reach a Crisis Services Agency for Adults:

- East Tennessee
  - Frontier Health: 1- 877-928-9062 (Counties: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington)
  - Ridgeview Psychiatric Hospital & Center: 1-800-870-5481 (Counties: Anderson, Campbell, Morgan, Roane, Scott)
  - Helen Ross McNabb: 1-865-539-2409 (Counties: Blount, Knox, Loudon, Monroe, Sevier, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Union)
  - Volunteer Behavioral Health Care System: 1-800-704-2651 (Counties: Bledsoe, Bradley, Cannon, Clay, Cumberland, DeKalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs,Overton, Pickett, Putnam, Polk, Rhea,Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, Wilson)
- Middle Tennessee
  - Centerstone: 1-800-681-7444 (Counties: Bedford, Cheatham, Coffee, Dickson, Franklin, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Moore, Perry, Robertson, Stewart, Wayne)
  - Mental Health Cooperative: 1-615-726-0125 (Counties: Davidson)
  - Volunteer Behavioral Health Care System: 1-800-704-2651 (Counties: Bledsoe, Bradley, Cannon, Clay, Cumberland, DeKalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs, Overton, Putnam, Pickett, Polk,

Rhea, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, Wilson)

- West Tennessee
  - Carey Counseling Center: 1-800-353-9918 (Counties: Benton, Carroll, Gibson, Henry)
  - Pathways of Tennessee: 1-800-372-0693 (Counties: Crockett, Dyer, Haywood, Henderson, Lake, Madison, Obion, Weakley)
  - Professional Care Services: 1-800-353-9918 (Counties: Fayette, Lauderdale, Tipton)
  - Quinco Community Mental Health Center: 1-800-467-2515 (Counties: Chester, Decatur, Hardin, Hardeman, McNairy)
  - Alliance Healthcare Services: 1-901-577-9400 (Counties: Shelby)

Eligibility

Verify the individual's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at UHCprovider.com > **Eligibility**.

Authorizations

Individuals may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering nonemergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **1-800-690-1606.**

Collaboration with other health care professionals

Coordination of care

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

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

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

Behavioral health assessment requirements

When individuals are admitted for services, assess their physical and mental health status. This includes:

- A psychiatric assessment involving the person's presenting problem, psychiatric history, historical response to crises, psychiatric symptoms, diagnosis using the current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM), mental status exam, and history of alcohol and drug abuse
- A screening for medical history, and medication history
- A substance use assessment with frequently used over-the-counter medications, alcohol, and other drugs; and history of prior alcohol and drug treatment episodes. The history should show how substance use affects the community-functioning assessment.
- A community-functioning assessment with how they function in living arrangements, daily activities, social support, financial dealings, physical health, and behavioral health
- An assessment of their strengths, current life status, personal goals and needs
- Include the assessment documentation in the person's record

Individualized treatment plans

Complete individualized treatment plans for any person who receives behavioral health services within 30 calendar days. We will update plans based on specific program requirements. You may update them more often based on the person's progress. Note whether the person, or their family members or legal guardian, took part in the treatment plan development and reviews.

Align individualized treatment plans with diagnoses

based on the assessments previously mentioned. Include measurable goals and time frames to reach those goals. Also include a preliminary discharge plan. Place individualized treatment plans in the person's record.

Care providers of multiple services may create 1 comprehensive treatment plan for a person if at least 1 goal is written and updated as appropriate for each service provided.

If a need exists that was found during the initial assessment or course of treatment, the treatment plan must contain the following:

- Concerns for which the person is seeking treatment
- Person's goals related to those concerns
- Measurable objectives to address the goals
- Target dates for reaching those objectives
- People involved in meeting each objective
- Measurable action steps to accomplish each objective
- Steps for crisis prevention and/or resolution. This includes identification of crisis triggers (situations, signs, and increased symptoms) and active steps or self-help methods to prevent, reduce or defuse crisis situations.
- Names and phone numbers of contacts who can help resolve a crisis
- Individual's preferred treatment options. This includes psychopharmacology in the event of a mental health crisis

Portal access

Website: **UHCprovider.com**

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services, on this site. Use them to verify eligibility, review electronic claim submission, view claim status, and submit notifications/ prior authorizations.

View the Prior Authorization list, find forms and access the care provider manual. Or call the Provider Services at **1-800-690-1606** to verify eligibility and benefit information (available 8 a.m.-5 p.m. local time, Monday through Friday).

Website: **providerexpress.com**

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services.

Claims

Submit claims using the CMS 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis codes, CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in **Chapter 13**.

Behavioral health supervision for nonlicensed clinicians

Mental health, substance abuse facilities, and CMHC care providers who hire non-licensed clinical staff to perform clinical activities (i.e., clinical assessments and psychotherapy) must have a licensed clinician supervising them. The supervisor must have regular, in-person, 1:1 contact with the noncredentialed clinicians to review the provided treatment and/or services. The supervision must be specific to the rendered service. It must include direct supervision during the initial service. This may be followed by general supervision for the rest of the service at the supervisory care provider's discretion.

- Direct supervision means the supervising care provider must be immediately available (i.e., in person, by phone or through telehealth/video conferencing) to assist and direct throughout the rendered service. This may include the supervisor's review and signing of the treatment plan during the initial service.
- General supervision means the service is performed under the overall direction and control of the supervising clinician. However, their presence is not required during the performance of the intervention.

