



District Dual Choice Program

UnitedHealthcare Community Plan

Feb. 17, 2022

United
Healthcare
Community Plan

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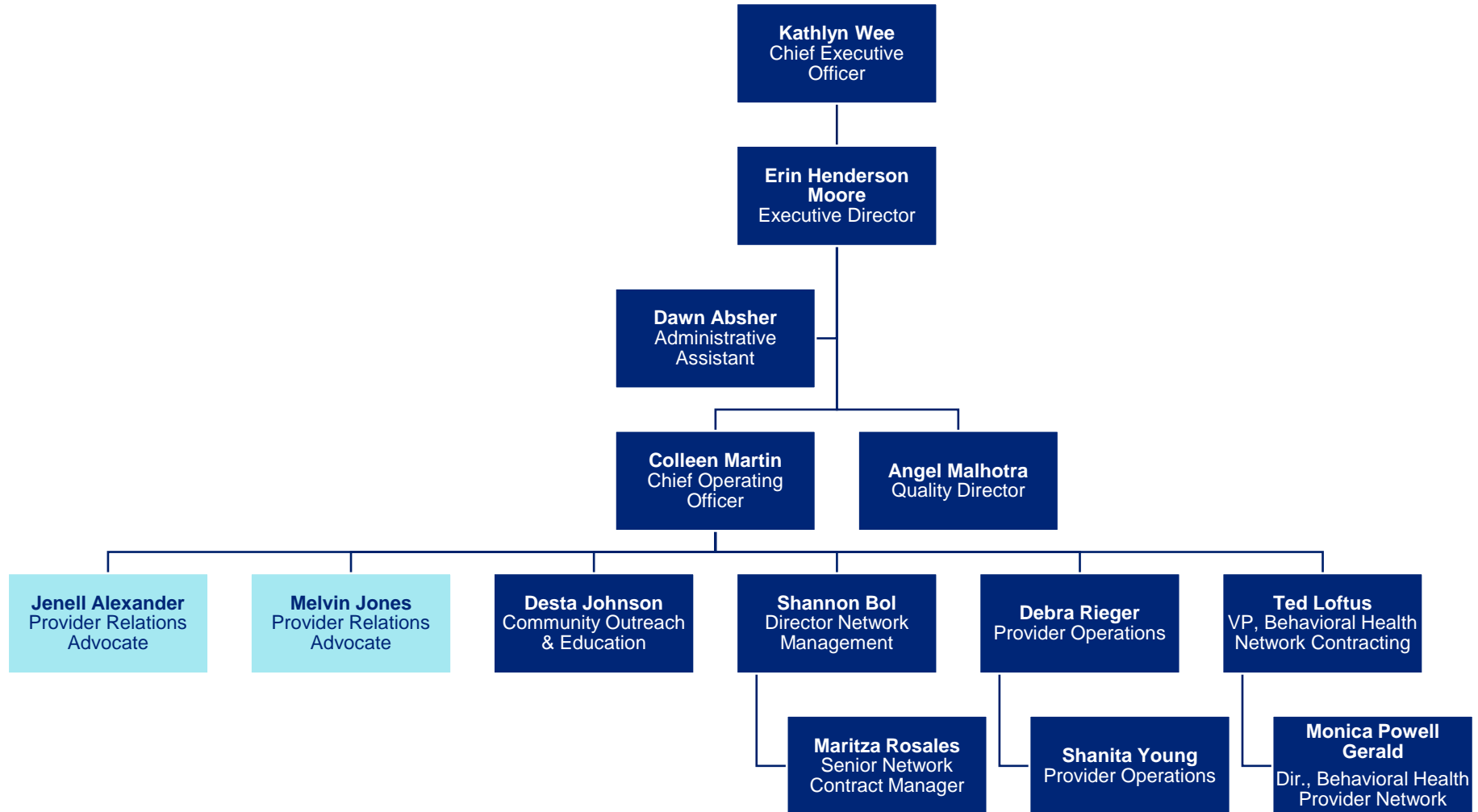
- Key network personnel
- Program overview and benefits
- Continuity of care
- Provider Portal
- Billing process
- Upcoming resources





Key network personnel

Our local network team



HCBS provider advocate team

- Your Home- and Community-Based Services (HCBS) provider advocates:
 - Serve as your primary contact with UnitedHealthcare Community Plan
 - Are your “navigational specialists” when dealing with all areas of UnitedHealthcare Community Plan
 - Keep you advised of new and amended programs and processes
 - Specialize in issue resolution
- DC-based provider advocates:
 - Jennell Alexander and Melvin Jones, Jr.
 - Email DCHCBSproviders@uhc.com





Program overview and benefits

Program overview



The District Dual Choice program is exclusively for dually eligible beneficiaries. The District Dual Choice program is a comprehensive program that integrates Medicare and Medicaid benefits into a single program. That means that there will be **1 set** of comprehensive benefits, and UnitedHealthcare will coordinate the delivery of services to help coordinate the unique needs of individuals. This simplifies health care for participants and promotes greater care coordination.

