

2019 Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary Care
Nebraska



Welcome

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

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

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

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.



If you have questions about the information or material in this manual, or about our policies, please call [Provider Services](#) at **866-331-2243**.

Important Information about the Use of This Manual

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

This manual will be amended as policies change.

PARTICIPATION AGREEMENT

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

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Chapter 1: Introduction

UnitedHealthcare Community Plan supports the Nebraska state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.
- Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- Children eligible for the Children’s Health Insurance Program (CHIP).
- Categorically Needy – Blind and Disabled Children and Adults who are not eligible for Medicare.
- Medicaid eligible families.
- Women eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).
- Medicaid beneficiaries 65 years or older and not members of the blind/disabled population or members of the Section 1931 adult population.
- Medicaid beneficiaries participating in a Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the state’s 1915(c) waiver of the Social Security Act.
- Retroactively-eligible Medicaid beneficiaries, when mandatory enrollment for managed care has been determined.
- Members eligible during presumptive eligibility.

DHSS will determine enrollment eligibility.



If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at 866-331-2243.

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

WHOLE PERSON CARE MODEL

The Whole Person Care (WPC) program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. WPC examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. WPC provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. WPC provides:

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including primary care provider (PCP), pharmacist, medical and behavioral director,

and peer specialist.

- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

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

Care Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health

care professionals such as PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers. UnitedHealthcare Community Plan offers several options to support care providers who need assistance.

Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **800-641-1902**, TTY 711. You may also call Provider Services at **866-331-2243**.

SECURE CARE PROVIDER WEBSITE

UnitedHealthcare Community Plan provides a secure portal to network care providers, facilities and medical administrative staff called Link at UHCprovider.com. This website offers an innovative suite of online health care management tools, including the ability to view all online transactions for UnitedHealthcare Community Plan members. It can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.



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

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limit.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box on UHCprovider.com, and the search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we

direct you to specific web pages on our [UHCprovider.com](https://www.uhcprovider.com) provider portal. You can now use certain direct URLs, which helps you find and remember specific webpages easily and quickly. You can access our most used and popular web pages on [UHCprovider.com](https://www.uhcprovider.com) by typing in that page's direct URL identified by a forward slash in the web address, e.g. [UHCprovider.com/claims](https://www.uhcprovider.com/claims). When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

PROVIDER SERVICES

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



[Provider Services](#) can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Call Provider Services at **866-331-2243**.

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

NETWORK MANAGEMENT DEPARTMENT

Within UnitedHealthcare Community Plan, the Network Management Department can help you with your contract, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing and other related issues.



If you need to speak with a network contract manager about credentialing status or contracting, call our [Network Management Phone Team](#) at **800-284-0626**.

CULTURAL COMPETENCY RESOURCES

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

UnitedHealthcare Community Plan offers the following support services:

- **Cultural member materials:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

Cultural competency is at the heart of serving our members, their special health needs and their unique circumstances. Cultural sensitivity plays a vital part in realizing our goal of supporting member recovery and resiliency in ways that are meaningful and appropriate for individuals in their communities and relevant to their unique cultural experiences.

Our philosophy to help ensure culturally competent care providers emphasizes a “whole member” approach, taking into account the member’s environment, background and culture. We are also committed to disability competency in which individuals and systems provide services effectively to people with various physical and behavioral disabilities. This includes modifications of a treatment facility, treatment environment and access. We believe care delivery includes respecting the worth of each individual and preservation of their personal dignity. These considerations include:

- Compliance with American Disabilities Act (ADA) indicated through policies and procedures
- Mobility and accessibility, including wheelchair ramps and entrance access
- Accessible medical equipment and services adapted to member needs and disability (i.e., adjustable examination table)
- Community resources and assistance, including transportation

If you find you are unable to assist a member’s access needs, including counseling or referral services, contact Provider Service Center at **866-331-2243**, so we can refer the member to a network care provider who is able to make the necessary accommodations for member care.

CARE PROVIDER PRIVILEGES

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

ambulatory surgery center privileges and/or dialysis center privileges.

DIRECT CONNECT

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

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

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



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

COMPLIANCE

HIPAA mandates 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.

You must have and use the NPI number registered with DHHS (billing and rendering) to be reimbursed for services provided to UnitedHealthcare Community Plan members. Each claim must include the billing and rendering NPI number, along with other fields such as billing taxonomy code and the office nine digit zip code registered with DHHS.

Because the Nebraska Department of Health and Human Services uses the above data, it is important that this data combination is the same data combination used in the provider registration process for a DHHS Provider Identification Number.

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.

How to Contact Us

Topic	Contact	Information
Benefits	UHCprovider.com/benefits 866-331-2243	Confirm a member’s benefits and/or prior authorization.
Chiropractor Care	myoptumhealthphysicalhealth.com 800-873-4575	We provide members requesting manual spine manipulation to correct spinal alignment (subluxation): <ul style="list-style-type: none"> • 12 treatments per calendar year for members 21 and older. Visits incurred and paid as primary under other insurance will not count towards the Medicaid annual maximum visit limit. • Members 20 and younger are limited to 18 treatments in the initial five months from the first visit date for the reported diagnosis. After the fifth month, a maximum of one treatment per month is covered until the age of 21. In this instance, the benefit does not renew at the beginning of each calendar year. The benefit is per diagnosis, so the member is only eligible for one treatment per month, after the fifth month, until the age of 21 for that diagnosis. If the member loses Medicaid eligibility and becomes eligible again, the benefit would continue at one treatment per month, after the fifth month, until the age of 21 for that diagnosis. • Covers one set of x-rays per year.
Claims	Use the Link Provider Portal at UHCprovider.com/claims 866-331-2243 Mailing address: UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131 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.

Topic	Contact	Information
Claim Overpayments	<p>See the Overpayment section for requirements before sending your request.</p> <p>Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app</p> <p>800-727-6735</p> <p>Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</p>	<p>Ask about claim overpayments.</p>
Dental Services	<p>Managed Care of North America, Inc. (MCNA)</p> <p>844-351-6262</p> <p>TTY 800-833-7352</p> <p>mcnane.net</p>	<p>The state of Nebraska Department of Health and Human Services covers dental services through their vendor Managed Care of North America (not covered by UnitedHealthcare Community Plan). Anesthesia and facility charges associated with dental procedures and provided at a hospital facility or Ambulatory Surgery Center (ASC) are covered and must meet medical necessity. UnitedHealthcare Community Plan must approve prior authorization for facility use for services to be considered.</p>
Electronic Data Intake Claim Issues	<p>ac_edi_ops@uhc.com</p> <p>800-210-8315</p>	<p>Ask about claims issues or questions.</p>
Electronic Data Intake Log-on Issues	<p>800-842-1109</p>	<p>Information is also available at UHCprovider.com/edi.</p>
Eligibility	<p>To access the app, sign in to UHCprovider.com/eligibility to access Link, then select the UnitedHealthcare Online app</p> <p>Provider Services: 866-331-2243 or Nebraska Medicaid Eligibility System: 800-642-6092</p>	<p>Confirm member eligibility.</p>

Topic	Contact	Information
Enterprise Voice Portal	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, Waste and Abuse	866-242-7727	Notify us of suspected fraud or abuse by a care provider or member.
Healthy First Steps/ Obstetrics (OB) Referral	800-599-5985 or 877-813-3417 Fax: 877-353-6913	Refer high-risk OB members. Fax initial prenatal visit form.
LabCorp for Providers	800-833-3984	LabCorp is the preferred lab provider.
Medicaid [Department of Health and Human Services]	Medicaid.gov 877-255-3092 (toll free) 402-471-9128 (Lincoln area)	Contact Medicaid directly.
Medical and Behavioral Claim, Reconsideration and Appeal	Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app 866-331-2243 Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	800-641-1902 TTY 711	Assist members with issues or concerns. Available 7 a.m. – 7 p.m. Central Time, Monday through Friday.

Topic	Contact	Information
Mental Health & Substance Abuse (United Behavioral Health)	United Behavioral Health Prior authorization requests: 866-604-3267 Claims/customer service eligibility and benefit information: 866-331-2243 Update provider practice information, and ask about guidelines, policies and the national network manual: 877-614-0484 Appeals and grievances: 866-556-8166 providerexpress.com	Refer members for behavioral health services. (A PCP referral is not required.) Request a prior authorization, ask about claims and customer service eligibility and benefit information, submit appeals and grievances, update care provider practice information, review guidelines and policies and view the national network manual.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	800-641-1902 TTY 711 TDD 711	Available 8 a.m. – 5 p.m. Central Time, Monday through Friday, except state-designated holidays.
National Credentialing Center (VETTS line)	877-842-3210	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Phone Team	800-284-0626	Ask about contracting and care provider services.
NurseLine	877-543-4293 TTY 711	Available 24 hours a day, seven days a week.
Obstetrics and Baby Care	Healthy First Steps 800-599-5985 or 877-813-3417 Fax: 877-353-6913 Obstetrical Needs Assessment Form (ONAF) UHCBabyBlocks.com	Links for pregnant moms and newborn babies.

Topic	Contact	Information
Optum Support Center	LinkSupport@optum.com 855-819-5909	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	professionals.optumrx.com 877-305-8952 (OptumRx) Pharmacy Benefit Manager Help Desk: 877-231-0131 Pharmacy Assistance Line: 877-231-0131 (contact for durable medical equipment (DME) received at a pharmacy)	OptumRx oversees and manages our network pharmacies. Available 8 a.m. – 8 p.m. Central Time, Monday through Friday.
Provider Advocate	Nebraska PR Team@uhc.com To locate your provider advocate and contact information, please use UHCprovider.com/NEcommunityplan > Contact Us > Nebraska Provider Advocates Contact Sheet	Contact your Nebraska Provider Advocate when assistance is needed to answer a question or resolve a claims payment-related issue.
Prior Authorization/ Notification for Pharmacy	UHCprovider.com/priorauth 800-310-6826 Fax: 866-940-7328	Request authorization for medications as required. Available 8 a.m. – 8 p.m. Central Time, Monday through Friday.
Prior Authorization/ Notification of Health Services	UHCprovider.com/priorauth 866-604-3267	Request authorization/notify of the procedures and services outline in the prior authorization/ notification requirements section of this manual. Complete and current list of prior authorizations.
Provider Services	UHCprovider.com/NEcommunityplan 866-331-2243	Available 7 a.m. – 8 p.m. Central Time, Monday through Friday.
Referrals	UHCprovider.com > Click Menu on top left, then select Referrals or use LINK Provider Services: 866-331-2243	
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/ smoking.

Topic	Contact	Information
Transportation	National MedTrans 833-586-4221(toll free) 844-488-9724 (TTY) nationalmedtrans.com/ne	National MedTrans: Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.
Utilization Management	866-331-2243	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.
Vaccines for Children (VFC) program	800-219-3224	Care providers 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. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.
Vision Services	844-636-2724 marchvisioncare.com	Prior authorization is not required for routine eye exams. Authorizations must be obtained from MARCH® Vision.
Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)	877-856-6351 Private Duty Nursing: 402-445-5000	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Website for Nebraska Community Plan	UHCprovider.com/NEcommunityplan	Access your state specific Community Plan information on this website.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

MAINSTREAMING OF MEMBERS

To help ensure mainstreaming of Nebraska Medicaid members, UnitedHealthcare Community Plan will take affirmative action to provide covered services to members without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual orientation, genetic information, or physical, or will take reasonable steps to help ensure subcontractors do the same. Prohibited practices include, but are not limited to the following, in accordance with 42 CFR 438.6(f):

- Denying or not providing a member a covered service or access to an available facility.
- Providing a member a medically necessary covered service that is different, or is provided in a different manner or time from that provided to other members, other patients or the public at large, except where medically necessary.
- Subjecting a member to segregation or separate treatment related to the receipt of a covered service, or restricting a member's enjoyment of an advantage or privilege enjoyed by others receiving a covered service.

- Assigning times or places for the provision of services on the basis of race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental health of the participants to be served.

COMMUNICATION BETWEEN CARE PROVIDERS AND MEMBERS

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

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

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

PROVIDE OFFICIAL NOTICE

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

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.
7. Material changes, cancellation or termination of liability insurance.

You may use the care provider demographic information update on form for demographic changes or update NPI information for care providers in your office. This form is located at [UHCprovider.com](https://www.uhcprovider.com) > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

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

ARRANGE SUBSTITUTE COVERAGE

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



For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at [UHCprovider.com](https://www.uhcprovider.com) > Find Dr.

ADMINISTRATIVE TERMINATIONS FOR INACTIVITY

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at [UHCprovider.com](https://www.uhcprovider.com) > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Email this information to the number on the bottom of the demographic change request form.

UPDATING YOUR PRACTICE OR FACILITY INFORMATION

You can update your practice information through the Provider Data Management application on [UHCprovider.com](https://www.uhcprovider.com). Go to [UHCprovider.com](https://www.uhcprovider.com) > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and faxing it to the appropriate number listed on the bottom of the form.

AFTER-HOURS CARE

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

If a member calls you after hours 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, member safety (risk reduction) efforts and data confidentiality procedures.

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

PROVIDE ACCESS TO YOUR RECORDS

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

PERFORMANCE DATA

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

COMPLY WITH PROTOCOLS

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



You may view protocols at UHCprovider.com.