The following applies when you bill for behavioral health professional services:

- All independently licensed clinicians providing care must have a unique NPI and Medicaid ID number for TennCare billing and payments
- When billing for professional services performed by an independently licensed clinician, identify the licensed rendering care provider in the NPI field 24j on the CMS 1500

Monitoring audits

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

Provider evaluation of performance plans

The Provider Evaluation of Performance (PEP) Plan details what is reviewed during on-site audits. It includes a minimum quality requirements summary. Use the summary to review your performance and initiate improvements.

We also audit our high-volume behavioral health network care providers based on the PEP Plan. Develop a working knowledge of the details outlined in the PEP Plan. For copies of the PEP Plan and audit tools, call Provider Services at **1-800-690-1606**. Ask to speak with a Behavioral Health Quality Improvement Department representative. You may also go to UHCprovider.com/tncommunityplan > **Behavioral Health**.

Adverse occurrence/sentinel event reporting

An adverse occurrence is a serious or unexpected behavioral health event involving possibly harmful effects to the person. The occurrence represents a possible quality of care issue.

Adverse occurrences include:

- Suicide death
- Suicide attempt with significant medical intervention requiring an emergency room visit or inpatient hospital stay
- Homicide
- Homicide attempt with significant medical intervention requiring an ER visit or inpatient hospital stay
- Abuse/neglect (physical, sexual, verbal) allegations
- Death, cause unknown
- Medical emergency (e.g., heart attack, medically unstable)
- Accidental injury with significant medical intervention requiring an ER visit or inpatient hospital stay
- Use of restraints/seclusion (physical, chemical, mechanical) with significant medical intervention while the person is in the care of a behavioral health inpatient, residential or crisis stabilization unit
- Treatment complications (medication errors and adverse medication reaction) with significant medical intervention requiring an ER visit or inpatient hospital stay
- Elopement (inpatient and residential services only, as related to minors or involuntary admissions for adults)

Behavioral health network care providers must submit adverse occurrence reports to all appropriate agencies as required by licensure and state/federal laws. Submit within 1 business day following the event.

Reporting forms are available at UHCprovider.com/tncommunityplan > **Behavioral Health**.

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention** – Prevent OUD before they occur through pharmacy management, provider practices, and education
- **Treatment** – Access and reduce barriers to evidence-based and integrated treatment
- **Recovery** – Support case management and referral to person-centered recovery resources
- **Harm reduction** – Access to Naloxone and facilitating safe use, storage, and disposal of opioids
- **Strategic community relationships and approaches** – Tailor solutions to local needs
- **Enhanced solutions for pregnant parent and child** – Prevent neonatal abstinence syndrome and supporting parents 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 SUD/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify covered persons 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 > Resources > **Drug Lists and Pharmacy**. Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prescribing opioids

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

Find more information about Tennessee Substance Abuse Services at **tn.gov/behavioral-health/substance-abuseservices**.

The Tennessee Department of Mental Health and Substance Abuse Services website offers contact information and resources for care providers and individuals for services related to:

- Crisis intervention
- Mental health
- Substance abuse

Resources include best practice guides, training information and licensing requirements.

Expanding MAT access and capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have a robust MAT network.

To find a behavioral health MAT provider in Tennessee:

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

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

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

Chapter 10: Individual Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/TN	1-800-690-1606
Member Handbook	UHCCommunityPlan.com/TN > Medicaid Plan > UnitedHealthcare Community Plan > View Plan Details	

Looking for something else?

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

Our Member Handbook has a section on individual rights and responsibilities. In it, we ask that covered persons treat you with respect and courtesy. Find the Member Handbook on UHCCommunityPlan.com.

Privacy regulations

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

Access to protected health information

Covered persons may access their medical records or billing information either held 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

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

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

Right to request restrictions

Covered persons have the right to ask you or us to restrict the use and disclosures of their PHI for treatment, payment and health care operations. This request may be denied. If it is granted, the covered entity is bound by any restriction to which is agreed. Document these restrictions. We must agree to restrict disclosure. Individuals may request to restrict disclosures to family members or to others who are involved in their care or its payment.

Right to request confidential communications

Individuals 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 covered person states disclosure could endanger them. Requests for confidential communication do not require their explanation. Keep a written copy of the request.

Individual rights and responsibilities

Native American access to care

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

Individual rights

Covered individuals may:

- Request information on advance directives and execute one
- Give and 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, bullying, 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
- Change health plans. If they are new to TennCare, they can change health plans once during the 45 days after enrolling in TennCare. After that, they can ask to change health plans through an appeal process. There are certain reasons why a person can change health plans. Refer to the Member Handbook for more information.
- End their enrollment in TennCare at any time
- 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 without fear of poor treatment from UnitedHealthcare Community Plan, care providers, or TennCare
- Appeal any payment or benefit decision we make
- Review and get copies of 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 individual rights and responsibilities policies
- Get more information upon request, such as how our health plan works, how we pay our care providers and a care provider's incentive plan, if they apply
- Exercise any of these rights without being treated poorly by UnitedHealthcare Community Plan or its care providers
- Get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, disability, or any other classification protected under the applicable federal and state civil rights laws. The individual has a right to file a complaint if they think they have been treated unfairly. If they complain or appeal, they have the right to keep getting care without fear of bad treatment from UnitedHealthcare Community Plan, providers, or TennCare.