The District Dual Choice plan is a voluntary health plan that combines all the benefits and coverage of Medicare Advantage and Medicaid under one plan. Additionally, the District Dual Choice plan offers Long-Term Support Services (LTSS) for elders and respite care for families and caregivers.

UnitedHealthcare Community Plan manages this plan and reimburses you according to contracted rates. Please make sure to always validate eligibility and benefits before providing service.



Product overview: Benefit design



- **Highly Integrated (HIDE-SNP)** Medicare (Federal) and Medicaid (Joint Federal and District) benefit package
 - All members are 21+ and receive both Medicare and Medicaid benefits
 - QMB, QMB+, FBDE, EDP Waiver
 - Combines all the benefits and coverage of Original Medicare and Medicaid under one plan
 - Including prescriptions
 - Interdisciplinary care team to support enrollees
 - LTSS coordination through care manager
 - Assigned care navigator upon enrollment



Covered benefits

Full benefit dual eligible

- All Medicare-covered services, including doctors, hospital care, prescriptions
- Supplemental benefits covered by Medicare Advantage, including:
 - Dental
 - Vision
 - Combined healthy food + OTC
 - Routine hearing coverage
- Comprehensive Medicaid benefits, including behavioral health and LTSS (if eligible)

Partial benefit dual eligible

- All Medicare-covered services, including doctors, hospital care, prescriptions
- Supplemental benefits covered by Medicare Advantage, including:
 - Dental
 - Vision
 - Combined healthy food + OTC
 - Routine hearing coverage
- Cost-sharing for Medicaid and Medicare benefits





Continuity of care

Continuity of care



- **Health care providers should not cancel appointments or services with current patients.** UnitedHealthcare will honor any ongoing treatment that was authorized prior to the beneficiary's enrollment into the Medicare-Medicaid integrated program for up to 180 days after the transition.
- **Providers will be paid.** Providers should continue providing any services that were previously authorized, regardless of whether the provider is currently participating in the UnitedHealthcare network. UnitedHealthcare will pay for previously authorized services at 100% of the current Medicaid rate throughout the continuity of care period.
- **Providers will be paid promptly.** During the continuity of care period, UnitedHealthcare is required to follow all timely claims payment contractual requirements. DHCF will monitor complaints to help ensure that any issues with delays in payment are resolved.



Supporting continuity of care through the transition period



- UnitedHealthcare Community Plan will receive transition data from the case management agencies (CMAs)
 - Transition summary details include enrollee status report, individual care plan, prior authorization information and any other important transition information needed to support care coordination and continuity of care
 - Data is ingested into the case management electronic medical record (EMR)
- The UnitedHealthcare team will conduct a series of transition meetings with CMAs to complete warm handoffs to support continuity of care and a seamless enrollee transition
- Additional details on transition of care will be discussed during the Care Management Readiness Review session
- Current authorizations will be built in the UnitedHealthcare authorization system for continuity of care