OFFICE HOURS

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

PROTECT CONFIDENTIALITY OF MEMBER DATA

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information,

we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES

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



You can locate more advanced directives information at: caringinfo.org.

RESOLVING DISPUTES

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send

you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

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

Also reference [Chapter 12](#) of this manual for information on provider claim reconsiderations, appeals and grievances.

Appointment Standards (Nebraska DHHS 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: within 24 hours
- Routine care appointment: within 14 calendar days
- Non-urgent "sick" care: within 72 hours, or sooner if clinically indicated
- Preventive care: within four weeks
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed 45 minutes. This includes time spent in the waiting room and examining room for members with appointments, unless the care provider is unavailable or delayed because of an emergency. Notify the member immediately if a care provider is delayed. Offer the member a new appointment if a wait of more than 90 minutes is anticipated.

- Family planning services: within seven calendar days
- Laboratory and x-ray services: within 48 hours (or as clinically indicated) for urgent care and within three weeks for routine appointments
- Behavioral health:
 - Emergency appointments: must be referred within one hour (generally) and within two hours in designated rural areas
 - Other specialty care: within 30 calendar days of referral or as clinically indicated

SPECIALTY CARE

Specialists should arrange appointments for:

- Routine appointment type: within 30 calendar days of request/referral or as clinically indicated

PRENATAL CARE

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 14 calendar days of request
- Second trimester: within seven calendar days of request
- Third trimester: within three calendar days of request
- High-risk: within three 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.

Care Provider Directory

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

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

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

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

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

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

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

For Non-delegated providers, visit [UHCprovider.com](https://uhcprovider.com) for the Provider Demographic Change Submission Form and further instructions.

PROVIDER ATTESTATION

Confirm your provider data every quarter through LINK or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access Link's My Practice Profile App to make many of the updates required in this section.

Prior Authorization Request

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

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

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

- Verify eligibility using Link at [UHCprovider.com/eligibility](https://uhcprovider.com/eligibility) or by calling Provider

Services. Not doing so may result in claim denial.

- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from Link:
 1. To access the Prior Authorization app, go to [UHCprovider.com](https://uhcprovider.com), then click **Link**.
 2. Select the **Prior Authorization and Notification app** on Link.
 3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

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

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

Urgent: 24 hours

Non-urgent: 10 business days

Requirements for 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 Nebraska Department of Health and Human Services (DHHS) members may seek services from any participating care provider. The Nebraska DHHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

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

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

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

For services provided by a nurse practitioner or physician assistant, submit the claim under the nurse practitioner or physician assistant and not the supervising care provider. Services for durable medical equipment (DME), home health, and physical, occupational or speech therapies, all require an M.D. or DO be the ordering care provider type. Nebraska Department of Health and Human Services states physician assistants and nurse practitioners cannot be the ordering care provider for these types of services.



Members may change their assigned PCP by contacting [Member Services](#) at **800-641-1902** any time during the month. Customer Service is available 7 a.m. - 7 p.m. Central Time or 6 a.m. - 6 p.m. Mountain Time, Monday through Friday.

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

You may print a monthly Primary Care Provider Panel Roster by visiting [UHCprovider.com](#).

Sign in to [UHCprovider.com](#) > select the UnitedHealthcare Online application on Link > select **Reports** from the **Tools & Resources**. From the Report Search page, select the **Report Type** (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

The PCP Panel Roster provides a list of UnitedHealthcare Community Plan members currently assigned to a care provider.

Females 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 non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, seven days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services.

Recorded messages are not acceptable.

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

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

- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

Responsibilities of PCPs and Specialists Serving in PCP Role

SPECIALISTS INCLUDE INTERNAL MEDICINE, PEDIATRICS, AND/OR OBSTETRICIAN/GYNECOLOGY

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate. Coordinate referrals to appropriate community programs and services such as the Women, Infants, and Children Program (WIC) services program.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
 - Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
 - Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
 - Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
 - Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
 - Complying with the Nebraska DHHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.
- Medical residents in primary care practice: PCPs may use medical residents in primary care in all settings supervised by fully credentialed UnitedHealthcare Community Plan primary care providers. We will not assign members to medical residents.



For questions about member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at **866-331-2243**.

Rural Health Clinic, Federally Qualified Health Center or Primary Care Clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic or Federally Qualified Health Center as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.

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

Primary Care Provider Checklist

Take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify eligibility using Link at UHCprovider.com/eligibility, by calling Provider Services at 866-331-2243, or calling Nebraska Medicaid Eligibility System at 800-642-6092. Failure to verify member enrollment may result in claim denial.
- Verify member identity with photo identification each time the member has services, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare

Community Plan member either electronically or on paper using a CMS 1500 claim form or UB92 form. See Chapter 11 for more information on submitting forms.

Specialist Care Providers Responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Nebraska DHHS 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 members by phone 24 hours a day, seven 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.

Specialist Care Provider Checklist

Take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify eligibility using Link at UHCprovider.com/eligibility, by calling [Provider Services](#), or calling Nebraska Medicaid Eligibility System at **800-642-6092**. Failure to verify member enrollment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth to locate and view the current prior authorization information and notification requirements.
- Identify and bill other insurance carriers when appropriate.

Prenatal Care Responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating providers.



Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the [UnitedHealthcare Healthy First Steps](#) coordinator.

If you have questions, call [Healthy First Steps](#). To begin patient outreach, fax the prenatal assessment form.

An obstetrician does not need approval from the

member's care provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

Take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify the member's enrollment before rendering services. Go to Link at UHCprovider.com/eligibility, by contacting [Provider Services](#), or calling Nebraska Medicaid Eligibility System at **800-642-6092**. Failure to verify member enrollment and assignment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth.
- Identify and bill other insurance carriers, when appropriate.

Chapter 3: Care Provider Office Procedures and Member Benefits

Assignment to PCP Panel Roster

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

Sign in to UHCprovider.com > select Link > select the UnitedHealthcare Online application on Link > select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

Choosing a Primary Care Provider

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

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

will be effective on the request date.

Deductibles/Copayments

Deductibles and copayments are waived for covered services. Medicare and other insurance copays may still apply.

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

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

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

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

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

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



Obtain copies of the Member Handbook online by contacting [UnitedHealthcare Provider Services](#) or online at [UHCCommunityPlan.com](#) under Member Information.

IMMEDIATE ENROLLMENT CHANGES

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



Get eligibility information by calling the [Medicaid Inquiry line](#), by calling the NMES line at **800-642-6092** (toll free) or **402-471-9580** (Lincoln area), or by visiting the Nebraska DHHS eligibility page at [dhhs.ne.gov > DHHS Divisions > Medicaid & Long-Term Care > Client Eligibility Verification](#).



UNBORN ENROLLMENT CHANGES

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



Members may call ACCESSNebraska at **855-632-7633** (toll free), **402-473-7000** (Lincoln area) or **402-595-1178** (Omaha area).

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

PCP SELECTION

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



UnitedHealthcare Community Plan Members can go to [myuhc.com/communityplan](#) to look up a care provider.

599 CHIP ENROLLMENT

Unborn children of pregnant women otherwise ineligible for Medicaid may be covered under 599 Children's Health Insurance Program (CHIP). The 599 CHIP category covers a limited set of services: prenatal care and pregnancy-related services solely for the health of the unborn child. It does not cover postpartum care and medical issues separate to the pregnant woman's health and unrelated to the pregnancy.

Member Eligibility

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

Member ID Card

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



If a fraud, waste and abuse event arises from a care provider or a member, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the [Fraud, Waste, and Abuse Hotline](#) at **866-242-7727**.

UnitedHealthcare Community Plan ID cards will reflect the member’s Group ID number. The member’s ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. You may view a copy of the member’s ID card image online at UHCprovider.com/eligibility while verifying member eligibility. Also document the call in the member’s chart.

MEMBER IDENTIFICATION NUMBERS

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

PCP-Initiated Transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to member non-compliance, member’s condition or illness is better treated by another PCP, member-care provider relationship is not mutually acceptable, travel distance limitations, fraud or forgery or unauthorized use/abuse of services by the member. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, contact UnitedHealthcare Community Plan by fax at 402-445-5730, or mail with the specific event(s) documentation. Documentation includes DHHS form MS-24, the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider’s name.

Mailing address:

UnitedHealthcare Community Plan
 Attn: Health Services
 2717 N. 118th St., Suite 300
 Omaha, NE 68164

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.

3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Sample Health Member ID Card



Verifying Member Enrollment

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

- Provider Portal: access the Link portal through UHCprovider.com/eligibility.

- [UnitedHealthcare Provider Services](#), **866-331-2243**, is available from 7 a.m. – 8 p.m. Central Time, Monday through Friday.
- Nebraska Medicaid Eligibility System (NMES) at **800-642-6092**.

UnitedHealthcare Dual Complete (HMO SNP)

For information regarding UnitedHealthcare Dual Complete, please see Chapter 4 of the Administrative Guide for Commercial, Medicare Advantage and DSNP at UHCprovider.com/guides. For state-specific information, go to UHCprovider.com > Menu > [Health Plans by State](#).

Benefit Information

The following member benefits should not be considered exhaustive. Specific services to be delivered to Community Plan members are described in detail on the [Nebraska DHHS MLTC website](#).

 For questions about if a service is covered contact the Provider Service Center at **866-331-2243**.

Benefit	Services Included	Limitations
Ambulance Services	<p>Emergent ground transportation</p> <p>Non-emergent ground transportation: transportation should be made by the member’s care provider directly with the ambulance service.</p>	<p>Covered if medically necessary.</p> <p>Prior authorization not required if participating care provider. Non-participating care provider requires a prior authorization.</p>
	<p>Emergent air ambulance</p> <p>Non-emergent air ambulance transportation: transportation should be made by the member’s care provider directly with the air ambulance service.</p>	<p>Covered if medically necessary.</p> <p>Prior authorization required for participating and non-participating care providers.</p>
	<p>For more ambulance service information, please refer to Chapter 4 of this manual.</p>	
Bariatric Surgery	Inpatient and outpatient bariatric surgery and specific obesity-related service.	<p>Covered.</p> <p>Potential prior authorization required.</p>

Benefit	Services Included	Limitations
Behavioral Health – Inpatient and Residential	<ul style="list-style-type: none"> • Psychiatric services • Substance use treatment <p>For more behavioral health coverage information, please refer to Chapter 7 of this manual.</p>	Some services may require prior authorization.
Behavioral Health – Outpatient	<ul style="list-style-type: none"> • Admission evaluations and assessments • Outpatient therapy services including individual, group, and family therapy • Medication management <p>For more behavioral health coverage information, please refer to Chapter 7 of this manual.</p>	Some services may require prior authorization.
Cancer-Related Treatment	<p>Access to any related medically necessary service. This includes but is limited to hospitalization, doctor services, other practitioner services, outpatient hospital services, chemotherapy and radiation.</p> <p>Inpatient services:</p> <ul style="list-style-type: none"> • Authorization required for chemotherapy treatments in an inpatient setting. • Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy. <p>Outpatient services:</p> <ul style="list-style-type: none"> • For chemotherapy administration, outpatient facilities must submit charges using the appropriate revenue codes. • No authorization is required unless J codes, which must be submitted for review. 	<p>Covered.</p> <p>Potential prior authorization required.</p>

Benefit	Services Included	Limitations
Chiropractic Services	<p>Manual manipulation of the spine to correct spinal alignment (subluxation):</p> <ul style="list-style-type: none"> • 12 treatments per calendar year for ages 21 and older. Please note: visits incurred and paid as primary under other insurance will not count toward the annual maximum visit limit under Medicaid. • Members age 20 and younger are limited to 18 treatments in the initial five months from the date of the first visit for the reported diagnosis. After the fifth month, a maximum of one treatment per month is covered until the age of 21. In this instance, the benefit does not renew at the beginning of each calendar year. The benefit is per diagnosis, so the member is only eligible for one treatment per month, after the fifth month, until the age of 21 for that diagnosis. In addition, if the member loses eligibility with Medicaid and then becomes eligible again, the benefit would continue at one treatment per month, after the fifth month, until the age of 21 for that diagnosis. • Covers one set of x-rays per year. 	Covered.
Circumcision	<p>Outpatient service: no age limits.</p> <p>Inpatient service.</p>	<p>Covered.</p> <p>Prior authorization required.</p>
Cosmetic and/or Reconstructive Surgery	<p>Services or supplies provided in connection with cosmetic surgery are not covered, except as required for the prompt repair of accident injury or for improvement of the functioning of a malformed body member.</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Ablative procedures for venous insufficiency and varicose veins • Blepharoplasty and brow ptosis repair • Breast reduction • Panniculectomy and body contouring procedures • Rhinoplasty, septoplasty and turbinate resection • Gynecomastia 	<p>Potentially covered.</p> <p>Prior authorization required.</p>

Benefit	Services Included	Limitations
Dental Services	Routine dental services are not covered under UnitedHealthcare Community Plan. Care providers will need to contact Managed Care of North America Insurance Company (MCNA) at 844-353-6262, TTY 800-833-7352 or mcnane.net .	Not covered.
	For dental services performed in an outpatient setting, UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed as a medical necessary.	Covered. Prior authorization required for facility utilization.
	Fluoride varnish in an outpatient setting is covered for members 12 years of age and younger up to three times per calendar year. Fluoride varnish provided by a dentist: Contact Managed Care of North America Insurance Company (MCNA) at 844-353-6262, TTY 800-833-7352 or mcnane.net for age limits and frequency.	
Dialysis Service	Services covered only when provided by a certified end-stage renal disease facility (recipient may become Medicare eligible after three months facility treatment or one month home dialysis). Services covered as an outpatient only and include: <ul style="list-style-type: none"> • Maintenance hemodialysis • Peritoneal dialysis • Kidney transplant services • Physical therapy. Laboratory services are covered with the following restrictions: <ul style="list-style-type: none"> • Bone survey performed annually • Nerve conduction velocity test once every three months • EKG performed once every three months • Hepatitis associated antigen test performed once a month • Bone mineral density every six months • Chest x-ray every six months. 	Covered.
	<ul style="list-style-type: none"> • Take home supplies (ace bandages, splints, etc.) • Home dialysis (except CAPD) • IV fluids (unless justified by diagnosis) • Office or hospital visits by supervising MD on same day as a dialysis treatment • Office visit for sole purpose of dialysis maintenance when MD billed for monthly maintenance fees. • Hospital admissions and hospital daily care for sole purpose of dialysis. 	Not covered.