Individual responsibilities

Covered persons should:

- Follow instructions and rules in the Member Handbook about coverage and benefits
- Follow instructions and rules from those providing health care
- Understand their benefits so they can get the most value from them
- Show you their Medicaid 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
- Go to their PCP for all their medical care unless:
  - Their PCP sends them to a specialist
  - They are pregnant or getting well-woman checkups
  - They have an emergency
- 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
- Let their PCP know within 24 hours when they have received care at an ER
- 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
- Pay required copays
- Tell TennCare of any changes within their family, such as:
  - New name, address, or phone number
  - Family size
  - Employment
  - Health insurance
- Let UnitedHealthcare Community Plan know if another insurance company should pay their medical care. This includes auto, home, or worker's compensation.

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

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

A person cannot be removed from UnitedHealthcare Community Plan due to:

- Worsening health
- A pre-existing medical condition
- Expensive medical treatment
- How a person uses care provider services
- A mental health condition
- The person acting uncooperatively or disruptively due to their special needs

A person can only be removed from UnitedHealthcare Community Plan if they:

- Change health plans
- Move out of the UnitedHealthcare Community Plan area
- Let someone else use their ID cards or use their TennCare benefits to get medicines to sell
- End their TennCare or TennCare ends for other reasons
- Don't renew TennCare on time or don't give TennCare the requested information at that time
- Don't let TennCare and UnitedHealthcare Community Plan know about a change of address and can't be found
- Lie to get or keep TennCare enrollment
- Die

Chapter 11: 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, which fosters efficient and quality care for covered persons. Keep records for at least 10 years from the close of the Tennessee program agreement between the state and UnitedHealthcare Community Plan. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel
Procedural Elements	**Medical records are readable*** • Sign and date all entries • Individual name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the individual’s first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

Topic	Contact
History	An initial history (for individuals seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

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

***Critical element**

Medical record review

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

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for covered persons seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or notate covered person 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
- Individual education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Covered person hospitalization records should include, as appropriate:

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

Behavioral health record content requirements

Behavioral health treatment records must follow additional guidelines apart from medical record standards:

- Records may be on paper or in electronic format
- Each page in the treatment record contains the covered person's name or ID number
- Each record contains the covered person's address, employer or school, home and work phone numbers. This includes emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record include the responsible clinician's name, professional degree, license, and relevant ID number
- The record is in blue or black ink and maintained in a current, detailed, organized and comprehensive manner
- All modifications are done uniformly. Any error must be lined through so that it can still be read, then dated, and initialed by the person.
- Presenting problems, relevant psychological and social conditions affecting the covered person's medical and psychiatric status and the results of a mental status exam are documented and the source of such information is listed
- Include in a prominent place in the covered person's record a Declaration of Mental Health

Treatment for each covered person who has executed one. More information on and copies of the Declaration of Mental Health Treatment form is on tn.gov/behavioral-health/for-providers.html > Legal Forms > Mental Health & Substance Abuse Law > Declaration for Mental Health Treatment. This form is also on UHCprovider.com/tncommunityplan > Behavioral Health.

- Special status situations — such as imminent risk of harm, suicidal ideation or elopement potential — are prominently noted, documented and revised as appropriate. Also document the absence of such conditions.
- Each record indicates informed consent for medication and the covered person's understanding of the treatment plan are documented
- A medical and psychiatric history is documented, including previous treatment dates, care provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events. Also include a complete developmental history (physical, psychological, social, intellectual and academic).
- For covered persons 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs
- DSM diagnoses are documented and consistent with the presenting problems, history, mental status examination, and other assessment data
- Treatment involving the care of more than 1 member of a family should have separate treatment records for each identified and diagnosed covered person
- Billing records should reflect each member treated and the modality of care

Documenting continuity of care for behavioral health

Include continuity and coordination of care activities between the PCP, consultants, and other behavioral health and medical providers and health care institutions in the member's record. At a minimum, include the following documentation:

- A member's refusal to let you communicate with their other care providers
- Referrals to other providers, services, community resources and/or wellness and prevention programs
- All correspondence regarding the member's treatment, signed and dated
- Strengths and limitations in achieving treatment plan goals and treatment interventions consistent with those goals. Include dates for follow-up or complete termination summaries.
- A brief discharge summary within 15 calendar days following discharge from services or death
- Discharge summaries for psychiatric hospital or residential treatment facility admissions that occur while the member is receiving behavioral health services

Medical records standards for TennCare kids (EPSDT) examinations

An EPSDT visit includes 7 components. All 7 components are required at each age visit, and you must document them. If a member refuses a TennCare Kids (EPSDT) exam or treatment or any portion of the exam or treatment, document that refusal in the medical record.

To assist with your TennCare Kids chart documentation, the Tennessee Chapter of the American Academy of Pediatrics has developed age-specific screening review forms. You can find these recommended forms at tnaap.org.

