



Nebraska 2017

Provider Manual

Welcome

Welcome to the Community and State (C&S) plan manual. This comprehensive and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Care provider tools are available online through Link at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com). Link allows you to access information you need without jumping between websites or picking up the phone. Get member eligibility, benefits and claims information quickly and easily from a single, secure online location.

- Click [here](#) to access the UnitedHealthcare Administrative Guide for Medicare Advantage member information. Some states may also have Medicare Advantage information in their C&S manual.
- Click [here](#) to select a different C&S manual, or go to uhccommunityplan.com, then click For Health Care Professionals at the top of the screen. You can then select the desired state.

You may easily find information in the guide/manual using the following steps:

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

Depending on your version of Adobe, you may also be able use the binoculars icon to launch the search option.

We greatly appreciate your participation in our program and the care you provide to our members.

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Chapter 1: Welcome

This manual is designed as a comprehensive reference for information you and your staff need to conduct transactions and care coordination with us in the quickest and most efficient manner possible. Much of this material, as well as operational policies and additional information, are available at UHCCommunityPlan.com.

Our goal is to help ensure our members have convenient access to high-quality care provided according to the most current and effective treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

If you have any questions about the information or material in this manual, or about any of our policies or procedures, please contact Provider Services at 866-331-2243. The UnitedHealthcare Community Plan office is located at:

UnitedHealthcare Community Plan
2717 N 118th St., Ste 300
Omaha, NE 68164

We greatly appreciate your participation in our Medicaid program and the care you provide to our members.

Important Information Regarding the Use of This Manual

In the event of a conflict or inconsistency between your participation agreement and this manual, the provisions of your participation agreement will control unless otherwise stated in the agreement.

We reserve 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 operational policies change.

Communications to Providers

From time to time, there may be important information about policies and protocols that must be communicated to all participating providers. These communications may be done through *network bulletins* or through *Practice Matters* provider newsletter. If the information communicated through these methods is a change to any protocol set forth in this manual, you will see the updated information in this manual upon the next provider manual revision notification.

Network Bulletin – The network bulletin is a monthly publication posted to UnitedHealthcareOnline.com. The bulletin contains information and updates as well as administrative changes for all products, not just Medicaid. Articles located in the bulletin that are specific to Nebraska Medicaid providers will also be communicated through the provider newsletter called *Practice Matters*.

Practice Matters – *Practice Matters* is the provider newsletter published quarterly specific to Nebraska Medicaid products within UnitedHealthcare Community Plan of Nebraska. This newsletter includes policy changes and communicates clinical topics or reminders. Articles regarding policy or administrative updates will be included in this publication, but may also be found in the network bulletin as specified above. The *Practice Matters* newsletters are posted at UHCCommunityPlan.com For Health Care Professionals > Nebraska > Provider Newsletters.

About UnitedHealthcare Community Plan of Nebraska

UnitedHealthcare Community Plan of Nebraska has served Medicaid members since 1996. UnitedHealthcare Community Plan's corporate entity is UnitedHealth Group. UnitedHealthcare Community Plan provides benefits and service to members including:

- **TANF** – Temporary Assistance for Needy Families
- **CHIP** – Children's Health Insurance Program is Kids Connection
- **AABD** – Assistance to the Aged, Blind, and Disabled
- **KB** – Katie Beckett
- **DSNP** – Dual Eligible Special Needs Plan members (the aged, blind and disabled) who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid).
- **I/DD** – Intellectual/Developmental Disabled
- **SMI** – Serious Mental Illness



If you have any questions about the information or material in this administrative guide or about any of our policies or procedures, please contact Provider Services at 866-331-2243.

Our Approach to Health Care

Innovative health care programs are the hallmark of UnitedHealthcare. Our personalized programs encourage the utilization of services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help our chronically ill members avoid hospitalizations and hospital emergency room visits – in short, to live healthy, productive lives.