Benefit	Services Included	Limitations
Diabetic Supplies	<p>All diabetic supplies including, but not limited to: alcohol swabs, syringes, test strips and lancets. Diabetic supplies can be provided from a participating pharmacy. Certain diabetes testing supplies may be preferred. See our Drug Formulary on UHCprovider.com/NEcommunityplan for drugs covered under the Pharmacy Program tab.</p> <p>Glucometers: member must obtain an order/prescription from their care provider. The member will obtain the glucometer from a network DME provider/supplier or a UnitedHealthcare Community Plan contracted DME pharmacy.</p> <p>OptumRx for providers and pharmacies: 877-231-0131.</p>	<p>Covered.</p> <p>Prior authorization required on all DME codes with a retail purchase or cumulative rental cost of more than \$750 per line item. Outpatient only.</p>
Diagnostic Tests	<p>Radiology:</p> <ul style="list-style-type: none"> • CT; X-ray • MRI (magnetic resonance imaging) • MRA (magnetic resonance angiogram) • PET Scan (positron emission tomography) • Nuclear Medicine SPECT MPI (Myocardial perfusion imaging) • Select Nuclear Medicine Studies • Nuclear Cardiology <p>Laboratory:</p> <p>Lab visits: LabCorp 800-788-8765.</p> <p>You need to have a CLIA # on file or claims will deny.</p>	<p>Covered.</p> <p>Diagnostic tests must always be medically necessary.</p> <p>UnitedHealthcare Clinical Request Line for care providers: 866-889-8054</p>
Durable Medical Equipment (DME) and Medical Supplies	<p>Equipment and supplies for medical purpose. May include, but are not limited to, oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; orthotic devices; prosthetic devices; pacemakers; and medical supplies.</p> <p>Member must obtain an order/prescription from their care provider. The member will obtain the DME from a network DME provider/supplier or a UnitedHealthcare Community Plan contracted DME pharmacy.</p>	<p>Covered.</p> <p>An MD or DO must be the ordering care provider type. Per NE DHHS MLTC, physicians assistants and nurse practitioners cannot order these services.</p> <p>Prior authorization is required on all DME codes with a retail purchase or cumulative rental cost of more than \$750 per line item. Outpatient only.</p>

Benefit	Services Included	Limitations
<p>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</p>	<p>EPSDT service is Medicaid’s comprehensive preventive child health service for individuals younger than 21 years of age.</p> <p>Annual physicals for children ages 0-20 must meet EPSDT criteria comprehensive screenings and interim screenings include:</p> <ul style="list-style-type: none"> • Physical exam • Comprehensive health history • Vision screen • Health & developmental history • Hearing screenings • Measurements • Blood pressure • Vital signs • Nutritional counseling • Laboratory procedures • Health education/anticipatory guidance • Immunizations • Lead screenings • Environmental investigation • Dental screening 	<p>Covered.</p>
<p>Emergency, Post-Stabilization and Urgent Care</p>	<p>For a medical emergency or urgent care. Post-stabilization is care after an emergency. Member can get these services 24 hours a day, seven days a week at any emergency room.</p>	<p>Covered anywhere in the USA.</p>
<p>Family Planning</p>	<p>Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health.</p> <p>For more family planning information, please refer to Chapter 4 of this manual.</p>	<p>Covered.</p>
<p>Femoroacetabular Impingement Syndrome (FAI)</p>	<p>All planned elective hip arthroscopy for CPT codes 29914, 29915 and 29916.</p>	<p>Prior authorization required.</p>

Benefit	Services Included	Limitations
Hearing Services	Audiological testing to establish a need for a hearing aid to include: <ul style="list-style-type: none"> • Hearing evaluation (bone conduction & air conduction tests) • Speech audiometry • Hearing aid selection Treatment may include: <ul style="list-style-type: none"> • Auditory training; speech training • Aural rehabilitation (including hearing aid & cochlear implant orientation & fitting adjustments) • Augmentative communication 	Covered.
	Adults: As part of the adult health screening services, audiometry sweeps are covered for once every four years for members more than 21 years of age.	Covered.
	Hearing aids, necessary accessories are covered services with medical evaluation and items covered include: <ul style="list-style-type: none"> • Hearing aids • Initial care kit • Batteries –limit of 32 batteries per month • Repairs • Cords • Garments, harness and other accessories; custom ear molds • Rental fees • Loaner hearing aid fees • Dispensing fees • Hearing evaluation (including audiogram) and necessity, preferably determined by otologist • ITE aids limited to children 12 years of age or older with documented medical necessity (not covered for cosmetic reasons) 	Prior authorization required for ALL DME codes with a retail purchase or cumulative rental cost of more than \$750 per line item.

Benefit	Services Included	Limitations
Home Health Services	All services in the home: <ul style="list-style-type: none"> • Home health agencies • Private duty nursing • PT/OT/ST • Skilled nursing • Social worker • Home Infusion • Care provider home visit 	Covered. Prior authorization required. An MD or DO must be ordering physician type. Per NE DHHS MLTC, physicians assistants and nurse practitioners cannot be the ordering physician type for these services.
Hospice	In-home hospice and short stay inpatient hospice. MLTC provides two 90-day benefit periods during a client's lifetime. If additional benefit periods are needed, Medicaid provides three 60-day benefit periods. Hospice services beyond these benefit periods will be approved as an exception under the prior authorization provisions. The benefit periods may be used consecutively or at intervals.	Prior authorization required.
	Residential Inpatient Hospice Services are covered by NE DHHS MLTC.	Not covered.
	For more hospice information, please refer to Chapter 4 of this manual.	
Hospital – Inpatient	Inpatient hospital care. Includes medical, surgical, post-stabilization, acute and rehabilitative services.	Covered. Prior authorization required.

Benefit	Services Included	Limitations
Hospital – Outpatient	<p>Outpatient professional/medical services professional component (in/outpatient) of surgical services, including:</p> <ul style="list-style-type: none"> • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care • Administration of anesthesia by care provider (other than surgeon) or CRNA • Second surgical opinions • Same-day surgery performed in a hospital without an overnight stay • Invasive diagnostic procedures such as endoscopic examinations <p>Electroconvulsive therapy (ECT) requires a prior authorization.</p> <p>Out-of-Network: Not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.</p>	<p>Covered.</p> <p>Prior authorization required for non-emergent/non-urgent hospital services.</p>
Immunizations	<p>Immunizations are covered for adults.</p> <p>Covered for children, birth through 18 years of age, through the Vaccine for Children program (VFC). Care provider must file claims using the appropriate CPT and modifier. UnitedHealthcare Community Plan only covers the administration of the VFC program.</p> <p>Immunizations should be given in conjunction with EPSDT/well child visits or when other appropriate opportunities occur in accordance with Advisory Committee on Immunization Practices guidelines. Care providers must report required immunization data to the Nebraska State Immunization Information System.</p>	<p>Covered.</p>
Injectable Medications	<p>Rendered on an outpatient basis. Please visit UHCprovider.com/NEcommunityplan to view the current notification requirements for Nebraska for the list of injectable medications requiring a prior authorization. To locate, select the Prior Authorization and Notification tab. Care providers must include applicable NDC numbers and quantity on claim submissions.</p>	<p>Covered.</p> <p>Prior authorization required.</p>
Joint Replacement	<p>Outpatient and inpatient joint and total hip and knee replacement procedures.</p>	<p>Covered.</p> <p>Prior authorization required.</p>

Benefit	Services Included	Limitations
Mid-level Practitioners Services	Includes physician assistants (PA), advanced registered nurse practitioners (ARNP), family practice nurse practitioner (FPNP), pediatric nurse practitioner (PDNP), nurse anesthetists (CRNA), and nurse midwives.	Covered.
Neuropsych Testing	No prior authorization required if in-network.	Covered.
Newborn Services	Facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.	Covered.
	Non-routine newborn care, i.e. care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress) is covered.	Prior authorization required.
	<p>Out-of-Network: not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.</p> <p>Outreach to the mother will be conducted by UnitedHealthcare Community Plan to provide education to the pregnant mom regarding the importance of prenatal care and reminding the mother to contact ACCESSNebraska as soon as the baby is born:</p> <ul style="list-style-type: none"> • 402-595-1178 in the Omaha area • 402-473-7000 in the Lincoln area • 855-632-7633 outside Omaha or Lincoln 	Prior authorization required for non-emergent/non-urgent hospital services.
Nutritional Counseling	Services include outpatient education.	Covered.
Observation	48-hour observation.	Covered.
Orthotics and Prosthetics	Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than \$750.	Prior authorization required.
Outpatient and Care Provider Visits	Services at a hospital or care center when a member stays less than a day, Doctor visits, other care provider visits, family planning, preventive services, and clinic visits. Specialty care provider visits. Emergency room visits including both hospital and care provider charges.	Covered.

Benefit	Services Included	Limitations
Out-of-Network Services	A recommendation to a care provider who is not contracted with UnitedHealthcare Community Plan.	All out-of-network services require prior authorization, EXCEPT emergency services, family planning and tribal services.
Outpatient Surgery	<p>Services include but are not limited to:</p> <ul style="list-style-type: none"> • Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and hospital ASC) <p>Covered when medically necessary and not otherwise excluded.</p>	<p>Covered.</p> <p>Some surgeries require prior authorization.</p>
Pharmacy Program	<p>Drugs prescribed by a care provider. This includes education about how to take the drugs.</p> <p>See our Drug Formulary on UHCprovider.com/NEcommunityplan for drugs covered under the Pharmacy Program tab.</p> <p>For more pharmacy program information, please refer to Chapter 4 of this manual.</p>	<p>Covered.</p> <p>Some drugs on the state-approved formulary and preferred drug list may require prior authorization.</p>

Benefit	Services Included	Limitations
Podiatry Services	<p>Routine/Palliative Foot Care:</p> <p>Palliative foot care includes the cutting or removal of corns or calluses; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory clients; and any services performed in the absence of localized illness, injury, or symptoms involving the foot.</p> <p>Coverage of palliative foot care is limited to: one treatment every 90 days for non-ambulatory clients and one treatment every 30 days for ambulatory clients.</p> <p>Evaluation and management services are not covered in addition to palliative foot care on the same date of service, except:</p> <ol style="list-style-type: none"> 1. New member visits; or 2. Significant, separately identifiable evaluation and management services required to treat a condition above and beyond palliative foot care. <p>Covered for medically necessary services only; typically associated with severe circulatory disease, or loss of sensation of feet or member has been diagnosed with a systemic condition by a care provider that there is medical necessity for professional foot care; such as:</p> <ul style="list-style-type: none"> • Debridement of non-mycotic nails • Diabetes Mellitus • Arteriosclerosis • Buerger’s Disease • Chronic Thrombophlebitis • Peripheral Neuropathies 	Covered.

Benefit	Services Included	Limitations
Pregnancy-Related Services	UnitedHealthcare Community Plan covers all OB services through the member’s pregnancy. Services include pre and post-natal care, tests, doctor visits, and other services that impact pregnancy outcomes.	Covered.
	599 CHIP Enrollment: Unborn children of pregnant women that are otherwise ineligible for Medicaid may be covered under 599 Children’s Health Insurance Program (CHIP). The 599CHIP category covers a limited set of services: prenatal care and pregnancy-related services solely for the health of the unborn child; it does not cover postpartum care and medical issues separate to the pregnant woman’s health and unrelated to the pregnancy.	Covered.
	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. Request prior authorization if the member is inpatient longer than federal requirements allow. Please call 866-604-3267. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more prenatal visits. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit	Prior authorization required.
	Non-routine newborn care, i.e. care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress). For more maternity and newborn information, please refer to Chapter 4 of this manual.	Prior authorization required.