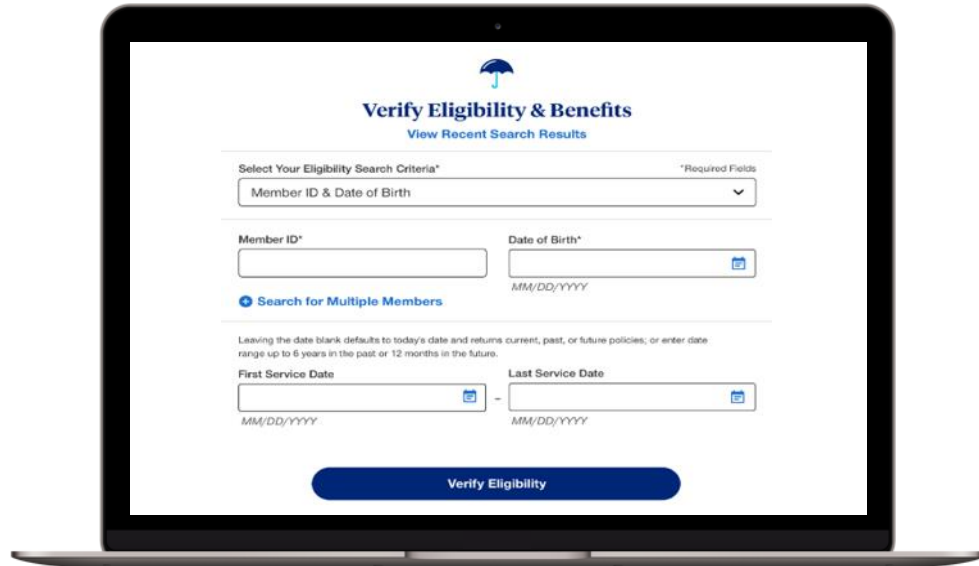


Provider Portal

Access the portal at UHCprovider.com

The screenshot shows a web browser window with the URL <https://www.uhcprovider.com/en/access.html>. The browser's address bar and tabs are visible at the top. The website header includes the United Healthcare logo, a search bar with the text "What can we help you find?", and navigation links for "Members", "Find Dr.", "New User & User Access", and "Sign In". Two blue arrows point to the "New User & User Access" and "Sign In" buttons. Below the header, the breadcrumb trail shows "Home > New user & user access". The main content area is titled "New user & user access" and "Roles and access for the portal". A large blue heading reads "New user & user access". Below this, a sub-heading states: "You can manage information, register, add, change and deactivate users all in the UnitedHealthcare Provider Portal." The text explains that the UnitedHealthcare Provider Portal allows users to take action and quickly access information regarding eligibility, prior authorization, claims, and electronic letters and reports. It also notes that to access secure content and sign in, users need to first register with a One Healthcare ID. Two blue buttons are visible: "Access and registration guide →" and "Register for live training →". A vertical "Feedback" button is located on the right side of the page.

Eligibility & Benefits



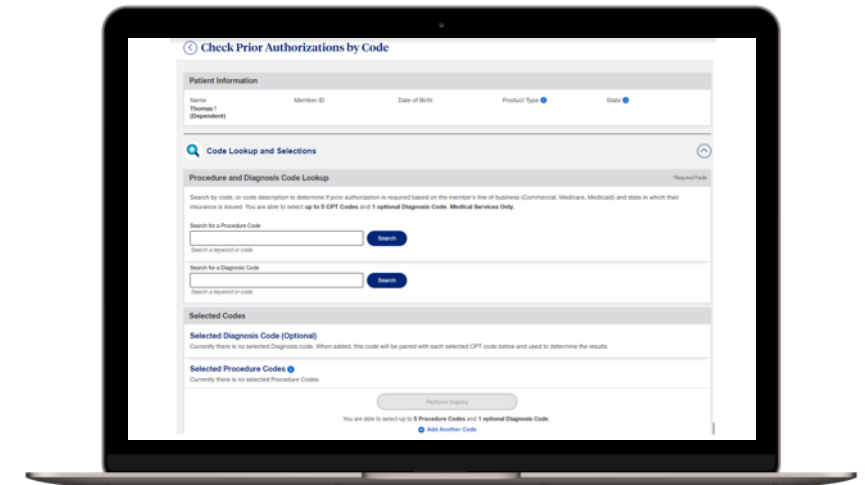
Features include:

- View or print an enrollee's digital ID card
- Copay, coinsurance and deductible amounts
- Referral and prior authorization requirements
- Care provider's network




Spotlight:

Check if prior authorization is required by code



Enrollee ID cards


Health Plan (80840) 911-87726-04

Member ID: 001500025 Group Number: DCDSNP

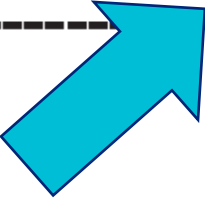
Member:
NEW M ENGLISH
Medicaid ID: 9999999995
PCP Name:
DOUGLAS GETWELL
PCP Phone: (717) 851-6816

Payer ID: 87726

MedicareRx
Prescription Drug Coverage
Rx Bin: 610097
Rx Grp: MPDCSP
Rx PCN: 9999

S1803 MT ROSE AVE STE B3
YORK, VA 174033051

H2228-045 UnitedHealthcare Dual Complete(PPO D-SNP)
Medicare limiting charges applied



In an emergency go to nearest emergency room or call 911. Printed: 01/10/22

Website: www.UHCCommunityPlan.com

Customer Service: 1-866-242-7726 TTY 711
NurseLine: 1-877-440-9407 TTY 711
Behavioral Health: 1-866-242-7726 TTY 711
Dental: 1-866-242-7726 TTY 711

For Providers: UHCprovider.com 1-888-350-5608
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240
For Dental Providers: UHCproviders.com 1-844-275-8750