The TennCare Kids medical records standards and requirements follow the Bright Futures Periodicity Schedule. Include the following:

1. **History/Developmental and Behavioral Assessment**
   - Past medical/social history (documented at least once)
   - Family history (documented at least once)
   - Initial history
   - Interval history
   - Current problems identified
   - Allergies identified or NKA noted
   - Developmental /behavioral assessment (age appropriate)
   - Comprehensive developmental/behavioral

screening
- Nutritional assessment (recommended)

2. **Comprehensive Unclothed/Suitably Draped Physical Exam**
   - Documentation must state "unclothed or suitably draped exam"
   - Document length, height and weight at each visit
   - BMI: perform beginning at age 2 and every year through 20 years
   - Patients, ages 2-17 years, must have documentation of BMI percentile measurement or a BMI percentile measurement plotted on an age growth chart and counseling for nutrition and physical activity
   - Patients ages 18 years and older must have BMI measurement value documentation
   - Blood pressure: document at each visit starting at age 3. Perform a risk assessment from birth through 30 months with follow up action if warranted.
   - Head circumference: document at each visit through the age 2
3. **Vision Screening**
   Conduct age-appropriate vision screenings based on the periodicity schedule. Perform a risk assessment through 30 months old. Beginning at age 3, use a standard testing method. After age 3, perform screenings and risk assessments according to age and the Bright Futures Periodicity Schedule.
4. **Hearing Screening**
   Perform a hearing screening at birth, then risk assessments and additional screenings according to age and the Bright Futures Periodicity Schedule. Refer the child to an audiologist as needed.
5. **Laboratory Testing and Screenings**
   Document the results of all laboratory tests in the medical record. This includes:
   - Newborn metabolic blood screening (0-2 months)
   - Critical congenital heart defect screening
   - Hematocrit and hemoglobin
   - Lead risk assessment
   - Tuberculosis testing
   - Dyslipidemia risk assessment
   - STI/HIV screening
6. **Immunizations**
   Administer immunizations during checkup visit or at any other contact with the child. Review the record to determine if any immunizations were due on the date of service and if immunizations are up to date. Obtain documentation of prior vaccinations administered elsewhere. Document any parent/guardian/patient's refusal to vaccinate.
7. **Health Education/Anticipatory Guidance**
   At each visit, document age-appropriate health education and topics discussed or written. Include anticipatory guidance. We review medical records at least yearly for compliance with TennCare Kids standards.

Pediatric health care recommendations

Bright Futures and American Academy of Pediatrics recommendations for Preventative Pediatric Health Care are on aap.org.

Continuity of care

- Appropriate documentation of referrals and follow-ups: Document all referrals to specialists and any follow-ups you carried out. Document referrals to WIC, Head Start, or other private and public resources.
- Dental referral (age 3 years or older): Document dental inspections, referrals and education. We recommend a direct dental risk assessment and referral for every child based on the periodicity schedule. Care provider referrals are recommended based on risk assessment. If medically necessary, a child may be referred at any age. At the visits for ages 3 and 6 years, determine whether the patient has a dental care provider.

Chapter 12: 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	1-877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	1-800-455-4521

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 covered persons 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 individual health care and services
- Monitoring and enhance patient safety
- Tracking covered person and provider satisfaction and take actions as appropriate

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

Cooperation with quality improvement activities

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

- Providing requested timely medical records
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Participating in 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 covered persons (or don't restrict office hours you offer Medicaid members)

Care provider satisfaction

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

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

Our main concern with the survey is objectivity. That's why 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 according to applicable Tennessee statutes and the NCQA. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current 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 covered persons.

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
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

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

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

First-time applicants must call the National Credentialing Center (VETTS line) to get a CAQH number and complete the application online.

For chiropractic credentialing, call **1-800-873-4575** 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 3 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 3 chances to answer the request before your participation privileges are terminated.

Performance review

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

Applicant rights and notification

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

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 2 business days from when we receive your request.

Confidentiality

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

Resolving disputes

Contract concerns

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

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

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

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

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

If a covered person has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the appeals process as shown in the Member Handbook and this manual.

Delegation oversight process

We may delegate certain functions of quality improvement, utilization management, credentialing, individual rights, and medical records to other entities

The ultimate authority and responsibility for those activities, however, remains with us. We perform continuous oversight of these functions and audit each one annually.

If we discover deficiencies, we request a corrective action plan (CAP). The CAP terms are agreed to by all parties. We monitor corrections. We can reclaim responsibility for a delegated function if deficiencies are not corrected.

Audit results are sent to the Credentialing Committee for Credentialing and the Corporate QI Committee for delegation approval.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

HIPAA aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all 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 fee-for-service 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.

Tennessee Medicaid ID number

TennCare requires all providers to be registered with them prior to payment release. If you do not already have a Tennessee Medicaid number, please register through TennCare's process at tn.gov/tenncare/providers.

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Background check requirements

Perform background checks on employees as required by the state licensing agency. This includes criminal background checks or a background check from a licensed private investigation company. Verify the employee's name does not appear on the state abuse registry or on the state and national sexual offender registries.

Complete background checks on any person who will have direct contact with those receiving services from a CHOICES health plan. Complete all background checks prior to the employee's start date. Your provider advocate's on-site assessments include a full review of background checks for employees hired on or after Jan. 1, 2017.

Ethics and integrity

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

Compliance program

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

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

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

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a

UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

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

To facilitate the reporting process of questionable incidents involving individuals or care providers, call **1-800-690-1606**.