Benefit	Services Included	Limitations
Rehabilitation Therapies	<p>Includes: physical, occupational, speech, therapies, as well as cardiac, pulmonary, and others.</p> <p>Cardiac rehab (maximum of 12 weeks or 36 sessions) without prior authorization.</p> <p>Must be restorative in nature and be related to an injury or acute episode.</p> <p>Physical, occupational, and speech therapy benefits limited to 60 combined visits per calendar year for members age 21 and older. Visits incurred and paid as primary under other insurance will not count toward the annual maximum visit limit under Medicaid.</p> <p>Maintenance physical therapy is not covered.</p> <p>Massage therapy accumulates toward the visit limit. No limit for members age 20 and younger.</p>	<p>Covered.</p> <p>An MD, DO or nurse practitioner must be the ordering care provider type for physical, occupational or speech therapy. Per NE DHHS MLTC, physicians assistants cannot order these services.</p>
Sexually Transmitted Diseases – Screening, diagnosis, and treatment.		Covered when medically necessary.
Skilled Nursing Facility (SNF)	Short-term acute rehabilitation.	Covered. Prior authorization required.
	Long-term custodial care.	Not covered.
Sleep Studies	Either an outpatient hospital setting or sleep study clinic.	Covered when medically necessary.
	ATTENDED sleep studies typically performed in a sleep clinic, facility or lab.	Covered.
	UNATTENDED sleep studies performed in the patient’s home.	Covered.
	Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a one to four lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG). For a sleep study to be reported as a polysomnography, sleep must be recorded and staged.	
Spinal Surgery	Inpatient and outpatient spinal surgeries.	Covered. Prior authorization required.

Benefit	Services Included	Limitations
Sterilization and Hysterectomies	<p>The plan covers once requirements are met. Requirements include but are not limited to:</p> <p>Sterilization – The regulations require that a written consent form (MMS – 110), male or female, must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is to be performed. The individual must be at least 21 years of age at the time the consent form is signed by the member.</p>	<p>Covered.</p> <p>All inpatient services require a prior authorization, in addition to the appropriate state consent form.</p>
	<p>Reversal of Voluntary Sterilization</p>	<p>Not covered.</p>
	<p>Hysterectomies – Services cannot be reimbursed if performed for sterilization purposes. Members undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result.</p> <p>Per Nebraska Administrative Code 18-004.0, “All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101,” Informed Consent Form,” (see 471-000-110) signed and dated by the member in which she states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility.</p> <p>For additional information, visit: dhhs.ne.gov/.</p> <p>Please see Chapter 4 of this manual for more information.</p> <p>All inpatient services require a prior authorization in addition to the appropriate state consent form.</p>	
Synagis	<p>Synagis requires prior authorization from OptumRx.</p> <p>Phone: 800-310-6826</p> <p>Fax: 866-940-7328</p> <p>The Season Respiratory Syncytial Virus Enrollment Form needs to be completed and sent to OptumRx. Please go to UHCprovider.com/NEcommunityplan > Pharmacy Resources tab to locate the Synagis Enrollment Form.</p>	<p>Covered.</p> <p>Prior authorization required.</p>
Telehealth and Telemonitoring Services	<p>Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a physician or practitioner for members in rural areas or other places.</p> <p>For more telehealth and telemonitoring information, please refer to Chapter 4 of this manual.</p>	<p>Covered for medically necessary services.</p>

Benefit	Services Included	Limitations
Tobacco Cessation	<p>Member must be 18 years of age, must be enrolled and actively participating in the Tobacco Free Quit line to be considered participating. Members may call 800-784-8669 to enroll.</p> <p>Up to four tobacco cessation counseling visits with their PCP are covered per session.</p> <ul style="list-style-type: none"> Coverage will include up to two 90 day sessions during a 12 month period. No more than four total visits will be covered during a 90 day session, and no more than eight total visits will be covered in the two 90 day sessions during any 12 month time period. <p>Drugs for the Tobacco Cessation program are covered under the Pharmacy Program.</p>	<p>Covered.</p> <p>Some limitations apply.</p>
Transportation Non-Emergency	<p>Non-emergent transportation services for UnitedHealthcare Community Plan members are provided by National MedTrans.</p> <p>Members must make transportation arrangements at least three calendar days before their medical appointment. A legally responsible adult must accompany children under the age of nineteen. Children age twelve and under should not be transported by a public or commercial provider without adult supervision.</p> <p>Non urgent appointments: call 833-856-4221, TTY: 844-488-9724.</p> <p>UnitedHealthcare Community Plan is responsible for non-emergent ambulance transportation.</p> <p>For more non-emergency transportation information, please refer to Chapter 4 of this manual.</p>	<p>Covered.</p> <p>Prior authorization required through National MedTrans.</p> <p>Covered.</p> <p>Prior authorization required for non-participating care providers.</p>
Transplants	<p>Transplant services, including donor services that are medically necessary and defined by Medicare as non-experimental.</p>	<p>Covered.</p> <p>Prior authorization required.</p>
Ventricular Assist Devices	<p>A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow.</p>	<p>Covered.</p> <p>Prior authorization required.</p>

Benefit	Services Included	Limitations
Vision Services MARCH® Vision Care Group Inc.	Vision exams, prescription lens, and eyeglasses. Eye exams: <ul style="list-style-type: none"> • One every 12 months (from date of last visit) for ages 20 and younger • One every 24 months (from date of last visit) for ages 21 and older • Diabetic eye exams, for any age, every 12 months Eye glasses (lenses and frame): <ul style="list-style-type: none"> • One pair every 12 months if there is significant change in your prescription MARCH® Vision toll free: 844-636-2724 , 8 a.m. – 5 p.m. marchvisioncare.com	Covered. Member must use a participating MARCH® Vision provider.
	Vision therapy/orthoptic training. Intraocular Lens.	Covered.
Weight Loss Surgery (Bariatric Surgery)	Members must meet several criteria before being approved for this procedure, for example documentation of participation and failure in legitimate weight loss program.	Covered.

Chapter 4: Medical Management

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

The following benefits should not be considered exhaustive. Specific services to be delivered to Community Plan members are described in detail on the [Nebraska DHHS MLTC website](#). Contact the Provider Service Center at 866-331-2243 for questions about if a service is covered.

Ambulance Services

AIR AMBULANCE

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

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

Non-emergent air transportation requires a prior authorization for participating and non-participating care providers.

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 if medically necessary. Prior authorization is not required for emergency transports.

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

NON-EMERGENT AMBULANCE TRANSPORTATION

UnitedHealthcare Community Plan members may get non-emergent transportation services through National MedTrans for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides. Members may get transportation when:

- They are bed-confined before, during and after transport; and
- The services cannot be provided at their home (including a nursing facility or ICF/MR).

Value-added non-emergent transportation services include substance abuse support groups, WIC appointments, parenting classes such as Lamaze, and pregnancy classes and meetings.



For non-urgent appointments, members must call for transportation at least three days before their appointment. Online requests can be made online anytime at nationalmedtrans.com/ne or by phone at **833-586-4221**.

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Make urgent non-emergency trips, such as when a member is sent home from the hospital, through National MedTrans. Schedule rides up to 30 days in advance.

Prior authorization is not required for participating care providers. Non-participating care providers require a prior authorization.



Members must call between 7 a.m. – 7 p.m. Central Time, Monday through Friday, to schedule transportation. If they have questions about their order, they may call **National**

MedTrans.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop.
- Has an appointment less than half a mile from the bus stop.

Care Management

UnitedHealthcare Community Plan provides care management services to members who require service coordination due to complex medical conditions or serious psychosocial issues that impact their ability to obtain appropriate care. The UnitedHealthcare Community Plan Medical Care Management Department has assessment tools to help identify members who may be at risk for multiple hospital admissions, increased medication usage, or would benefit from a multidisciplinary approach to their medical or psychosocial needs. Programs are available to assist members with chronic conditions such as diabetes, asthma, and obesity.



You may refer members for care management by contacting Care Management at **877-856-6351**.

Durable Medical Equipment

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

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable

- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary



See our Coverage Determination Guidelines at [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Emergency/Urgent Care Services

Emergency services do not require prior authorization.

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

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers.
- Emergency services based on a prudent layperson's definition of emergency health condition.
- 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, air and water transportation.
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal.

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

EMERGENCY ROOM CARE

For an emergency, the member should seek immediate care at the closest emergency room (ER). If the member

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

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

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If UnitedHealthcare Community Plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the member's care, UnitedHealthcare Community Plan lets the treating care provider talk with the health plan's medical director. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

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

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

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.



For a list of urgent care centers, contact [Provider Services](#) or view online at UHCprovider.com/NEcommunityplan > [Provider Search, Referral Listings and Home and Community Based Services Providers](#).

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.

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



Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission. Call the [Prior Authorization Department](#) or submit requests online using the [Prior Authorization and Notification Tool on Link at UHCprovider.com](#). Submit requests within 24 hours, unless otherwise indicated.

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 the Prior Authorization Department (UM Department, etc.)



The criteria are available in writing upon request or by calling the [Prior Authorization Department](#).

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

Family Planning

Family Planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear. (Pap smears as clinically

indicated using evidence-based medical guidelines.)

- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

Non-covered items include but are not limited to:

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

PARENTING/CHILD BIRTH EDUCATION PROGRAMS

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

VOLUNTARY STERILIZATION

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHHS Regulations for more information on sterilization.

Care Coordination/ Health Education

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

The program goals are to:

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

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

Hearing Services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger. Prior authorization may be required.

Hospice

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

HOME HOSPICE

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

Nebraska DHHS MLTC provides two 90-day benefit periods during a member's lifetime. If additional benefit periods are needed, Medicaid provides three 60-day benefit periods. Hospice services beyond these benefit periods will be approved as an exception under the prior authorization provisions. The benefit periods may be used consecutively or at intervals.

RESPIRE HOSPICE

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

INPATIENT HOSPICE

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control

or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

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

LAB SERVICES



LabCorp is the preferred lab provider. Contact [LabCorp](#) directly.

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

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

See the Billing and Encounters chapter for more information.

Maternity/Pregnancy/ Well-Child Care

PREGNANCY/MATERNITY

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

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal

sex or provide parents with a photograph of the fetus. We allow the first three obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedure will only be allowed for identified high risk members. High risk member claims must include the corresponding diagnosis code.



For more information about global days, go to UHCprovider.com.

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

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

UnitedHealthcare Community Plan must approve all out-of-plan maternity care except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage is limited up to the point of medical stabilization. Care providers should call **866-604-3267** to obtain prior approval for continuity of care.

Care providers should 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.

To notify UnitedHealthcare Community Plan of pregnancies, care providers should call Healthy First Steps at **800-599-5985** or fax the notification to **877-353-6913**.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for ob-gyn care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary, but may require prior authorization.

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.



If the UnitedHealthcare Community Plan member is inpatient longer than the federal requirements, a prior notification is needed. Please go to UHCprovider.com/priorauth or call the [Prior Authorization Department](#).

To notify UnitedHealthcare Community Plan of deliveries, call **866-604-3267** or fax to **800-897-8317**. Provide the following information within one business day of the admission:

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

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

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

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

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

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner, physician's assistant or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional

responsibility for the medical services provided and help ensure approval of the care plan.

NEWBORN ENROLLMENT

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her member ID card).

If the mother delivers out of state, the member would need to contact ACCESSNebraska at **855-632-7633** to provide birth notification. Nebraska DHHS would then enroll the baby to the health plan.

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

HOME CARE AND ALL PRIOR AUTHORIZATION SERVICES

The discharge planner ordering home care should call the [Prior Authorization Department](#) to arrange for home care.

HYSTERECTOMIES

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

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



Find the form on the Nebraska Department of Health and Human Services at dhhs.ne.gov/.

Exception: Nebraska DHHS MLTC does not require informed consent if:

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

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical

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

PREGNANCY TERMINATION SERVICES

Pregnancy termination services are not covered, except in cases to preserve the woman's life. In this case, follow the Nebraska DHHS MLTC consent procedures for abortion.

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

Use the following policy and procedures to qualify for reimbursement by the Nebraska DHHS MLTC. If a pregnancy termination is needed to preserve the woman's life, you must request prior authorization from the Medicaid Division before performing the pregnancy termination. If prior authorization is approved using the Nebraska DHHS MLTC guidelines, reimbursement will be made upon documentation submission reflecting Nebraska DHHS MLTC procedure approval.

Requests must be sent in writing to:

Department of Health & Human Services Medicaid Division

P.O. Box 95026
Lincoln, NE 68509-5026

Fax: 402-471-9092

STERILIZATION AND HYSTERECTOMY PROCEDURES

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

be at least 21 years old when they sign the form.

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

STERILIZATION INFORMED CONSENT

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

STERILIZATION CONSENT FORM

Use the consent form for sterilization:

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



You may also find the form on the Nebraska DHHS website at dhhs.ne.gov/.

Have three copies of the consent form:

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

Neonatal Resource Services (NICU Case Management)

Our Neonatal Resource Services program manages inpatient and post-discharge neonatal intensive care unit (NICU) cases to improve outcomes and lower costs. Our dedicated team of NICU nurse case managers, social workers and medical directors offer both clinical care and psychological services.

NEONATAL RESOURCE SERVICES

The Neonatal Resource Services (NRS) program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth (including babies who are transferred from PICU) and/or any infants readmitted within their first 30 days of life and previously managed in the NICU. All babies brought to the NICU are followed by NRS. (Detained babies will also be eligible for the program for the initial inpatient hospitalization only).