The unique UnitedHealthcare Whole Person Care Model™ features direct member contact by UnitedHealthcare clinicians trained to foster an ongoing relationship between the health plan and members suffering from serious and chronic conditions. The goal is to use high quality health care and practical solutions to improve members' health and keep them in their communities, with the resources necessary to maintain the highest possible functional status.

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, UnitedHealthcare's Healthy First Steps program uses an early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother's self-efficacy by identifying and building a mother support system;
- Ensure appropriate postpartum and newborn care;
- Develop the physician/member partnership and relationship before and after delivery.

In addition to the usual Health Plan reminders to get preventive care services, UnitedHealthcare employs its proprietary Universal Tracking Database to identify members who have fallen behind in scheduling appointments and providers who are failing to focus on preventive care and optimal treatment.

Specialty Care Managers include:

- Maternal, child health care managers and care navigators. These specialty care managers follow pregnant women in the Healthy First Steps® program. A care manager coordinates the member's care, including health education and outreach from the onset of pregnancy through the postpartum checkup;

- Care Managers/care navigators for members that have qualifying conditions.
- Care Managers/care navigators for members requiring private duty nursing.
- Care Managers/care navigators for specialized populations (I/DD, ABD, members participating in HCBS, members eligible to participate in Medicare and Medicaid).

Chronic Condition Management

A collaborative approach, inclusive of physical, behavioral, and social determinant considerations, is used to develop, implement and monitor the provision of care coordination, disease management and case management programs for Heritage Health members.

Educational materials and newsletters are used to remind members to comply with positive health actions such as immunizations, wellness, and EPSDT screenings. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) programs. All educational materials are based upon evidence-based guidelines or standards. All printed materials are written at a 6.9 grade reading level and are available in English and Spanish and other prevalent non-English languages. The materials are designed to support the physicians clinical management of members as they take responsibility for their health and provide them with the information necessary to manage their condition as successfully as possible and live a healthy life.

Members at highest risk with conditions such as asthma, Congestive Heart Failure (CHF), diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD) may receive more intense health coaching. Resources and tools are available to provide support to members and caregivers with conditions common to children with special health care needs and help them manage their illness. The health plan uses claims data (e.g. hospital admissions, ER visits, and pharmacy claims) to identify members with gaps in care and/or chronic conditions.

Referral – PCPs may make referrals to support practice-based interventions by contacting Health Services at 877-856-6351.

Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent care providers and facilities. The network includes health care professionals such as primary care providers, specialist physicians, medical facilities, allied health professionals, and ancillary service providers. UnitedHealthcare Community Plan offers several options to support providers who require assistance.

UnitedHealthcareOnline.com Online Resources

All online electronic functionality such as member eligibility, claim status, claim submission and electronic remits for UnitedHealthcare Community Plan members are accessible through UnitedHealthcareOnline.com. If you are not registered on UnitedHealthcareOnline.com, you may do so directly on the website. This secure portal offers an innovative suite of online health care management tools. Use of this website is intended for approved Community Plan providers, facilities and medical administrative staff and offers the convenience of online support 24-hours-a-day, 7-days-a-week. The provider portal can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

Visiting UnitedHealthcareOnline.com

Our website has a wealth of resources and information available for you to use in your day-to-day interactions with UnitedHealthcare, such as billing and claims, notifications, member eligibility, payment resources and more.

unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Contact%20Us/PhysHowto_sitecopy.pdf

UnitedHealthcareOnline.com:

- Patient Eligibility and Benefits
- Claim Status
- Claim Reconsiderations
- Single EOB Search
- Claim Submissions
- Notification/Prior Authorization Submission & Status
- Radiology Notification & Authorization Submission Status

- Reports
 1. PCP Panel Report
 2. Claim Trends
 3. Provider Profile
 4. EPSDT (PDF)
 5. Preventative Health Measures
 6. Emergency Department (ED) Report
- Provider Directory
- Medical Policies

UHCCommunityPlan.com Online Resources

UnitedHealthcareOnline.com offers many online resources as well for our complex provider community. Providers can access Prior Authorization Lists and fax form, Reimbursement Policies as well as Bulletins, Electronic Data Interchange Forms, companion guides and Pharmacy information online.