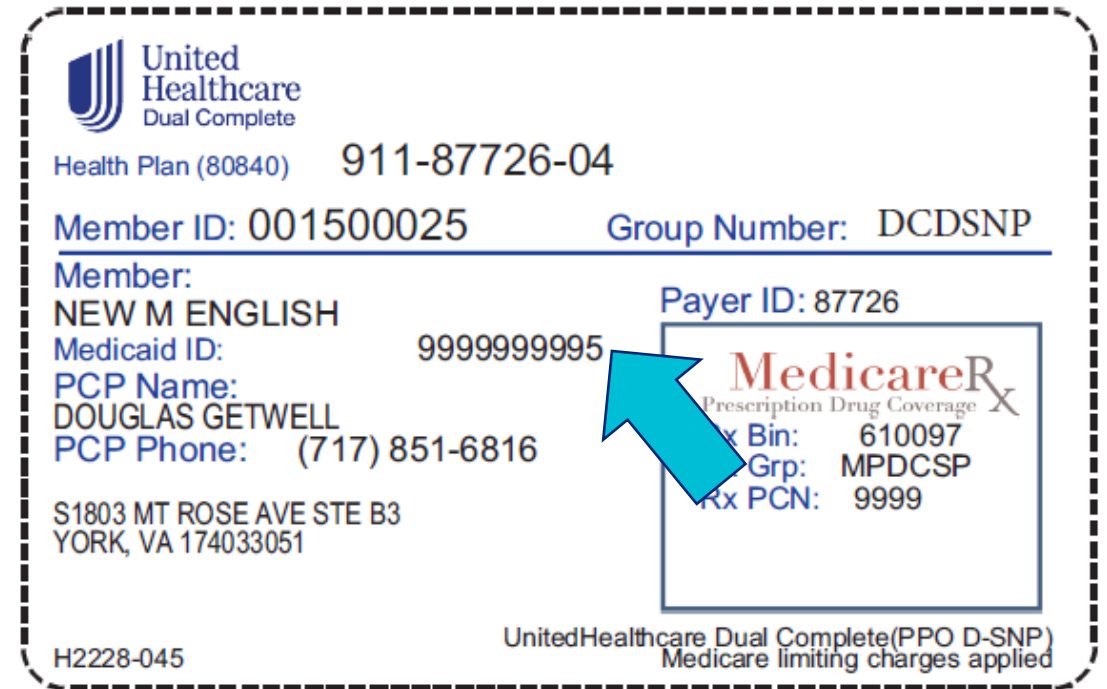
CP **Renew Active** **NO Referral Required**

Pharmacy Claims: OptumRX, PO Box 650287, Dallas, TX 75265-0287
For Pharmacists: 877-889-6510



Validating eligibility

- Utilize the Medicaid ID (not the member ID on top of the card) and date of birth (DOB)
- Utilizing the member ID will only pull the eligibility on the primary D-SNP policy



United Healthcare
Dual Complete

Health Plan (80840) 911-87726-04

Member ID: 001500025 Group Number: DCDSNP

Member:
NEW M ENGLISH
Medicaid ID: 9999999995
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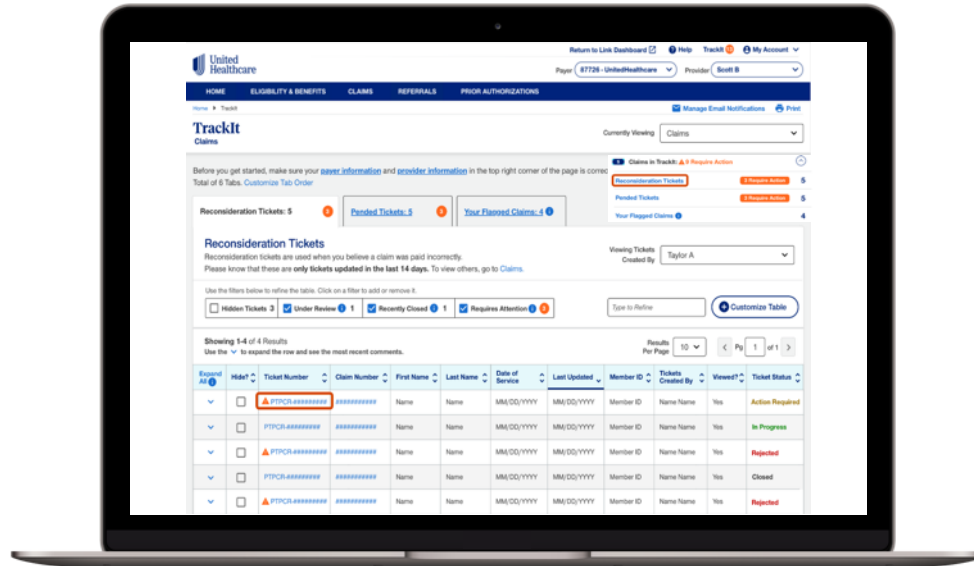
Payer ID: 87726

MedicareRx
Prescription Drug Coverage
Rx Bin: 610097
Grp: MPDCSP
Rx PCN: 9999

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New solution — TrackIt



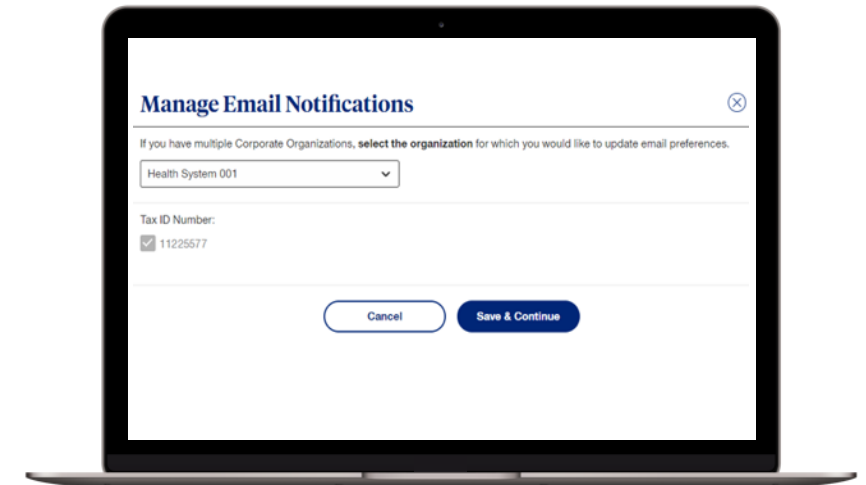
Features include:

- One location to see claims and prior authorizations that require action or information
- View updates and status of submitted reconsiderations, appeals and pended claims



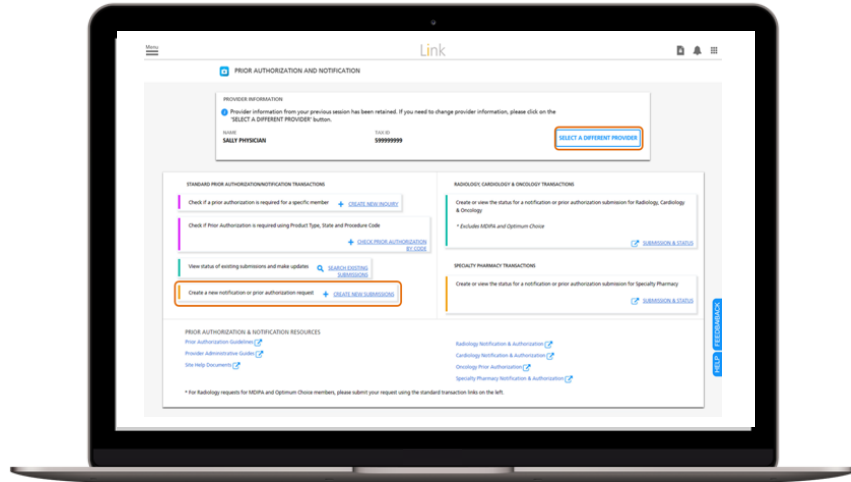
Spotlight:

Sign up for proactive emails to receive notification when the status of a claim or prior authorization has changed



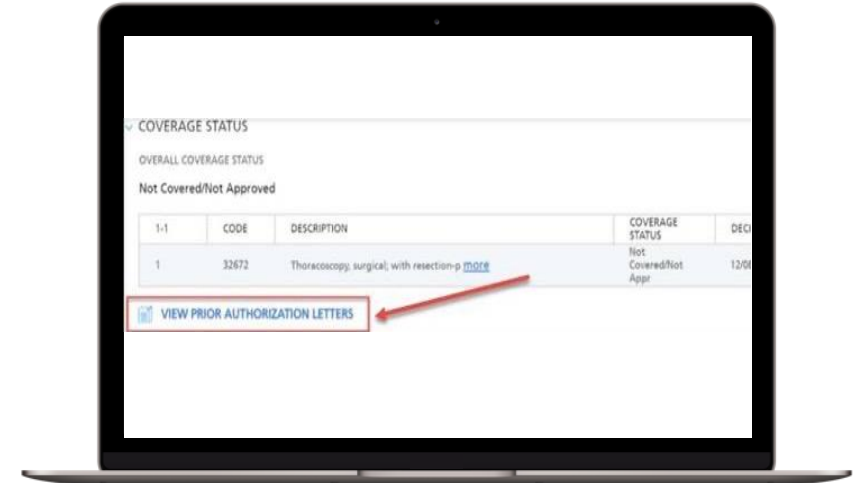
Prior authorization

UHCprovider.com



Spotlight:

Access prior authorization determination letters online



Features include:

- Determine requirements using the procedure code and plan type
- Submit or check the status of notification and prior authorization requests
- Get real-time authorization approvals for some requests
- Upload clinical notes, medical records or images to a request
- Hyperlink to access prior authorization letters in Document Vault



Claim submission self-paced user guide

For more information, go to UHCprovider.com/portal > Claim Submission > Claim Submission self-paced user guide.

- Provides a step-by-step process of submitting claims
- Submit professional claims for all UnitedHealthcare enrollees
- Easily see which fields are required as they are highlighted in yellow
- View on-screen messages that allow you to correct certain errors before you hit “Submit”
- Eliminate paper, postage and mail time



Additional online provider resources

Self-service tools on UHCprovider.com:

Eligibility & Benefits

- View, download, save the enrollee's digital ID card
- Check enrollee eligibility and review detailed benefits information
- Can also use the tool to find out if referrals, notifications and prior authorizations are required for the enrollee's plan

Claims

- View claim information for multiple UnitedHealthcare plans in a single tool
- View letters and remittance advice
- Flag claims for future viewing
- Submit additional information requested on closed or pended claims
- Submit claim reconsideration requests with or without electronic attachments





Out-of-network providers

Out-of-network providers

- UnitedHealthcare will make every effort to meet the needs of enrollees including contracting with providers who are currently out of network
- UnitedHealthcare will continue services for enrollees who are seeing out-of-network providers during the continuity of care/transition of care period
- UnitedHealthcare will outreach to recruit the provider into the network within the 90 days of the enrollee's enrollment in the UnitedHealthcare plan of District of Columbia Dual Choice program
- Should the provider not meet our standards, choose not to join the network or the enrollee does not select a new in-network provider after the 90 days, UnitedHealthcare will work with the enrollee to choose an in-network provider



Out-of-network utilization

UnitedHealthcare will reimburse providers for authorized out-of-network care both during and after the continuity of care/transition of care period.