NRS neonatologists and NICU nurses manage NICU members through evidence-based medicine and care plan use.

The NRS nurse case manager will:

- Work with the family, the care providers, and the facility discharge planner to help ensure timely discharge and service delivery.
- Develop care management strategies and interventions based on infant and family needs.
- Coordinate services prior to discharge and after discharge if the member is under NRS case management.

The NRS nurse case manager's role includes:

- Planning and arranging the discharge.
- Coordinating care options and prior authorization, including home care, equipment and skilled nursing.

- Arranging post-discharge support for a minimum of 90 days and up to 15 months based on infant ongoing acuity (except detained babies).
- Educating parents and families about available local resources and support services.
- Coordination with the Whole Person Care Team for additional case management needs and services.

Case managers provide benefit solutions to help families get the right services for the baby.



The agency or hospital discharge planner should pre-certify home care by calling the Prior Authorization Department at **866-604-3267** or submit requests online using the Prior Authorization and Notification Tool on Link at UHCprovider.com.

INHALED NITRIC OXIDE



Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com/Polices and [Protocols/Clinical Guidelines](https://UHCprovider.com/Protocols/Clinical%20Guidelines).

Pharmacy Services

DAY SUPPLY DISPENSING LIMITS

Members may receive up to a three month supply (90 days) of medication per prescription order or refill. You may reorder or refill a medication when 90% of the medication has been used. If you submit a claim before 75% of the medication has been used, based on the original claim submission day supply, the claim will reject with a “refill too soon” message.

EMERGENCY PRESCRIPTIONS

Provide a 72-hour emergency supply of a prescribed drug when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List, or because they are subject to clinical edits.

Dispense 72-hour emergency supply any time a PA cannot be resolved within 24 hours for a medication on the formulary appropriate for the member’s medical condition. If the prescribing care provider cannot be reached or is unable to request a PA, the pharmacy

should submit an emergency 72- hour prescription.

A pharmacy can dispense a product packaged in a fixed and unbreakable dosage form, e.g., an albuterol inhaler, as an emergency supply. You will receive a response by telephone or other telecommunication device within 24 hours of a PA request.

MEDICATION THERAPY MANAGEMENT PROGRAM (MTM)

Our Medication Therapy Management Program helps assist members in understanding and providing education about their medications and ways to improve their compliance with prescribed medication regimens. The program focus is to educate members about how to effectively communicate about their preferences and needs with their prescribers to promote shared decision-making.

PRECHECK MYSCRIPT

PreCheck MyScript is an app on Link — your gateway to UnitedHealthcare Community Plan’s online tools. This app helps make it easy to run a pharmacy test claim and get real-time prescription coverage detail for your patients who are UnitedHealthcare Community Plan members. If a medication requires prior authorization, a request can be submitted online within the app.

With PreCheck MyScript, you can:

- Check prescription coverage and price for UnitedHealthcare Community Plan members in real-time.
- Get information on lower-cost prescription alternatives, if available, to help save members money.
- See which prescriptions currently require prior authorization, or are non-covered or non-preferred.
- Request prior authorization and receive status and results.

HOW TO ACCESS THE APP



Sign in to Link by going to UHCprovider.com/NEcommunityplan and click on the Link button in the top-right corner. Then, select the Link Marketplace from your Link dashboard and search for the PreCheck MyScript app. Add the app to your dashboard to begin.

PREFERRED DRUG LIST (PDL)

UnitedHealthcare Community Plan Pharmacy Program adheres to the state-approved preferred drug list (PDL). We also provide coverage for additional drugs not found on the PDL. You may access the list of covered drugs from our website at UHCprovider.com/NEcommunityplan > Pharmacy Resources and Physician Administered Drugs.

PRIOR AUTHORIZATION

Some drugs on the state-approved formulary and PDL may require prior authorization. Pharmacists receiving drug prescriptions requiring prior authorization should work with the prescribing care provider if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate, the care provider should then contact the UnitedHealthcare Pharmacy Department at 800-310-6826 with questions about the prior authorization process. The preferred drugs and those requiring prior authorization will be designated in the list of drugs at UHCprovider.com/NEcommunityplan > Pharmacy Resources and Physician Administered Drugs.

QUANTITY LIMITS

UnitedHealthcare Community Plan has medication quantity limits. The following describes the quantity limitation types:

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.
- Quantity limits based on efficient medication dosing (also known as dose optimization).
 - The Efficient Medication Dosing Program focuses on consolidating medication dosage to the most efficient daily quantity to increase therapy adherence and also promote the efficient use of health care dollars.
 - Program limits are based on FDA approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity limits in the prescription claims processing system will limit dispensing to consolidate dosing.
 - The Pharmacy Claims Processing System will prompt the pharmacist to request a new prescription order from the care provider.

Per state regulations, certain quantity limits apply to mental health drugs. Adjustments to the Quantity Limitations program drug list will be made as needed and care providers notified accordingly. We recognize a number of patient-specific variables must be taken into account when drug therapy is prescribed, and therefore overrides will be available through the medical exception (prior authorization) process.



For more information about drug-specific quantity limits go to UHCprovider.com/NEcommunityplan > Pharmacy Resources and Physician Administered Drugs or call the UnitedHealthcare Pharmacy Department at 800-310-6826.

Restricted Services

UnitedHealthcare Community Plan Restricted Services is a program to control misuse and abuse of Medical Assistance services. Our Restricted Services Program restricts Medicaid recipients to a specific care provider and/or a specific pharmacy provider, this is also known as a lock-in. We will not pay claims if a member uses another pharmacy without prior authorization. We can notify members and care providers about our Restricted Services Program information.

Restrictions do not apply to emergency services. Members can change care providers with cause.

See more information about the Restricted Services Program in Chapter 7 of this manual.

Pharmacy Contact Information

PHARMACY CLAIMS PROCESSING INFORMATION

Find information about pharmacy claims processing at UHCprovider.com/NEcommunityplan > [Pharmacy Resources and Physician Administered Drugs](#) or at OptumRx.com.

These websites provide pharmacy claims processing information including, but not limited to:

- Payer sheets

- Paper claim submission requirements
- Compound prescriptions requirements
- Prospective drug utilization review (DUR) response requirements
- Rx BIN: 610494
- Rx GRP: ACUNE
- Rx PCN: 4444

Medicare and other insurance copays may still apply.

Pharmacy Services Call Center: **800-310-6826**, 8 a.m. – 8 p.m. Central Time and 7 a.m. – 7 p.m. Mountain Time, Monday through Friday.

Pharmacy Services Fax: **866-940-7328**.

OptumRx Pharmacy Benefit Manager Technical Help Desk (pharmacies call): **877-231-0131**, 8 a.m. – 8 p.m. Central Time and 7 a.m. – 7 p.m. Mountain Time, Monday through Friday.

Prior authorization request fax forms can be found at UHCprovider.com/NEcommunityplan > Pharmacy Resources and Physician Administered Drugs.

Specialty Pharmacy Medications

The Specialty Pharmacy Management Program provides high quality, cost effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

- It is used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network.

Drugs on the Preferred Drug List (PDL) that are part of this program are identified by a “SP” in the

“Requirements and Limits” section of each page.

Telehealth and Telemonitoring Services

Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a care provider or practitioner for members in rural areas or other places, are a covered benefit for medically necessary services. Health care providers that provide telehealth and telemonitoring services must follow all applicable state and federal regulations governing their practice and the services they provide. All telehealth communications must comply with all applicable federal and state requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

UnitedHealthcare Community Plan will cover telemonitoring services when the following conditions have been met:

- The member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data.
- The originating site has space for all program equipment and full transmission capability.
- The care provider’s record contains data that supports the medical necessity of the service, all transmissions, and subsequent review received from the member, and how the data transmitted from the member is used in the continuous development and implementation of the member’s plan of care.



Please review our prior authorization list online at UHCprovider.com/priorauth to verify if prior authorization is required for the telehealth and telemonitoring services.

Tuberculosis (TB) Screening

and Treatment; Direct Observation Therapy (DOT)

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

RESPONSIBILITIES

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

Vision Services

UnitedHealthcare Community Plan uses MARCH® Vision Care as its Medicaid vision vendor. Members may self-refer to any MARCH® Vision Medicaid network provider for services. To aid members in making a provider selection, please refer them to MARCH® Vision at marchvisioncare.com or they may call member services toll free at **800-641-1902**.

Please remind the member to mention they are a UnitedHealthcare Community Plan member and they have MARCH® Vision coverage when making an appointment with a MARCH® Vision care provider. They will also need to provide the UnitedHealthcare Community Plan ID number. For plan coverage details, members may call **877-542-9238**.



Call MARCH® Vision toll free at **844-636-2724**, 8 a.m. - 5 p.m., or go online to marchvisioncare.com.

Medical Management

Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD CM.
- Anticipated date(s) of service.

- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.



For behavioral health and substance use disorder authorizations, please contact **United Behavioral Health**.



If you have questions, please call **Prior Authorization Intake**, or submit requests online using the Prior Authorization and Notification Tool on Link at UHCprovider.com.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent Pre-service	<p>Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt of request</p> <p>NOTE: An extension of up to 14 days may be possible at your or the member’s request, or if there is justification for more information and the delay is in the member’s best interest</p>	Within 24 hours of the decision	Within two business days of the decision
Urgent/ Expedited Pre-service	<p>Within 72 hours of request receipt</p> <p>NOTE: an extension of up to 14 days may be possible at your or the member’s request, or if there is justification for more information and the delay is in the member’s best interest</p>	Within 72 hours of the request	Within 72 hours of the request
Concurrent Review	<p>Within 24 hours from receipt of the request</p> <p>If at least one attempt to obtain clinical information is made and documented within the initial 24 hour TAT, the TAT is extended to 72 hours from the initial request</p>	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	<p>Within 30 calendar days of receiving all pertinent clinical information</p>	Within 24 hours of determination	Within 24 hours of determination and member notification within two 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, home health care and ambulatory facilities. We perform an on-site facility review or phone review for each day's stay using MCG, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

CONCURRENT REVIEW DETAILS

Concurrent Review is notification within 24 hours or one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or 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, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four 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 MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition.
- Maintain health.
- Prevent the onset of an illness, condition or disability.
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity.
- Prevent the deterioration of a condition.
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age.
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member.
- Not experimental treatments.

Determination Process

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

Evidence-Based Clinical Guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to UHCprovider.com/NEcommunityplan > [Policies and Clinical Guidelines](#).

Medical and Drug Policies and Coverage Determination Guidelines

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

Referral Guidelines

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

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Nebraska DHHS MLTC. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **800-641-1902**.

- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Serious Reportable Events and Reportable Adverse Incidents

Consistent with the Affordable Care Act administered through the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare Community Plan will implement the Provider Preventable Conditions initiative requirements, which include:

1. Reimbursement adjustment for health care acquired conditions (HCAC)
2. Present on admission (POA) indicator requirement
3. No reimbursement for 'never events' and
4. Other provider preventable conditions (OPPC) as defined by any additional state regulations that expand or further define the CMS regulations.



For more information about this reimbursement policy, HCAC and POA, go to [UHCprovider.com](https://www.uhcprovider.com) > Menu > Policies & Protocols > Community Plan Policies > Reimbursement Policies for Community Plan > Health Care Acquired Conditions and Present on Admission Policy (Provider Preventable Conditions).

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 care provider from our list (except emergency treatment, Native American access to care, and family planning services), including services received outside of the United States.
- Any care covered by Medicaid but not through managed care:
 - Long-term care services in a nursing home.
 - Intermediate care facilities for members with an intellectual/developmental disability (I/DD).
 - Home- and community-based waiver services.
 - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
 - Residential inpatient hospice services.
 - School-based services.
 - Medicaid state plan personal assistance services.
 - Non-emergent transportation services.
- 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.

Services Requiring Prior Authorization



For a list of services that require prior authorization, go to [UHCprovider.com/priorauth](https://www.uhcprovider.com/priorauth).

DIRECT ACCESS SERVICES – NATIVE AMERICANS

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

SEEK PRIOR AUTHORIZATION WITHIN THE FOLLOWING TIME FRAMES

- **Emergency or Urgent Facility Admission:** within 24 hours, unless otherwise indicated.
- **Inpatient Admissions; After Ambulatory Surgery:** within 24 hours, unless otherwise indicated.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business

days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.



Call **866-604-3267** or submit requests online using the Prior Authorization and Notification Tool on Link at UHCprovider.com.

Utilization Management Guidelines



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

Utilization Management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on 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 members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UTILIZATION MANAGEMENT (UM) APPEALS

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decision may file an UM appeal. Adverse benefit determination decisions may include UnitedHealthcare Community Plan's decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. See Appeals in [Chapter 12](#) for more details.

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

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.

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



Visit the Nebraska DHHS MLTC website at dhhs.ne.gov/ for Health Checks and Treatment Services for Conditions disclosed during Health Checks (EPSDT) criteria, please reference Chapter 33.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule. UnitedHealthcare Community Plan is required to and will report compliance with EPSDT standards to the state of Nebraska, based on claims data and chart review.

Coding

UnitedHealthcare Community Plan reports compliance with EPSDT standards to the state based on claims data and chart review. **Appropriate ICD CM Code and CPT coding are crucial to this effort.** Find more information on ICD codes at UHCprovider.com > Menu > Resource Library > ICD-10 Resources.