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 Tennessee 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 Tennessee 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 covered persons. Records must be kept for at least 10 years from the close of the Tennessee program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure covered persons 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 Tennessee program standards.

You must cooperate with the state or any of its authorized representatives, the THS, 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.

Practice management

Practice management is a clinical team that coordinates with other departments to help you with the following key elements:

- Manage practice patterns that appear to fall outside typical patterns, and the measurement of improvement over time
- Identify and resolve potential practice patterns that may constitute Fraud, Waste and/or Abuse (See Fraud, Waste and Abuse section.)
- Evaluate compliance with Care Advocacy processes and contractual obligations

Practice Management uses intervention strategies may include a direct conversation with the care provider, education, peer-to-peer reviews, and site and/or treatment record audits.

A Practice Management intervention may involve ongoing monitoring, CAPs, referrals to peer review, noncoverage (adverse) benefit determinations, or referral to Credentialing Committee or Program and Network Integrity (PNI).

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 covered persons 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 covered person care
- Privacy in exam rooms
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

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

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	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	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 13: Billing and Submission

Key contacts

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

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.

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, go to UHCprovider.com/guides > View online version > Our Claims Process.

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. Or call Provider Services.

Your clean claims must include your NPI and federal TIN.

Tennessee Medicaid ID number

TennCare requires all providers to be registered with them prior to payment release. If you do not already have a Tennessee Medicaid number, please register through TennCare's process at tn.gov/tenncare/providers.

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 covered person's coverage on the dates of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or noncovered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

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

Modifier codes

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

Individual ID card for billing

The individual's ID card has both the person's ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with this ID.

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

Submit claims for all services by the terms in your contract if you participate in the network, or 120 days from the date of service if you don't participate. Otherwise, we deny the claim for timely filing.

If additional information for some services, situations or state requirements is needed, include that information with the initial submission.

Submit any services completed by nurse practitioners or physician assistants who are part of a collaborative

agreement.Use their tax ID and NPI, and we will process the claims just like other physicians'.

Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/en/policies-protocols.html**. Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol**.

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 95378
- 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 **EDI Companion Guides**.

Importance and usage of EDI acknowledgment/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.

e-Business support

UnitedHealthcare Community Plan offices are open 8 a.m.-6 p.m. (Eastern Time), Monday through Friday. They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for **EDI Claims** and **EDI Log-on Issues**.

Find more information at **UHCprovider.com**. Click Resources, then Resource Library to find Electronic Data Interchange menu.

Electronic payment solution: OptumPay™

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/health care 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 Resources, then Resource Library to find the EDI section.

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

Completing the UB-04 form

Bill all facility claims, inpatient, outpatient and ER services using revenue codes on the UB-04 claim form.

Visit **nubc.org** to learn how to complete the CMS UB-04 form.

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 covered person 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 covered persons:

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

Subrogation and coordination of benefit

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

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

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

Reclamation

Reclamation refers to situations where UnitedHealthcare Community Plan or TennCare has recovered a payment that was made on a claim that should first have been submitted to a person's third-party insurance.

In some cases, care providers who seek payment from third-party insurance after reclamation has taken place have their claims denied as being duplicate claims These care providers may be eligible for a refund from UnitedHealthcare Community Plan or TennCare.

- If TennCare recovered the payment, complete the Medicaid Reclamation Claim Provider Refund Request form at tn.gov/tenncare > Providers > **Miscellaneous Forms**
- If UnitedHealthcare Community Plan recovered the payment, you may request to start an inquiry to research the issue. Call **1-800-727-6735**. Include the following:
  - Your contact information, including address, phone, and fax numbers
  - Name of other carrier
  - EOB from other carrier
  - Date check issued by other carrier
  - Dollar amount of check submitted by other carrier

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 > Resources > Health Plans, Policies, Protocols and Guides > For Community Plan > 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 appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

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

Clinical laboratory improvements amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for 340B drugs

The Division of TennCare has announced billing requirements for care providers who are registered on the Medicaid Exclusion File and participate in the federal 340B Drug Pricing Program. The modifier requirement will be determined by an NDC. While we encourage you to use the appropriate modifiers effective May 1, 2021, we won't disallow drugs administered in an office/outpatient setting until Dec. 1, 2021.

Professional and facility claims with a date of service

on or after Dec. 1 for drugs administered in an office/outpatient setting will need one of these modifiers:

- **JG** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members
- **TB** – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes)
- **UD** – Drug or biological acquired with the 340B drug pricing program discount
- **UC** – Drug or biological acquired without the 340B drug pricing program discount

Effective Dec. 1, 2021, if a drug service is disallowed because a modifier isn't included on each applicable claim line, the line level denial will show:

- **Reason code 16** – Claim/Service lacks information or has submission/billing error(s)
- **Remark code N822** – Missing procedure modifier(s)

Claims paid on a case rate or bundled payment are excluded from the modifier requirement. There will be no changes to the current reimbursement for drugs administered on an office/outpatient basis through the 340B Drug Pricing Program. If a claim is submitted without a valid NDC number, the entire claim will reject on the front end and will be sent back for correction.