UHCCommunityPlan.com:

- Provider Information (welcome and contact information)
- Claims and Member Information
- Provider Manual
- Pharmacy Program
- Reimbursement Policy
- Newsletters
- Bulletins
- Provider Forms
- Billing and Reference Guides
- Cultural Practice Guidelines
- Clinical Practice Guidelines
- Electronic Data Interchange (EDI)
- Authorizations and Notifications
- Cultural Competency Library

Provider Service Center

This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service Representatives trained specifically for UnitedHealthcare. The Provider Service Center can assist you with questions on Medicaid benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc. and can be reached at 866-331-2243. Hours of operation 7:00 a.m. to 8:00 p.m. Central time. The Provider Service Center works closely with all departments in UnitedHealthcare.

Network Management Department

Within UnitedHealthcare Community Plan, the Network Management Department is the point of contact if you need assistance with a contract, credentialing and in-services (i.e., training with on-line systems). The Network Management Department is staffed with network account managers who are available for visits, contracting, credentialing, and specific issues in working with UnitedHealthcare.



If you need to speak with a network contract manager at any time for assistance with credentialing status or contracting, please call Network Management at 800-284-0626.

In the event 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 provider who is able to make the necessary accommodations for member care.

Cultural Competency Resources

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 his or her 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

How to Contact Us

Provider Service Center	866-331-2243 7:00 a.m. to 8:00 p.m. CT.	To inquire about a patient's eligibility or benefits, or check claim status. You can also use the Provider Portal at UHCCommunityPlan.com .
Nebraska Provider Advocate	Nebraska PR Team@uhc.com To locate your provider advocate and contact information, please use UHCCommunityPlan.com > For Healthcare Professionals > Select your State > Nebraska > Provider Information > Provider Advocate Look-up.	To notify the Nebraska Provider Advocate when assistance is needed to answer a question or resolve an issue related to claims payment
Claims Hotline Claims Address: UnitedHealthcare P.O.Box 31365 Salt Lake City, UT 84131	866-331-2243	To inquire about the status of a claim, or to ask a question about proper completion or submission of claims. You can also use the Provider Portal at UHCCommunityPlan.com .
Prior Authorization/Notification of Health Services	866-604-3267 fax 866-622-1428	To authorize/notify of the procedures and services outlined in the prior authorization/notification requirements section of this guide
Radiology Prior Authorization:	866-889-8054 fax 866-889-8061	To request prior authorization of the procedures and service outlined in the prior authorization requirements of this guide.
Whole Person Care Model (Care Management)	877-856-6351	To refer high-risk members (asthma, diabetes, obesity, other chronic conditions). To refer members who need Private Duty Nursing
Healthy First Steps	877-813-3417	To refer OB members
Pharmacy Services	Pharmacy Prior Authorization Service: 800-310-6826 Fax 866-940-7328 Monday through Friday 8:00 a.m. to 8:00 p.m. CT. Pharmacy Benefit Manager for claims assistance: (pharmacies call) 877-231-0131 Monday through Friday 8:00 a.m. to 8:00 p.m. CT. Provider Services Call Center 866-331-2243 Monday through Friday 7:00 a.m. to 8:00 p.m. CT.	To request prior authorization for prescription medication outlined in the prior authorization requirements of this guide: 800-310-6826. For comprehensive durable medical equipment (DME) received at a pharmacy, contact the Pharmacy assistance line at: 877-231-0131.
Fraud and Abuse	800-455-4521 or 1-866-242-7727	To notify us of suspected fraud or abuse on the part of a provider or member of workplace abuse.
Mental Health and Substance Use	866-604-3267 866-331-2243 877-614-0484 providerexpress.com 866-556-8166	Prior Authorization requests Claims/Customer Service eligibility and benefit information. Update provider practice information, review guidelines and policies and view national network manual. Appeals and Grievances
Dental Services		Routine dental services are not covered by UnitedHealthcare Community Plan but by NE DHHS MLTC. Anesthesia and facility charges associated with dental procedures performed at a hospital facility or ambulatory Surgery Center (ASC) are covered and must meet Medical Necessity. Facility utilization must be prior authorized by UnitedHealthcare Community Plan for services to be considered.