- Out-of-network provider requests are reviewed for medical necessity
- Out-of-network provider is contacted and offered standard non-participating fee schedule



Out-of-network Provider Portal registration

- Registering for the Provider Portal as a non-participating provider
 - Go to the portal registration page at UHCprovider.com/out-of-network-registration
- **Step 1: Create a One Healthcare ID**

Create One Healthcare ID

One Healthcare ID securely manages your account so that you can use one One Healthcare ID and password to sign in to all integrated applications.



Already have One Healthcare ID? [Sign in now](#)

Profile Information

First name

Last name

Year of birth

 A small circular icon containing a question mark, used for help or support.

Sign In Information

Your email address



Out-of-network Provider Portal registration (cont.)

- Step 2: Select your organization type

The screenshot shows the United Healthcare Provider Portal registration page. At the top left is the United Healthcare logo. The main heading is "Welcome to the Provider Portal!". Below this is a sub-heading: "First, select your organization type below." There are three main selection cards: 1. "Healthcare Professional or Facility" with a stethoscope icon, describing roles like Physician, Hospital/Clinic, etc., and requiring a TIN. 2. "Revenue Cycle Management/ Billing Company" with a dollar sign icon, describing roles like Billing Agent, Managed Billing, etc., and requiring a TIN. 3. "Business Vendor" with a briefcase icon, describing roles like Clearinghouse, Practice Manager, etc., and requiring a TIN. Each card has a "Register" button with a right-pointing arrow. At the bottom right, there is a progress indicator showing "1/1 topic 1" and "6% completed".



Out-of-network Provider Portal registration (cont.)

- **Step 3: Connect your organization's tax ID number (TIN) and confirm your information**

Select the job function(s) that most closely aligns to your role.

Please select all that apply.

Administrative Staff

General responsibilities, roles, and tasks include: billing and medical coding, writing transcriptions executive management, managing the reception desk, participating in human resource functions, participating in IT functions, technician work for biomedical equipment, administrative assistant work.

Clinical Staff

Support Staff

General responsibilities, roles, and tasks include: document medical history of patients, use and maintain medical equipment, give diagnostic tests, observe vitals, provide a prognosis based on the treatment process

Clinician

General responsibilities, roles, and tasks include: prescribe medication to treat or cure illnesses, create treatment plans, update patients' medical information on charts, give referrals when a treatment beyond their speciality is needed. This category requires providing your individual NPI

National Provider Identification #*

1/1
topic 1

6%
complete



Out-of-network Provider Portal registration (cont.)

- **Step 4: Select your job function and portal access**
- **Step 5: Portal approval**
- **Step 6: Submit claims**
 - **This process can take multiple business days**

Select the tasks that you need access to.

Please select all that apply.

- Select All

- Approve and Manage Access
- Eligibility and Benefits Checks
- Provider, Practice and Facility Management
- Claims and Payment Management
- Prior Authorizations and Referrals
- Reporting