Check your Medicaid exclusion file participation

The Medicaid Exclusion File is maintained by the Health Resources and Services Administration (HRSA). You can view the file and check your participation at **340bopais.hrsa.gov/MedicaidExclusionFiles**. Contact the HRSA directly to update your participation status.

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of service codes

Go to **cms.gov** for Place of Service codes.

Asking about a claim

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

Provider Services

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

- Covered person's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

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

UnitedHealthcare Community Plan Provider Portal

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 covered person's eligibility
- Submit claims reconsiderations
- Review coordination of benefits information
- Use the integrated applications to complete multiple transactions at once
- Reduce phone calls, paperwork and faxes

You can even customize the screen to put these common tasks just 1 click away.

Find Provider Portal training at UHCprovider.com/training.

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

For information about submitting a claim correction, see Chapter 14: Claims Reconsiderations, Appeals and Grievances.

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 5240
Kingston, NY 12402-5240

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

For paper claims

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

- Covered person's name
- Date of service
- Claim date submission (within the 120-day timely filing period)

Timely filing

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

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

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

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

To be timely, we must receive the claim within 120 days 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 60 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

TennCare claims for services must be submitted by 120 days from the date of service or the claim will be denied for timely filing.

If a member is retroactively enrolled, the 120 days begins at the time TennCare notifies us of a person's eligibility.

If we receive a claim, and it requires additional information to be processed, the claim will be denied with a request for additional information. You must submit a corrected claim with required information within

120 days from the date of service or 120 days of our initial denial, whichever is later.

Should a covered person have primary coverage, the 120-day period begins on the date shown on the primary carrier's EOB.

If a claim is denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- EOB or similar document from primary health payer dated within 120 days of claim submission to us
- Confirmation of denial from primary payer within 120 days of claim submission to us
- Copy of billing statement to covered person showing dates of bills or provision of person's health plan insurance information so that payment can be coordinated
- Electronic report stating we accepted the claim. Computer-generated activity report will show the date an electronic claim was originally submitted to us. An acceptable report must contain: cover person's name or identification number, date of service, indication that original claim was submitted electronically).

Balance billing

Do not balance bill covered persons if:

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

You may balance bill the person for noncovered services if the person provides written consent prior to getting the service. You can review other circumstances that let you bill a person at tn.gov/tenncare > Providers > TennCare Rules > **1200-13-14-.08**. If you have questions, please contact your provider advocate.

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

Claims submission for TennCare Medicaid/ Medicare covered persons

File claims electronically for Medicare/Medicaid dual-eligible covered persons (Eligibility Class 17) with Medicare for primary payment. Traditional Medicare should crossover to the Division of TennCare for Medicare co-insurance amounts. If Medicare denies the claim for non-covered benefit, but TennCare covers the service, attach the EOB to the claim and submit to us.

File paper claims for Medicare/Medicaid dual-eligible members (Eligibility Class 17) with Medicare for primary payment. After Medicare pays primary, you must file the paper claim with the EOB to the Division of TennCare for reimbursement of Medicare coinsurance amounts.

Mail paper claims for secondary payment to:

- Institutional Claims:
  Tennessee Division of Medicaid
  P.O. Box 470
  Nashville, TN 37202-0470
- Professional claims to:
  Tennessee Division of Medicaid
  P.O. Box 460
  Nashville, TN 37202-0460

The Division of TennCare pays Medicare copayments and coinsurance for Medicare/Medicaid dual-eligible members. Do not bill the member for such charges.

Claims submission for TennCare standard/ Medicare members (Not Medicaid-eligible)

The Division of TennCare and UnitedHealthcare Community Plan are not responsible for copayments and coinsurance for TennCare Standard enrolled persons who also have Medicare (TennCare Standard/ Medicare dual eligibility). The covered person pays these costs after Medicare pays as the primary insurance. If Medicare denies the claim as a non-covered benefit, and TennCare covers the service, attach the EOB to the claim and submit to us.

The Division of TennCare does not pay Medicare

copayments and coinsurance for TennCare Standard/ Medicare dual-covered persons. Do not submit such charges to the Division of TennCare for payment.

Nonstandard billing for observation services

The most common example of a nonstandard billing requirement is billing for observation services when the admitting physician wrote an inpatient admission order. In this case, to receive payment for observation services, the facility provider must bill us as follows:

- Change the Type of Bill from inpatient to outpatient (13x)
- Convert the Room and Board revenue code to Observation (76x)
- Bill corrected claims for observation charges, when inpatient services are denied, within 120 days of receiving the decision to uphold a denial of inpatient services. Include a copy of the letter of denial for inpatient services.

In this example, make no changes to your medical records. Report the days as inpatient on census reports and reflect charges under the Room & Board revenue codes on your financial system. This will keep you in compliance with Medicare reporting but will allow payment under the terms of your contract with us. Payment at the approved observation level will not be recouped. Inpatient stays for observation may be subject to retroactive audit. If the inpatient level of care was denied due to lack of medical necessity, but the observation level of care was appropriate, we will not recoup the allowed observation contractual reimbursement.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible covered persons. Therefore, you must bill and obtain an EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

Smart Edits

Smart Edits is a claims optimization tool that allows care providers to review and repair problematic claims before they enter our claims processing system. When care providers submit claims accurately and in compliance with the latest policies and regulations, they have less re-work, quicker approvals and faster payments.