Transportation	844-531-3783 (Toll Free) 402-401-6999 (Omaha Local) TTY 402-401-6998 iridenow.com	IntelliRide: <ul style="list-style-type: none">• Call to schedule transportation or for transportation assistance.• To arrange non-urgent transportation, please call three days in advance
Member Services	800-641-1902 TTY 711	Available 7 a.m. to 7 p.m. CT, Monday through Friday to assist members with their questions and help them get the care they need. Interpreter service is also available if the language is other than English.
Superior Vision Benefit Management, Inc.	866-819-4298 superiorvision.com	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from Superior Vision.

Nebraska Provider

Quick Reference Guide

Claims Process

To help ensure prompt payment for services:

- 1 Review and copy** both sides of the member's UnitedHealthcare Community Plan ID card.
- 2 Notify** Health Services of planned procedures and services on our Prior Authorization list.
- 3 Prepare** a complete and accurate electronic or paper claim form. Complete a CMS 1500 (formerly HCFA) or UB-04 form.
- 4 Submit** claims electronically on UnitedHealthcareOnline.com. Be sure to use our electronic payer ID number (87726) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315.

If you do not have access to internet services, you can mail the completed claim to:

UnitedHealthcare Community Plan in Nebraska
P.O. Box 31365
Salt Lake City, UT 84131

Complete Claims

A complete claim includes the following:

- Patient's name, date of birth, address and ID number.
- Name, signature, address and phone number of care provider performing the service, as stated in your contract document.
- National Provider Identifier (NPI) number.
- Care provider's tax ID number.
- CPT-4 and HCPCS procedure codes with modifiers where appropriate.
- ICD CM diagnostic codes.
- Revenue codes (UB-04 only).
- Date of service(s), place of service(s) and number of services (units) rendered.
- Referring care provider's name (if applicable).
- Information about other insurance coverage, including job-related, auto or accident information, if available.
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers and CPT 99360 care provider standby.
- Attach an anesthesia report for claims submitted with 23, QS, G8 or G9 modifier.
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable).
- EPSDT – correct referral indicator must be indicated. Indicators are: AV, S2, NU, ST.
- Include the exact NDC that appears on the product administered.

IMPORTANT NOTE: You must submit claims within your timely filing limit.

How to Contact Us:

UnitedHealthcareOnline.com/Link Application

Secure website to verify member eligibility, check status of claims, submit claims, claim reconsideration request, reports, provider data management.

UHCCommunityPlan.com

This website allows you to get updated provider information that includes:

- Provider newsletters.
- Provider manual.
- Clinical practice guidelines.
- Provider bulletins.
- Reimbursement policies.

Provider Services (866-331-2243)

Available from 7:00 a.m. to 8:00 p.m. CT, Monday through Friday. This is an automated system. Please have your Tax ID and NPI number ready. Call Provider Services to:

- Ask questions about benefits.
- Verify member eligibility.
- Check claim status.
- Ask questions about your participation or notify us of demographic and practice changes.
- Request information regarding credentialing.

Prior Authorization Health Services – For a complete and current list of prior authorizations, go to: UHCCommunityPlan.com/Provider Information/Prior Authorization or call 866-604-3267. Fax prior authorization to 866-688-1428.

Prior Authorization Radiology – Outpatient Imaging Procedures For a complete and current list of prior authorizations, go to: UHCCommunityPlan.com/Radiology Tab or call 866-889-8054.

Care Management/Disease Management (877-856-6351)

– **Private Duty Nursing** call 402-445-5000 or email to NE_CareManagement@uhc.com

Nebraska Provider Advocate – When assistance is needed to answer a question or resolve an issue related to claims payment. Nebraska_PR_Team@uhc.com. To locate your provider advocate and contact information, please use UHCCommunityPlan.com > For Healthcare Professionals > Select your State > Nebraska > Provider Information > Provider Advocate Look-up.