PROCEDURE AND ICD CM CODES

If a member presents for a preventive or well visit, use these codes:

- **Newborn:** 99431-99433, ICD10 = Z00.129 or Z00.121: Routine infant or child health check, development testing of infant or child. ICD10 = Z38.00 through Z38.2.
- **Child:** 99381-99384, ICD10 = Z00.129 or Z00.121: Routine infant or 99391-99394 child health check, development testing of infant or child.
- **Adult:** 99385 and ICD10 = Z00.00 or Z00.01: Routine general 99395 medical exam at health care facility; health checkup. OR
- **ICD10 = Z00.8:** Unspecified general medical exam.

If a member also addresses a medical diagnosis during the visit, use the appropriate ICD-CM code in addition to one of the above “Z” codes.

UnitedHealthcare Community Plan will assume an EPSDT exam has been performed for a given age category when one of the previously-listed codes is used.

Correct Claim Referral Indicator:

- **AV:** Member refused referral;
- **S2:** Member is currently under treatment for diagnostic or corrective health problem;
- **NU:** No referral given; or
- **ST:** Referral to another care provider for diagnostic or corrective treatment. We will deny the claim if a referral indicator is not listed.

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.

Immunization Data – Required State Reporting

You are required to submit immunization data to the Nebraska State Immunization Information System. The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that connects and shares immunization information among public clinics, private care provider offices, local health departments, schools, hospitals, and other health care facilities that administer immunizations.



For more information go to dhhs.ne.gov/.

Interperiodic Screens

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

Interperiodic Screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part

in school athletics. This also applies for other school physicals when required as conditions for educational purposes.

Lead Screening/Treatment

Refer to the Department of Health Lead Program at **888-242-1100** if you find a child has a lead blood level over 15ug/dL. Call **877-856-6351** to refer the child to our Care Management team. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Vaccines for Children program (VFC)

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

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



Contact [VFC](#) or DHHS public health at **800-798-1696** with questions, or visit the Nebraska DHHS VFC page at dhhs.ne.gov/.
Phone: 402-471-0301
Fax: 573-526-5220

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

- Eligible for Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured (these children have health insurance but the benefit plan does not cover immunizations).

Children in this category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

Chapter 6: Value-Added Services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **866-331-2243** unless otherwise noted.

Adult Immunizations

In addition to the preventive care core offerings, we offer all adult members pneumonia, flu and shingles shots, routine vaccinations and immunizations.

Adult Male Circumcisions

We offer adult male members the option of circumcision due to evidence of reduced risk of urinary tract infections, some sexually transmitted diseases, and protection against penile cancer in circumcised men.

Annual Physical Exams

We offer adults an option for a physical. Physical exams for members 21 and older are covered with an in-network PCP (e.g. EPSDT, adult routine physicals).

Physicals are available for children younger than 21 (e.g. children in school/sports physicals).

Baby Blocks™ Program

Baby Blocks™ is a web-based, mobile tool that reminds and rewards pregnant women and new mothers to get prenatal, postpartum and well-child care. Baby Blocks™ is available to pregnant UnitedHealthcare Community Plan members or their newborns.

BABY BLOCKS™ BENEFIT

Baby Blocks engages members with text and email appointment reminders. Members who enroll early in their pregnancy can earn up to eight rewards by following prenatal and postpartum recommendations.

How it Works

1. Care providers and UnitedHealthcare Community Plan reach out to members to enroll them in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointments at UHCBabyBlocks.com.
3. Members get reminders of upcoming appointments and record completed visits at UHCBabyBlocks.com.
4. At milestones throughout the program, members choose a reward for themselves or their baby.

How You Can Help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and talk about the program.
3. Encourage the member to enroll at UHCBabyBlocks.com.



Members self-enroll on a smartphone or computer. They can go to UHCBabyBlocks.com and click on “Register.”

Baby Showers

We invite expectant mothers to a baby shower where they receive education on the importance of timely prenatal and postpartum care, immunizations and EPSDT screenings.

Breast Pumps

We will pay the cost of a member's portable electric breast pump.



Call Member Services at **800-641-1902**, **TTY 711** if you have questions about the program or need to find an in-network medical equipment company. The medical equipment company will need a physician prescription.

Early Intervention Program

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

If you are treating a child who may be in need of such services, please refer to the appropriate Early Intervention regional site. For more information, call the Nebraska CHILDFIND at **888-806-6287**.

Foster Care

ON MY WAY

On My Way teaches youth aging out of foster care how to navigate the complex social support systems, including health care. Members can access On My Way through our care management system.

Youth in foster care often do not have access to the same kind of support and guidance of other teens. These youth struggle for independence while trying to make smart life decisions. This requires support and guidance, even for young adults who have grown up in a stable and supportive environment. Our interactive mobile and web-enabled game breaks the transition process into manageable steps and connects foster youth with the support/guidance they need and want (e.g., they can easily connect with peer support staff).

Dr. Health E. Hound

Our UnitedHealthcare Community Plan mascot delivers nutritional education and promotes fitness and healthy habits.

Healthify

This web-based referral tool helps members gain access to food, housing, employment, energy, support groups, child care, and clothing. It is for members at risk for poor outcomes or inappropriate health care use.

Healthy First Steps

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

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

- Increase early identification of expectant mothers 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.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
- Foster a care provider-member collaboration before

and after delivery as well as for non-emergent settings.

- Encourage members to stop smoking with our Quit for Life tobacco program.
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs.
 - Providers caring for pregnant women and women with dependent children should coordinate referrals to appropriate community programs and services such as the Women, Infants, and Children (WIC) services program.
- Program staff act as a liaison between members, care providers, and UnitedHealthcare for care coordination.



Tell UnitedHealthcare Community Plan when a member becomes pregnant. Faxing a Prenatal Risk Assessment form to the [Healthy First Steps program](#) at **877-353-6913** will initiate case management program outreach.

Immunizations

We provide immunizations for adult members who are identified with IDD/TANIF/ABD. This includes pneumonia, flu and shingles shots, and routine vaccinations.

Give immunizations in conjunction with EPSDT/well child visits or when other appropriate opportunities occur per Advisory Committee on Immunization Practices guidelines. Care providers are required to submit immunization data to the Nebraska State Immunization Information System.

The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that connects and shares immunization information among facilities that administer immunizations. For more information go to [NESIIS](#).

See [Chapter 5](#) of this manual for more information about the Vaccines for Children (VFC) program.

Mobile Apps

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **Social Media** provides assistance on Facebook, Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) by delivering health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.

Member Awards

Members receive rewards for completing healthy activities.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **877-543-4293** to reach a nurse.

UHC Latino



[uhclatino.com](#), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Wandering and Elopement

Wandering, also called elopement, is a safety issue that affects some service individuals with disabilities, their families and the community. Wandering is when someone leaves a safe area or a responsible caregiver, resulting in a risk of injury or harm.

We address safety concerns as part of a member's plan of care and help caregivers develop prevention and response plans. We provide members and families with door and window alarms (up to six per household) to support wandering minimization.

Chapter 7: Mental Health and Substance Use

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

The National Optum Behavioral Health manual is located on providerexpress.com.

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

You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the Department of Health and Human Services website at nppes.cms.hhs.gov > go to the section titled "Apply to be a Medicaid Provider."

NOTE: Atypical care providers do not have to have an NPI number, per Nebraska Medicaid. Nebraska Medicaid defines "atypical" providers as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), personal care aides, mental health personal care aides/community treatment aides, mental health home health care aides and non-emergency transportation providers. Not applicable for SSAD, MHCP and DPFS.

Credentialing

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Covered Services

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

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



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

substance use issues.

Benefits may include (depending on the member's age and other factors):

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

- Medication management
- Outpatient therapy (individual, family or group)
- Injectable psychotropic medications
- Substance use disorder (SUD) and opioid use disorder (OUD) treatment
- Psychological evaluation and testing
- Initial diagnostic interviews
- Sex offender risk assessment
- Community treatment aide (CTA) services (for children only)
- Hospital observation room services (up to 23 hours and 59 minutes in duration)
- Child-parent psychotherapy
- Parent child interaction therapy
- Applied behavioral analysis
- In-home psychiatric nursing
- Peer support services
- Multi-systemic therapy
- Functional family therapy
- Electroconvulsive therapy
- Telemental health
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation
- Professional resource family care
- Halfway house
- Therapeutic group home
- Therapeutic community
- Assertive community treatment (ACT) and Alternative (Alt) ACT
- Day rehabilitation

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits

application on Link at UHCprovider.com, or contact [Provider Services](#) or the Nebraska Medicaid Eligibility System (NMES) at **800-642-6092**.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth, or by calling **866-604-3267**. Prior authorization request forms specific to autism services are available at providerexpress.com.

Portal Access

Website: UHCprovider.com

Access Link, the gateway to UnitedHealthcare Community Plan's online tools, on this site. Use the tools 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 Provider Services at **866-331-2243** to verify eligibility and benefit information (available 7 a.m. – 8 p.m. Central 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 at **877-614-0484**.

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

- Prevention:
 - Prevent Opioid-Use Disorders 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 mom and child:
 - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
 - Identify needs early and measure progress.

INCREASING EDUCATION & AWARENESS OF OPIOIDS

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide

access to clinical practice guidelines, free substance use disorders/OD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

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

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.

RESTRICTIVE SERVICES (LOCK-IN) PROGRAM

Pharmacy and prescriber lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances, etc.).

A care provider, pharmacy, hospital facility or managed care plan may refer a UnitedHealthcare Community Plan to restricted services. Submit restricted services requests and documentation to UnitedHealthcare Community Plan for review.

UnitedHealthcare Community Plan Restrictive Services

2717 North 118th Street, Suite 300
Omaha, NE 68164
800-284-0626

Based on determination made by UnitedHealthcare

Community Plan, the member may be placed on one of the following category restrictions:

- **Category 1:** One pharmacy
- **Category 2:** One pharmacy and one primary care provider
- **Category 3:** One pharmacy, one primary care provider and one hospital
- **Category 4:** One pharmacy and one prescribing care provider
- **Category 9:** All medical services

If a member meets the program criteria, a letter is sent notifying them and discusses their ability to appeal the decision.

The health plan may assist in finding a new PCP for the member. However, it is the member's responsibility to make the initial call to the new care provider and disclose they are under restricted services. The new PCP may choose to refuse the member, but must agree to see them for 30 days if they have open slots and are accepting new patients. The member will identify the care provider(s) or facility they agree to receive restricted services from. Members are allowed to change care providers with cause.

Claims will not be paid if a member uses another pharmacy without prior authorization. Restrictions do not apply to emergency services.

Expanding Medication Assisted Treatment (MAT) Access & Capacity

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

To find a behavioral health MAT provider in Nebraska:

1. Go to UHCprovider.com,
2. Select "Find a Care Provider" from the menu on the home page
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 8: Member Rights and Responsibilities

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

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

Members may access their medical records or billing information either held at your office or through us. If their information is electronic, they may ask that you or us 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 information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, members may have a disagreement statement added to their health information.

ACCOUNTING OF DISCLOSURES

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

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization

- To correctional institutions or law enforcement officials
- For which federal law does not need us to give an accounting

RIGHT TO REQUEST RESTRICTIONS

Members 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. Members 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

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

Member Rights and Responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: [UHCCommunityPlan.com](https://www.uhc.com/Nebraska/Provider-Information/Member-Handbook) > Nebraska > Provider Information > Member Handbook.

NATIVE AMERICAN ACCESS TO CARE

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

MEMBER RIGHTS

Members may:

- Request information on advance directives.
- 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 without interference from us.
- Refuse treatment through an advance directive or withhold treatment consent.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers at any time for any reason.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or

treatment, regardless of benefit coverage.

- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.

MEMBER RESPONSIBILITIES

Members should:

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

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

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

Chapter 9: Medical Records

Medical Record Charting Standards

You are required to keep complete and orderly medical records, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: <ul style="list-style-type: none"> • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location.
Record Organization	<ul style="list-style-type: none"> • Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be: <ul style="list-style-type: none"> - In order. - Fastened, if loose. - Separate for each member. - Filed in a manner for easy retrieval. - Readily available to the treating care provider where the member generally receives care. - Promptly sent to specialists upon request. • Medical records are: <ul style="list-style-type: none"> - Stored in a manner that helps ensure privacy. - Released only to entities as designated consistent with federal requirements. - Kept in a secure area accessible only to authorized personnel.

Topic	Contact
Procedural Elements	<p>Medical records are readable*</p> <ul style="list-style-type: none"> • Sign and date all entries. • Member name/identification number is on each page of the record. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member’s first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*
History	<p>An initial history (for members seen three or more times) and physical is performed. It should include:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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
<p>Problem Evaluation and Management</p>	<p>Documentation for each visit includes:</p> <ul style="list-style-type: none"> • Appropriate vital signs (Measurement of height, weight, and BMI annually) <ul style="list-style-type: none"> - Chief complaint* - Physical assessment* - Diagnosis* - Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: <ul style="list-style-type: none"> - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

*Critical element

SCREENING AND DOCUMENTATION TOOLS

Another helpful tool is the [Behavioral Health Treatment Record Audit Tool](#). These tools were developed to help you follow regulatory requirements and practice.