If a claim triggers a Smart Edit, the edit appears on the care provider's 277CA clearinghouse rejection report within 24 hours. Care providers see 3 types of edits as well as an informational banner:

- **Return edits** occur when a claim in question is likely to result in a denial, overpayment or medical record request. Care providers have 5 calendar days to repair the claim before it's released into our claims processing system. An informational banner will accompany a return edit, which shares our website, where care providers can learn more.
- **Rejection edits** occur when a claim requires immediate attention. Care providers must act on these claims and correct the error before the claim can enter our claims processing system. If no action is taken, we will not receive the claim. An informational banner will also accompany a rejection edit to guide care providers.
- **Informational edits** provide targeted messages back to our submitters and do not hold the claim for repair. These edits can communicate changes to reimbursement policies or notices for administrative requirements.

Care providers learn about Smart Edits through:

- Email
- Network Bulletin
- Smart Edits page on **UHCprovider.com**
- Self-paced interactive guides
- Outbound phone calls to highest affected care providers

Chapter 14: Claim Reconsiderations, Appeals and Grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider Agreement.

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

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**	**Care Provider Contact Information**	**Care Provider Website 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 5280 Kingston, NY 12402-5240	UHCprovider.com/claims	1-800-690-1606	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	We must receive within 60 business days	30 business days
Care Provider Claim Reconsideration (Step 1 of claim payment 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 5280 Kingston, NY 12402-5240	UHCprovider.com/claims	1-877-842-3210	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	Care providers have 365 days to submit reconsideration or appeal from the initial denial	30 business days
Care Provider Claim Provider Advocate Escalation (Step 2 of claim payment dispute)	A review in which you did not agree with the outcome of the reconsideration.	Care provider				Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.		30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
Situation	**Definition**	**Who May Submit?**	**Submission Address**	**Online Form for Mail**	**Care Provider Contact Information**	**Care Provider Website For Online Submissions**	**Care Provider Filing Time Frame**	**UnitedHealthcare Community Plan Response Time Frame**
Care Provider Claim Formal Appeal (Step 3 of claim payment dispute)	A formal appeal if your Step 2 reconsideration was not resolved to your satisfaction.	Care provider		UHC provider.com/claims		Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	You have 365 days to submit reconsideration or appeal from the initial denial	Acknowledge 30 calendar days Response 60 calendar days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or covered person.	Care provider	UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220	UHC provider.com/claims	1-800-690-1606	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	120 business days	30 business days
Individual Appeal (State Fair Hearing)	A request to change an adverse benefit determination that we made.	• Individual • Individual's authorized representative (such as care provider, friend or family member) on behalf of the individual with the individual's written consent	TennCare Solutions P.O. Box 593 Nashville, TN 37202-0593	tn.gov/tenncare	1-800-878-3192 Fax: 1-888-345-5575	N/A	60 calendar days from receipt of Notice of Adverse Benefit Determination	Urgent:1 week (approx) Standard: 90 calendar days Response times may be extended for cause
Individual Grievance	A covered person's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Individual • Individual's authorized representative (such as care provider, friend or family member) on behalf of the individual with the individual's written consent	UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220	N/A	1-800-690-1606	N/A	N/A	90 calendar days

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

Denial

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

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

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

Other top reasons for denial include:

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

Claim correction

What is it?

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

When to use:

Submit a corrected claim to fix 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 5220
Kingston, NY 12402-5240

Additional information:

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

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 covered person demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong covered person 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 5220
Kingston, NY 12402-5240

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

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

For medical necessity denials –

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.
- **Phone:** Call Provider Services at **1-800-690-1606** or use the number on the back of the covered person's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

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

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

Independent review process

You may file a request with the Commissioner of Commerce and Insurance for an independent review when disputing claims denied by UnitedHealthcare Community Plan. You can get sample copies of the Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the Tennessee Department of Commerce and Insurance at **tn.gov/commerce** > OurDivisions > TennCare Oversight > MCO Dispute Resolution > **Independent Review Process**. You may also call Tennessee at **1-615-741-2677**.

Your rights and the rules governing this process are in the Tennessee Annotated Code (T.C.A.) 56-32-126.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

A submission report is not proof of timely filing for electronic claims. You must also include 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, 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 covered person name
  - Correct date of service
  - Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments based on 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
- Individual 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	Individual has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Individual terminated

Appeals (step 2 of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your 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: Provider Disputes
  P.O. Box 5220
  Kingston, NY 12402-5220

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. If you have questions, call Provider Services.
- 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.

Provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services at **1-800-690-1606**
- **Mail:** Send care provider name, contact information and your grievance to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 5220
  Kingston, NY 12402-5220

You may only file a grievance on a covered person's behalf with their written consent. See Individual Appeals and Grievances Definitions and Procedures.

Individual appeals (state fair hearings) and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances and follows appeal rules for individuals as outlined by the Division of TennCare.

Individual benefit appeals (state fair hearings)

What is it?

An appeal (state fair hearing) lets an individual share why they think Tennessee Medicaid services should be reconsidered for approval when UnitedHealthcare Community Plan makes an adverse benefit determination. Reasons for adverse benefit determinations include:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of the MCO to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- The denial of an individual's request to dispute a financial liability, including cost sharing, copayments and other individual financial liabilities

When to use?