1/1
topic 1

6%
complete





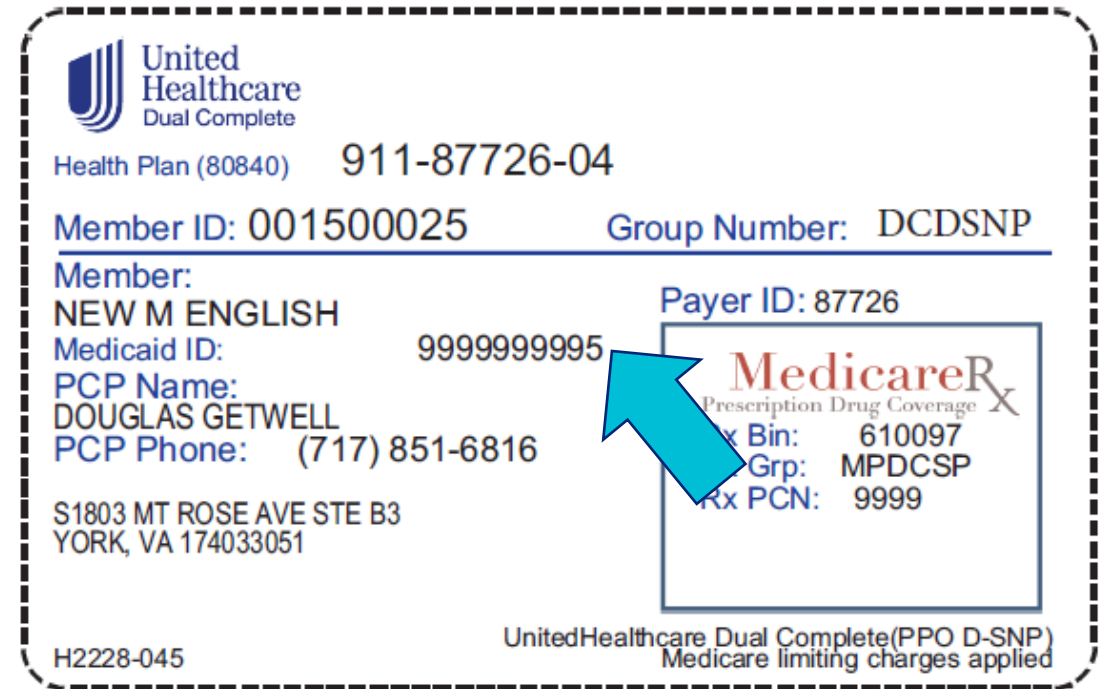
Billing process

Our claims process



Reviewing claims

- Utilize the Medicaid ID (not the member ID on top of the card) and DOB
- Utilizing the member ID will only pull the primary D-SNP claims



United Healthcare
Dual Complete

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MedicareRx
Prescription Drug Coverage
Rx Bin: 610097
Grp: MPDCSP
Rx PCN: 9999

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Billing and reimbursement



- You should continue to bill for HCBS services using the existing Healthcare Common Procedure Coding System (HCPCS) codes, modifiers and units that DHCF uses
- We'll reimburse you according to your Agreement, as noted in the Payment Appendix section
- Submit claims for payment after the service is provided
- We only reimburse for services rendered that are approved in advance
- Bill services using the appropriate form
- Follow all elements of the clean claim requirements when submitting claims
- Use valid ICD-10 coding, when appropriate
- Avoid balance billing to the enrollee



Electronic claims submission



- Avoid clearinghouse fees for EDI claims submissions
- **For electronic submission, the Payer ID is 87726**
- Visit [UHCprovider.com](https://uhcprovider.com) > Sign in > Claims & Payments > Submit a Claim
- Clearinghouse of your choice: If you receive 835 electronic remittance advice (ERA) through a vendor, please ask them to enroll you for the 835 through OptumInsight
- There are several ways to get help and learn more about EDI:
 - **Online:** Go to [UHCprovider.com/edi](https://uhcprovider.com/edi)
 - **Call:** EDI Support: **800-210-8315**
 - **Email:** ac_edi_ops@uhc.com



Paper claims submission



You can mail paper claims to the address on the back of the enrollee ID card, which is:

UnitedHealthcare Community Plan
District Dual Choice Program
P.O. Box 5240
Kingston, NY 12402-5240

Standard timely filing:

- In-network providers: 180 days from the date of service
- Out-of-network providers: 180 days from the date of service



Top denials and how to avoid them

Claim denial reason	Root cause	Action required
Duplicate claim	A duplicate claim was submitted.	No action is required.
DOS outside member effective dates	The enrollee is no longer active with UnitedHealthcare Community Plan.	Verify the health plan and submit claim to that health plan for payment.
No authorization on file	There's no authorization on file for that covers the enrollee, DOS or procedure code billed.	Ensure a valid company authorization is on file for the enrollee, DOS and procedure code.
Invalid procedure/POS combination	The procedure code is billed with an inappropriate/incorrect place of service.	You'll need to submit the corrected claim using the corrected claim process, ensuring the appropriate POS is billed for the procedure code listed on the claim.
NPI not billed	The NPI number is either missing from the claim or isn't in the correct format.	You'll need to submit the corrected claim using the corrected claim process, ensuring the NPI number is included and in the correct format.
Correct billing address needed	The billing address on the claim doesn't match the billing address UnitedHealthcare Community Plan has on file.	Contact your provider advocate to confirm your billing address. If needed, you can submit a corrected claim using the corrected claim process, ensuring the correct billing address is listed on the claim.





Resources

Provider training sessions

- The new UnitedHealthcare Community Plan District Dual Choice program
- Online tools and resources to verify eligibility, submit claims and more
- Best practices for claims submission and timely filing
- Prior authorization requirements and process
- Resolving issues by reaching out to the right contacts
- Accessing quick reference guides to answer common questions