Medical Record Review

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

- Problem list with:
 - Biographical data with family history.
 - Past and present medical and surgical intervention.
 - Significant medical conditions with date of onset and resolution.
 - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).

- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

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

Payment Error Rate Measurement (PERM) Audit

A Payment Error Rate Measurement (PERM) audit complies with the Improper Payments Information Act of 2002 (IPIA); Public Law 107-300, amended in 2010 by the Improper Payments Elimination and Recovery Act or (IPERA). These laws help improve fiscal oversight, identify fraud and abuse, and protect taxpayer dollars.

We will send a medical record request and identify it as a PERM – REQUEST FOR RECORDS. The letter describes the medical record documentation needed to support the claims, when it is due, and where to send it. You have 30 days to respond to the request. If you do not submit the requested medical record within this time frame, you will be faced with an improper payment. This is because we have no evidence to determine whether the services were provided, medically necessary and properly coded and paid. UnitedHealthcare Community Plan and/or MLTC have the authority to recover any incorrect payments you receive.

Medical Record Documentation Standards Audit Tool Sample

Provider Name		
Provider ID#:	Provider Specialty:	
Reviewer Name:	Review Date:	Score:
Member Name/Initials:	Member ID#:	

Confidentiality & Record Organization & Office Procedures	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
	1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office. location (as applicable).								
2. Staff is trained in medical record confidentiality.									
3. The office uses a Release of Information form that requires member signature.									
4. There is a policy for timely transfer of medical records to other locations/ care providers.									
5. There is an identified order to the chart assembly.									
6. Pages are fastened in the medical record.									
7. Each member has a separate medical record.									
8. Medical records are stored in an organized fashion for easy retrieval.									
9. Medical records are available to the treating practitioner where the member generally receives care.									
10. Medical records are released to entities as designated consistent with federal regulations.									
11. Records are stored in a secure location only accessible by authorized personnel.									
12. There is a mechanism to monitor and handle missed appointments.									

History	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Medical and surgical history is present.									
2. The family history includes pertinent history of parents and/or siblings.									
3. The social history minimally includes pertinent information such as occupation, living situation, etc.									

Preventative Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Evidence of current age appropriate immunizations.									
2. Annual comprehensive physical (or more often for newborns).									
3. Documentation of mental & physical development for children and/or cognitive functioning for adults.									
4. Evidence of depression screening.									
5. Evidence of screening for high-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition counseling									
6. Evidence that Medicare members are screened for functional status and pain.									
7. Evidence of tracking and referral of age and gender appropriate preventive health services.									
8. Use of flow sheets or tools to promote adherence to clinical practice guidelines/preventative screenings.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation for each visit includes:									
1. Appropriate vital signs (i.e., weight, height, BMI measurement annually).									
2. Chief complaint.									
3. Physical assessment.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
4. Diagnosis.									
5. Treatment plan.									
6. Treatment plans are consistent with evidence-based care and with findings/diagnosis.									
7. Appropriate use of referrals/consults, studies, tests.									
8. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.									
9. Timeframe for follow-up visit as appropriate.									
10. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.									
11. Unresolved issues from the first visit are followed-up on the subsequent visit.									
12. There is evidence of coordination of care with behavioral health.									
13. Education, including counseling, is documented.									
14. Member input and/or understanding of treatment plan and options is documented.									
15. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented.									

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & + & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} & + & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} \\
 \text{(Questions)} & & \text{(\# N/A)} & & \text{(Adjusted \#} & & \text{(Adjusted \#} & & \text{(Score)} \\
 & & & & \text{of Questions)} & & \text{of Questions)} & &
 \end{array}$$

If a care provider scores less than 85%, review five more charts. Only review those elements the care provider received a “NO” on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element is recalculated as a “YES” in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation remains.

***Items are MUST PASS**

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

What is the Quality Improvement Program?

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

The program consists of:

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

You must comply with all quality-improvement activities.

These include:

- Providing requested timely medical records.
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participation 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.
- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, secure email or secure fax.
- Practitioner appointment access and availability surveys.
- Allow the plan to use your performance data.
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members.)

Care Provider Satisfaction

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

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

Our main concern with the survey is objectivity. That's

why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

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

Credentialing Standards

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

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

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

Medicaid ID and Disclosure of Ownership Form are enrollment requirements. The MCO must notify the Medicaid Agency of your disclosures on persons convicted of crimes within 10 working days from the date it receives the information. The MCO must also promptly notify the Medicaid Agency of action it takes on your program participation application. The Medicaid Agency will notify the Inspector General within 20 working days of notification by the MCO.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care

provider network. You must go through the credentialing and recredentialing process before you may treat our members.

CARE PROVIDERS SUBJECT TO CREDENTIALING AND RE-CREDENTIALING

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 **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

ADVANCE DIRECTIVES

As part of re-credentialing, we may audit records of primary care providers, hospitals, home health agencies, personal care providers and hospices. This process helps us determine whether you are following policies and procedures related to advance directives. These policies include:

- Respecting members' advance directives, and placing them prominently in medical records.
- Adhering to charting standards that reflect the member's advance directives.

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.

RE-CREDENTIALING PROCESS

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

PERFORMANCE REVIEW

As part of the re-credentialing process, UnitedHealthcare Community Plan looks in its Quality Management

database for information about your performance. This includes member complaints and quality of care issues.

APPLICANT RIGHTS AND NOTIFICATION

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. You may call the NCC to correct your information at any time. If the NCC finds erroneous information, a representative will contact you by fax or in writing. You must submit corrections within 30 days of notification by phone, fax or in writing to the number or address the NCC representative provided. You also have the right to receive the status of your credentialing or recredentialing application by calling the NCC (VETTS) number listed in How to Contact Us.

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

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

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

SECURITY

Covered entities must meet basic security measures:

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

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



Find additional information on HIPAA regulations at [cms.hhs.gov](https://www.cms.hhs.gov).

Ethics & Integrity

INTRODUCTION

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others

is necessary for our continued success and that of our business associates. It's also the right thing to do.

COMPLIANCE PROGRAM

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

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

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

REPORTING AND AUDITING

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

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



To facilitate the reporting process of questionable incidents involving members or care providers, call our [Fraud, Waste and Abuse line](tel:866-242-7727) at 866-242-7727.

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 Nebraska 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 Nebraska Department of Health and Human Services.

RECORD RETENTION, REVIEWS AND AUDITS

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

review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

You must cooperate with the state or any of its authorized representatives, the Nebraska Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

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

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

DELEGATING AND SUBCONTRACTING

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

Office Site Quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has

set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

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

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

CRITERIA FOR SITE VISITS

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

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

Chapter 11: Billing and Submission

Our Claims Process



For claims, billing and payment questions, go to [UHCprovider.com](https://www.uhcprovider.com).

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.



For a complete description of the process, go to [UHCprovider.com/guides](https://www.uhcprovider.com/guides) > View online version > Chapter 9 Our Claims Process.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.



If you have not applied for a NPI, contact [National Plan and Provider Enumeration System \(NPPES\)](#). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call the [UHG VETSS](#) line or [Provider Services](#).

Your clean claims must include your NPI and Federal Tax Identification Number. Also include the Unique Care Provider Identification Number (UPIN) laboratory claims.

Nebraska DHHS MLTC Medicaid ID

You must have a Nebraska Medicaid provider ID number to render services for a Nebraska Heritage Health plan member and receive payment from us. You must receive this ID number prior to claims payment. This ID number is assigned by the Nebraska DHHS MLTC.



To apply for a Nebraska DHHS MLTC Medicaid ID, visit the Nebraska DHHS webpage to access the MC-19 form and Provider Screening and Enrollment information: [dhhs.ne.gov/](https://www.dhhs.ne.gov/).

General Billing Guidelines

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

Claims Payment Requirements

UnitedHealthcare Community Plan must pay care providers interest at an annualized rate of 12%, calculated daily for the full period that a payable clean claim remains unpaid beyond 60 days from receipt by UnitedHealthcare Community Plan. Interest owed to the care provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

Modifier Codes

Use the appropriate [modifier codes](#) on your claim form. The modifier must be used based on the date of service.

Member ID Card for Billing

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

Acceptable Claim Forms

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

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

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

Clean Claims and Submission Requirements

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

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

We may require additional information for some services, situations or state requirements. The claim requires no special treatment preventing timely payment under the Agreement terms. Please refer to your Agreement for timely filing guidelines.

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

All claims must have a valid rendering provider NPI number and billing provider NPI number combination matching the care provider information enrolled with the Department of Health and Human Services (DHHS). We will reject electronic claim submissions and deny paper claims that do not have a matching rendering and billing provider NPI combination.

Claims must include the correct billing taxonomy code and nine-digit office ZIP code registered with DHHS. Because the Nebraska DHHS uses this data, it's important for your claim data to match the data used in your DHHS Provider Identification Number registration process.

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.

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.

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- All claims are set up as "commercial" through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

If you treat another diagnosis, use that ICD CM code as well.



For more information, contact [EDI Claims](#) at **800-210-8315**. You can also see enshealth.com or contact [Provider Services](#).

EDI Companion Documents

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

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

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



The companion documents are located on UHCprovider.com/edi > Go to companion guides.

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.



To get your reports, make sure your software vendor has connected to our clearinghouse OptumInsight at enshealth.com.

If you are not yet an OptumInsight client, we will tell you how to receive Clearinghouse Acknowledgment Reports.

e-Business Support

UnitedHealthcare Community Plan offices are open 8 a.m. – 5 p.m. Central 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 Menu, then Resource Library to find Electronic Data Interchange menu.

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP

Completing the CMS 1500 Claim Form



Companion documents for 837 transactions are on UHCprovider.com, Click Menu, then Resource Library to find the EDI section.

Visit the [National Uniform Claim Committee](#) website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

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

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

Capitated Services

CAPITATED CARE PROVIDERS

Capitation is a payment arrangement for health care

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

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

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

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

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital they received emergency room 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.

Subrogation and Coordination of Benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the

injury or illness.

- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations.

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

Hospital and Clinic Method of Billing Professional Services

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

Correct Coding Initiative (CCI)

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

COMPREHENSIVE AND COMPONENT CODES

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

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

- **Sequential procedures:** Only report the procedure that achieves the expected result.

MUTUALLY EXCLUSIVE CODES

Mutually exclusive code edits apply to procedures that are unlikely or impossible to perform at the same time, on the same member, by the same care provider.

CCI guidelines are available in hard copy, on CD ROM, and in software packages from your CPT and ICD CM code vendor, many specialty organizations, and the U.S. Department of Commerce's National Technical Information Service.

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. Note: Block 23 can only contain one condition. Additional conditions should be reported on a separate CMS 1500 claim form.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 410-786-3531 or go to the [cms.gov](https://www.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 one unit with the appropriate charge in the charge column.
- The beginning date of service is equal to the initial prenatal visit and the ending date of service is equal to the last prenatal visit prior to delivery.
- Nebraska allows billing antepartum care with one visit on a separate line.
- Use CPT Evaluation and Management codes (99201-99215*) or OB visits (59425-59426) to report prenatal visits.
 - Only use CPT Evaluation and Management (E/M) codes 99201-99215 when three or less prenatal visits are performed.
 - Use global delivery codes: 59400, 59519, 59610 and 59618.

Ambulance Claims (Emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP. The accident state must be listed in box 10 and ambulance claims must not bill diagnosis code 799.99.

National Drug Code (NDC)

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.

In field 24A shaded area of the CMS-1500 claim form, enter the N4 NDC qualifier in the first two positions, followed by the 11-digit NDC (no dashes or spaces), and

then a space and the NDC units of measure qualified, followed by the NDC quantity. All should be left-justified in the pink shaded area above the date of service.

The billed units in column G (days or units) should reflect the HCPCS units and not the NDC units. Do not base billing on the NDC units. Billing based on the NDC units may result in underpayment.

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](https://www.cms.gov) for Place of Service codes.

Asking About a Claim

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

PROVIDER SERVICE

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

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

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

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

You can view your online transactions with Link by

signing in to Link on UHCprovider.com with your Optum ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

LINK: YOUR GATEWAY TO UNITEDHEALTHCARE COMMUNITY PLAN ONLINE PROVIDER TOOLS AND RESOURCES

Link lets you move quickly between applications. This helps you:

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

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

Find Link training on UHCprovider.com.

Resolving Claim Issues

 To resolve claim issues, contact [Provider Services](https://UHCprovider.com) at 866-331-2243, use [Link](https://UHCprovider.com) 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:

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

TIMELY FILING

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

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

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

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

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

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

Balance Billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- UnitedHealthcare Community Plan denies a claim for late submission, unauthorized service or as not medically necessary.
- A claim is pending review by UnitedHealthcare Community Plan.

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.



If you don't know who your provider advocate is, email [Nebraska PR Team@uhc.com](mailto:Nebraska_PR_Team@uhc.com).
A provider advocate will get back to you.