When the individual has given you their written consent to appeal on their behalf.

Where to send:

Call, mail or fax the information within 60 calendar days from receipt of our Notice of Adverse Benefit Determination to:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Toll-free: 1-800-878-3192 (TTY 1-866-771-7043)

Fax: 888-345-5575

How it works:

When we make an adverse benefit determination, and the individual appeals the determination, they have the right to:

- Give their written consent to have a care provider, family member, friend, or lawyer to appeal on their behalf

- Ask UnitedHealthcare Community Plan Member Services for help completing appeal forms and other procedural steps
- Send written comments or documents to be considered for the appeal
- Present evidence, and allegations of fact or law, in person and in writing
- Receive a copy of the rule used to make the decision
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- If a hearing is held, attend the hearing on the phone or go to the local Family Support Division office and have someone attend with them
- Ask for continuation of service during the appeal if the individual is a Medicaid recipient (not available for CHIP). However, the individual may have to pay for the service if the final resolution of the appeal is adverse. (As the provider, you cannot ask for a continuation. Only the individual may do so.)
- Ask for an expedited appeal if waiting for the service could harm the individual's health. (A care provider may help by completing the "Provider's Expedited Appeal Certificate" available from TennCare at the link below.)

Find more information about TennCare individual appeals at tn.gov/tenncare > Members/Applicants > How to file a medical appeal?

A copy of the form is online at UHCprovider.com.

Individual grievance

What is it?

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

When to use:

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

Where to send:

You or the covered person may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 5220
Kingston, NY 12402-5220

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance.

Processes related to reversal of our initial decision

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

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

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

Fraud, waste and abuse

Report fraud, waste and abuse by calling **1-800-690-1606** or using uhc.com/fraud.

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 covered persons. 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, covered persons, care providers, government programs

and the public. In addition, it aims to protect individuals' 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 covered persons 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 UnitedHealth Group policy on Fraud, Waste and Abuse at uhc.com/fraud. You may also call **1-800-690-1606** (UnitedHealthcare Community Plan tipline) or **1-800-433-3982** (Division of TennCare & Office of Inspector General).

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.

This includes the List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management, and the Social Security Administration Death Master File.

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

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

What you need to do for exclusion checks

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

Chapter 15: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	1-800-690-1606
News and Bulletins	UHCprovider.com > Resources > News	
Provider Manuals	UHCprovider.com/guides	

Looking for something else?

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

Connect with us on social media:

Communication with care providers

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

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

- UHCprovider.com–This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- UHCprovider.com/TNcommunityplan–The UnitedHealthcare Community Plan of Tennessee page has state-specific resources, guidance and rules
- **Policies and protocols**–UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans library includes UnitedHealthcare Community Plan policies and protocols
- **Tennessee health plans**–UHCprovider.com/TN is the fastest way to review all of the health plans UnitedHealthcare offers in Tennessee. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**–This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the portal in Chapter 1 of this manual or by visiting UHCprovider.com/portal. You can also access UHCprovider.com/training > Digital Solutions for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News–**Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at cloud.provideremail.uhc.com/subscribe You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

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

Care provider education and training

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

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

Email communication – required contact information

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

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Care provider office visits

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 resolve any issues.

e-Alerts

We also send you communications by e-Alert. This communication method may be used for reminders about educational opportunities or upcoming health fairs.

It also helps reinforce communications from the Network Bulletin, Practice Matters newsletter or information posted on the care provider website.

Request to receive e-Alerts through your provider advocate. If you miss an e-Alert, we publish them on UHCprovider.com/tncommunityplan > **Bulletins and Newsletters**.

Care provider manual

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

Forms

Find the following forms on the state's website at tn.gov/tenncare > Providers > **Miscellaneous Forms**:

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

Chapter 16: 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 individual)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Adverse Benefit Determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
2. The reduction, suspension, or termination of a previously authorized service
3. The denial, in whole or in part, of payment for a service
4. The failure to provide services in a timely manner, as defined by the state
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals
6. For a resident of a rural area, the denial of a covered person's request to exercise their right, to obtain services outside the network
7. The denial of a covered person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other covered person financial liabilities

Acute Inpatient Care
Care provided to covered persons 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 covered person'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. Individuals 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 covered person gets in the hospital.

Appeal (state fair hearing)
An administrative hearing requested if the covered person does not agree with a Notice of Adverse Benefit Determination from UnitedHealthcare Community Plan.

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 covered person.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned covered persons 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 covered person in conjunction with the covered person, their representative and their 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
PCPs, specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to covered persons. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

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

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

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a covered person. 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 covered person. 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 covered person. 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 covered person from 1 level of care to another.

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

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

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

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, 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 2 or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

Electronic Medical Record (EMR)
An electronic version of a covered person'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 state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term "covered person" or "individual." 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 a covered person in a health plan.

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

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

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

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

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

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with nonmedical 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 covered persons under the terms of their Agreement.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant persons, 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 covered person 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 covered person 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 covered persons 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 covered persons.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Tennessee DHHS.

Specialist
A care provider licensed in the state of Tennessee 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 nonphysician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the covered person does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

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 covered persons. 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 covered persons get. It also determines their level or length of care. The goal is to help ensure they get the care they need without wasting resources.