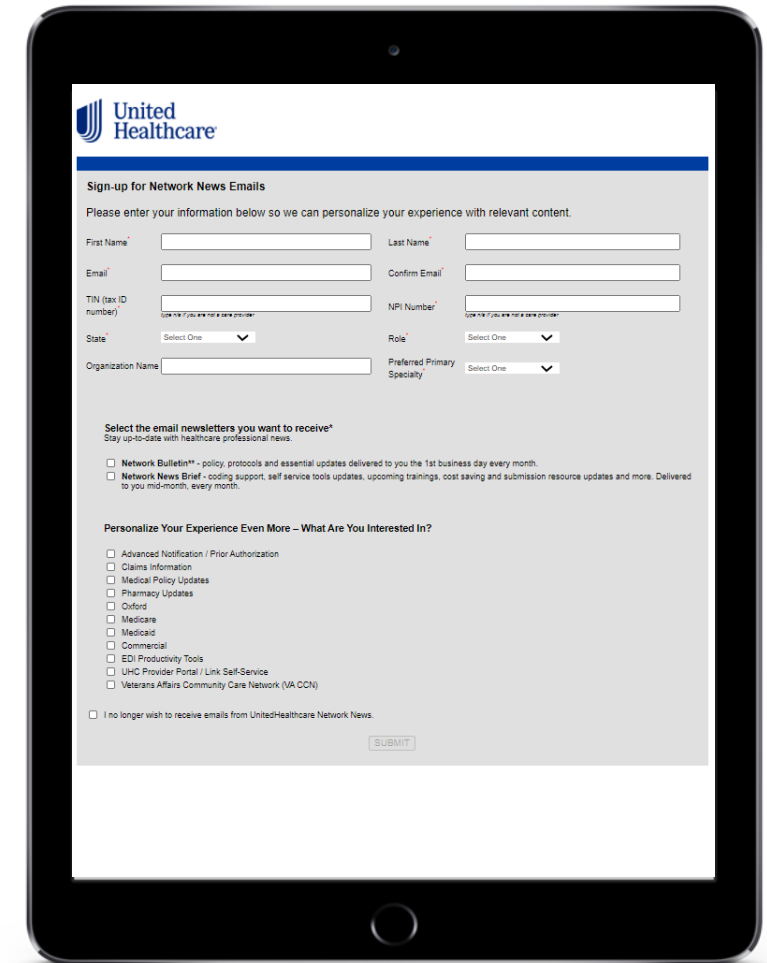
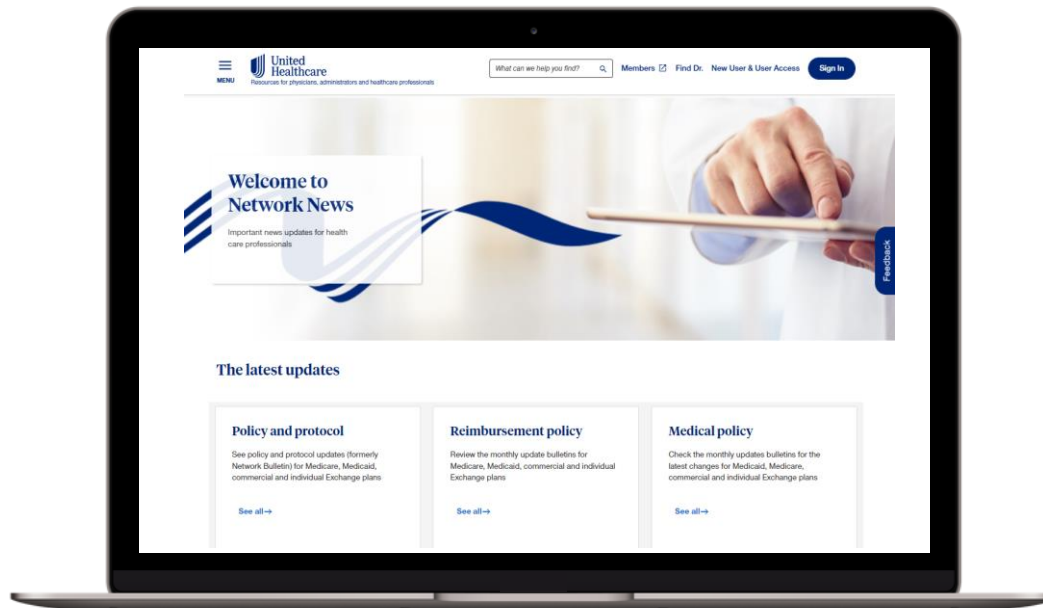
Date	Time
Jan. 27, 2022	11 a.m. ET
Feb. 1, 2022	11 a.m. ET
Feb. 3, 2022	11 a.m. ET
Feb. 8, 2022	11 a.m. ET
Feb. 10, 2022	11am EST
Feb. 17, 2022	11 a.m. ET
Feb. 22, 2022	11 a.m. ET
March 3, 2022	11 a.m. ET
April 7, 2022	11 a.m. ET



Network News

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On-demand provider training



UHCprovider.com/training is the source for on-demand education created specifically for UnitedHealthcare providers. It provides in-depth information and meaningful updates from UnitedHealthcare 24/7 and can be accessed from any device.

UHCprovider.com/training topics

- Claims and Payments: Get the most recent claims processing information
- Healthcare Professional Education and Training,
UHCprovider.com/en/resource-library/training.html
- Reform and Regulations: Get up-to-date regulatory data
- State-Specific Information: Each state has its own page for state-specific information and resources



How we communicate with you

Administrative guide/Medicaid provider manual:

- Updated annually
- Available mid-January via the **UHCprovider.com** DC Medicaid (Community Plan) page at UHCprovider.com/DC > UnitedHealthcare Community Plan of District of Columbia Homepage > Provider Manual > District of Columbia
- Frequently asked questions document
- Self-paced provider training
- LTSS billing matrix (coming soon)





Thank you