Third Party Resources

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

Medicare Crossover Claims

You are required to enter Medicare information at both the claim and line level. When entering Medicare information at the claim level, please help ensure the amount entered is the sum of the amounts entered at the line level.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

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



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 Fax Or Mail	Care Provider Contact Information	Care Provider Website For Online Submissions	Care Provider Filing Timeframe	UnitedHealthcare Community Plan Response Timeframe
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 31365 Salt Lake City, UT 84131	UHC provider.com/claims	866-331-2243	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Must receive within the timeframes specified in your Agreement	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan Provider Claim Disputes P.O. Box 31365 Salt Lake City, UT 84131	UHC provider.com/claims	866-815-5334 Fax: 801-994-1224	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Must receive within 365 calendar days of the claim processing date	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
Situation	Definition	Who May Submit?	Submission Address	Online Form For Fax Or Mail	Care Provider Contact Information	Care Provider Website For Online Submissions	Care Provider Filing Timeframe	UnitedHealthcare Community Plan Response Timeframe
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com/claims	866-331-2243 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Within 60 calendar days of the provider remittance advice/reconsideration decision	30 business days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com/claims	866-331-2243	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	N/A	15-90 calendar days
Member Appeal	A request to change an adverse benefit determination that we made.	<ul style="list-style-type: none"> Member Member's authorized representative (such as friend or family member) with written member consent Care provider on behalf of a member with member's written consent 	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131	UHC provider.com/claims	800-641-1902	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Standard appeals – 60 calendar days	Urgent appeals - 72 hours Standard appeals - 30 calendar days
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	<ul style="list-style-type: none"> Member Member's authorized representative (such as friend or family member) with written member consent Care provider on behalf of a member with member's written consent 	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131	UHC provider.com/claims	800-641-1902	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	N/A	15-90 calendar days

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

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

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

The grid lists the types of disputes and processes that apply. These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

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

Denial

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

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

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

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

Other top reasons for denial include:

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

Duplicate Denials – To reduce receiving duplicate denials, submit one claim with all billed services for one member, one date of service when rendered by same care provider. If you bill for multiple dates of service, please ensure all billable services are listed for the dates of service.

The exception to these guidelines applies when the service(s) include:

- Different procedure codes
- Different modifiers
- Different NDC numbers
- Different place of service (POS)
- Billing by care provider of different specialty

All services billed on a UB-04 form need to be listed on one claim form.

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 Link. To access Link, sign in to UHCprovider.com using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 business days to receive payment for initial claims and 30 business days to receive a response to adjustment requests.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5240
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. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal – the claim needs to be corrected through resubmission. You have up to 12 months from the date of service to submit a clean claim.

Common Reasons for Rejected Claims:

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

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

How to use:

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

UnitedHealthcare Community Plan
Provider Claim Disputes
P.O. Box 31365
Salt Lake City, UT 84131-0365

Warning! If your claim was denied and you resubmit it, you will receive a [duplicate claim rejection](#). A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information

or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration (step one of dispute)

What is it?

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

When 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, mail or fax:

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **866-331-2243** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

UnitedHealthcare Community Plan

Provider Claim Disputes
P.O. Box 31365
Salt Lake City, UT 84131

This form is available at UHCprovider.com.

- Fax: Send the Claim Reconsideration Request Form to **801-994-1224**.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

Valid proof of timely filing a claim includes:

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

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan. To be considered timely, the claim must be received by UnitedHealthcare Community Plan within the timely filing period from the date on the other carrier's correspondence. If the claim is received after the timely filing period, it will not meet timely filing criteria.

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

How to use:

Submit a reconsideration request electronically, phone, mail or fax with the following information:

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

Additional Information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

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

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

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

Where to send:

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

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

Instructions and forms are on UHCprovider.com.

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. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your Agreement.

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

Sample Overpayment Report

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

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

Care Provider Claim Appeals (step two of dispute)

What is it?

An appeal is a second review of a claim reconsideration decision (step one).

When to use:

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

How to use:

Submit related documents with your appeal within 60 calendar days from the provider remittance advice (PRA) date. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the appeal to:

UnitedHealthcare Community Plan

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

- **Fax:** Send the appeal to **801-994-1082**.

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?

A grievance is a written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. You may file a grievance on your own behalf.

When to file:

You may file a grievance about:

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

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

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services toll free at **866-331-2243** or TTY **711**
- **Mail:** Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan

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

Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances.

MEMBER BENEFIT APPEALS

What is it?

An appeal is a formal way for a member to request a reconsideration of any adverse benefit determination, including:

- 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 timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments and other member financial liabilities.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call, mail or fax the information

within 60 calendar days from the date of the adverse benefit determination:

UnitedHealthcare Community Plan

Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

800-641-1902 (toll-free)

TTY: 711 for the hearing impaired

Available 7 a.m. – 7 p.m. Central Time and 6 a.m. – 6 p.m. Mountain Time, Monday through Friday. If you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan.

You, acting on the member's behalf, or a member have the right to present the appeal in person 8 a.m. – 5 p.m., Central Time, Monday through Friday, at:

UnitedHealthcare Community Plan

2717 N. 118th St
Suite #300
Omaha, NE 68164

How to use:

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

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- If someone else helps the member with their appeal, the member will need to sign a form called Assignment of Record (AOR). The form grants permission to the other party to help the member on their behalf with the appeal process.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health. You have 72 hours to provide certification of the appeal and

evidence and allegations in person or in writing. Provider certification is a written confirmation from you that the expedited request is urgent.

- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.
- We resolve a standard appeal 30 calendar days from the day we receive it.
- We resolve an expedited appeal 72 hours from the time we receive it.

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

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

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



A copy of the form is online at UHCprovider.com.

MEMBER GRIEVANCE

What is it?

A grievance is a written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. A member may file a grievance verbally or in writing. You may file a grievance on a member's behalf when acting as the member's authorized representative.

When to use:

You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: **800-587-5187** (TTY: **711**)

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance, or as quickly as the member's health condition requires. We offer a 14 calendar day extension if the member or UnitedHealthcare Community Plan requests additional time.

Member State Fair Hearings

What is it?

A State Fair Hearing is a request by a member or you (on a member's behalf) to appeal a decision made by the health plan, addressed to the state.

When to use:

The member or their representative may request the state of Nebraska for a State Fair Hearing only after receiving notice that the health plan is upholding the adverse benefit determination.

How to use:

Write a letter to the state within 120 calendar days from the appeal decision notice to:

Department of Health and Human Services
MLTC Appeal Coordinator
P.O. Box 94967
Lincoln, NE 68509-4967

- The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.
- The member may call the Nebraska DHHS MLTC Legal Services at **402-471-7237**.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

MEMBER CONTINUATION OF SERVICES

Members may ask for continuation of services during the State Fair Hearing. However, the member may be required to pay for the health service if the service is continued and it is decided that the member should not have received the service.

Processes Related to Reversal of Our Initial Decision

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

1. As quickly as the member’s health condition requires, 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.

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.

Timelines for Grievances and Appeals

Grievance	
Time to file	Members and care providers may submit at any time.
Time to resolve	We will try to resolve within 15 days, but when additional time is needed, a resolution analyst will notify the care provider with the reason for the delay and help ensure the complaint is resolved within 90 days.
Claims Adjustment – Claims reconsideration	
Time to file	Must be filed within 365 calendar days of the claim processing date.
Time to resolve	30 business days.
Claims Adjustment – Claims Appeal	
Time to file	Within 60 calendar days of the provider remittance advice/reconsideration decision.
Time to resolve	30 business days of receipt.
Claims Adjustment – Claims Appeal – Overpayment Refund Request	
Time to file	Within the timeframe listed in your contract.
Time to resolve	Within 30 business days.
Utilization Management (UM) Appeal	
Time to file	Upon receipt of an adverse benefit decision, the member or care provider must submit an appeal within 60 calendar days.
Time to resolve	30 days. Expedited reviews/decisions are available within 72 hours when medically necessary.

Fraud, Waste and Abuse



Call the toll-free [Fraud, Waste and Abuse Hotline](#) at **866-242-7727** to report questionable incidents involving plan members or care providers.

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

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

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



Find the UnitedHealth Group policy on Fraud, Waste and Abuse at **866-242-7727**.

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

UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

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

EXCLUSION CHECKS

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

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

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 13: Care Provider Communications & Outreach

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

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care Provider Websites

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

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

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements

- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

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



You may also find training on various topics at UHCprovider.com > Menu > Resource Library. Look under More Resource Topics, then click Training.

Care Provider Office Visits

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

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Nebraska network at least three times a year. The newsletters include articles about:

- Program updates

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

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on UHCprovider.com, Click Menu, then Resource Library, News to quickly share urgent information that affects the entire network.



Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on UHCprovider.com/guides > Provider Communication Chapter 17.

Care Provider Manual

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

Find the following forms on the state's website at dhhs.ne.gov/:

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

Care Provider Marketing Guidelines

UnitedHealthcare Community Plan of Nebraska will comply with the following care provider marketing guidelines requirements:

UnitedHealthcare Community Plan of Nebraska will obtain and keep on file your written consent when conducting any form of marketing in your office. We

will not require you to distribute health plan-prepared marketing communications to your patients. We will not provide you with incentives or giveaways to distribute to (potential) health plan members.

We will not allow you to solicit enrollment or disenrollment in a health plan, or distribute health plan-specific materials at a marketing activity. We will not provide printed materials to you with instructions about how to change health plans to other health plan members.

We will instruct you about the following communication requirements:

- If you wish to inform your patients of your affiliation with one or more health plans, you must list each health plan with whom you contract.
- You may display or distribute health education materials for all contracted health plans, or you may choose not to display or distribute for any contracted health plan.
- Health education materials must adhere to the following guidelines:
 - Health education posters can be no larger than 16 x 24 inches.
 - Children's books, donated by us, must be in common areas.
 - Materials may include our name, logo, telephone number and website address.
 - You are not required to distribute and/ or display all provided health education materials from each health plan with whom you contract.
 - You can choose which items to display as long as you distribute items from each contracted health plan, and that the distribution and quantity of items displayed are impartial.
 - You may display Managed Care Organizations (MCOs) marketing materials, provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all health plans with whom you have a contract.
 - You may display health plan participation stickers, but if you do you must display stickers for all contracted health plans, or choose not to display stickers for any contracted health plans.
 - Health plan stickers indicating that you participate

with a particular health plan cannot be larger than 5 x 7 inches and cannot indicate anything more than “the health plan is accepting or welcomed here”.

- You may inform your patients of the benefits, services and specialty care services offered through the health plans in which you participate. However, you may not recommend one health plan over another, offer patients incentives for selecting one health plan over another, or assist the patient in deciding to select a specific health plan in any way, including but not limited to faxing, using the office phone, or a computer in the office.

Upon health plan contract termination, if you contract with other health plans you may notify your patients of the change and the impact of the change on them, including the contract termination date. You must continue to see current patients enrolled with us through the termination date, according to all terms and conditions specified in your Agreement.

We will not produce branded materials instructing members about how to change to a different health plan. You must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance.

Chapter 14: Glossary

AABD

Assistance to the aged, blind and disabled

Abuse (by care provider)

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

Abuse (of member)

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

Acute Inpatient Care

Care provided to members sufficiently ill or disabled requiring:

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

Advance Directive

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

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 an member's request to exercise his or her right, to obtain services outside the network.
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Ambulatory Care

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

Ambulatory Surgical Facility

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

Ancillary Provider Services

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

Appeal

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

Authorization

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

Auto Assignment

An automated method of enrolling a Nebraska DHHS MLTC-eligible member with a contracted health plan.

Billed Charges

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

Capitation

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

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.

Clinical Coordinator

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

CMS

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

Contracted Health Professionals

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

Coordination of Benefits (COB)

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

Covered Services

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

Credentialing

The verification of applicable licenses, certifications and

experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes

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

Delivery System

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

Disallow Amount (Amt)

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

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

Discharge Planning

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

Disenrollment

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

Dispute

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

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

Durable Medical Equipment (DME)

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)

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

Electronic Data Interchange (EDI)

The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)

The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)

An electronic version of a member's health record and the care they have received.

Eligibility Determination

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

Emergency Care

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

Encounter

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

Enrollee

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

Enrollment

The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an

enrollee or member of a health plan.

Evidence-Based Care

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

Expedited Appeal

An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or 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 member's rights regardless of whether remedial action is requested. Grievance includes an member's right to dispute an extension of time proposed to make an authorization decision.

Health Plan Employer Data and Information Set (HEDIS)

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

HIPAA

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

Home Health Care (Home Health Services)

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

In-Network Provider

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

Katie Beckett (KB)

A program that provides home health nursing and other medical services to children less than 18 years of age who otherwise would be hospitalized because of their high level of health care needs.

Medicaid

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

Medical Emergency

An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in serious danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary

Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI

National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care

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

Participating Care Provider

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

Preventive Health Care

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

Primary Care Provider (PCP)

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

Prior Authorization (Notification)

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

Provider Group

A partnership, association, corporation, or other group of care providers.

Quality Improvement Program (QIP)

A formal set of activities to ensure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Quality Management (QM)

A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple

organizational components and committees.

Rural Health Clinic

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

Service Area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by Nebraska DHHS MLTC.

Specialist

A care provider licensed in the state of Nebraska and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing

An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF

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

Third-Party Liability (TPL)

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

Timely Filing

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

Title XIX

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

UnitedHealthcare Community Plan

An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota.

UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)

Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.