Healthy First Steps – OB Members

877-813-3417 or Fax 877-353-6913

Pharmacy Services

- Pharmacy Benefit Manager Help Desk 877-231-0131
- Pharmacy Prior Authorization 800-310-6826 Fax 866-940-7328
- Forms located on UHCCommunityPlan under Pharmacy Program tab.
- Pharmacy Preferred Drug List (PDL) UHCCommunityPlan.com under Pharmacy Program tab.

Member Services/Interpreter Services (800-651-1902)

7:00 a.m. to 7:00 p.m. CT, Monday - Friday. Member Services is available to assist members with any issues or concerns.

Nebraska Provider

Quick Reference Guide

Additional Contact Information

Mental Health and Substance Use

Prior Authorization requests 866-604-3267

Claims/Customer Service eligibility and benefit information.
866-331-2243

Update provider practice information, review guidelines and policies and view national network manual.
877-614-0484 providerexpress.com

Appeals and Grievances 866-556-8166

Non Emergent Medical Transportation – IntelliRide

844-531-3783 (Toll Free) – 402-401-6999 (Omaha local)
iridenow.com

Vision Services

Superior Vision – 866-819-4298 or SuperiorVision.com

Other Important Physical Health Information

Provider & Member Appeals Mailing Address United Healthcare Community Plan

P.O. Box 31364
Salt Lake City, UT 84131

Provider & Member Grievance Mailing Address

P.O. Box 31364
Salt Lake City, UT 84131

Provider Administrative Appeals: Claim Disputes United Healthcare Community Plan

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

Providers should call the Provider Service Center at 866-331-2243 about appeal inquiries

Claims Submission Address

UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131



Notify Health Services Within the Following Time Frames :

Emergency Admission - One business day of an emergency or urgent admission

Admission After Ambulatory Surgery
One business day of an inpatient admission

Non-Emergency Care (except maternity)
At least 14 calendar days prior to non-emergent non-urgent facility admissions and/or outpatient services

Call 866-604-3267 or fax prior authorizations to 866-622-1428



Chapter 2: Care Provider Responsibilities

General Provider Responsibilities

Non Discrimination

Providers will not refuse an enrollment/assignment or disenroll a covered person or otherwise discriminate against a covered person solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type.

Mainstreaming of Members

To ensure mainstreaming of Nebraska Medicaid members, the UnitedHealthcare Community Plan will take affirmative action so that members are provided covered services 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 must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f):

- i. Denying or not providing a member any covered service or access to an available facility.
- ii. Providing to a member any medically necessary covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary.
- iii. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.
- iv. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served.

Communication Between Care Providers and Members

The health care program requires a two-way communication between PCPs and other participating providers to help ensure

both quality and cost-effective health services are provided to UnitedHealthcare Community Plan members.

UnitedHealthcare does not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member for the member's health status, medical care or treatment options including any alternative that may be self-administered or providing any information the member needs to decide among all relevant treatment options.

All Provider Agreements executed by UnitedHealthcare contain language which encourages you to discuss treatment options and their associated risks and benefits with members, regardless of whether the treatment is covered under the member's benefit contract. Nothing in the UnitedHealthcare agreement is intended to interfere with the relationship between you and your patient, or with UnitedHealthcare's ability to administer its quality improvement, utilization management or credentialing programs.

UnitedHealthcare Community Plan members and/or their representative(s) have the right to actively participate in the planning and implementation of their care. In order to help ensure members and/or their representative(s) are afforded this opportunity, UnitedHealthcare has developed a policy which requires you:

1. To educate patients, and/or their representative(s) regarding their health needs
2. To share findings of history and physical examinations.
3. To discuss potential treatment options (without regard to plan coverage), side effects of treatment, management of symptoms
4. To recognize patients (and/or their representative) have the right to choose the final course of action among clinically acceptable choices
5. Must collaborate with the Plan Care Manager in developing a member specific Plan of Care for members enrolled in High Risk Care Management.

Provide Official Notice

You must notify us at the address in your contract of the following events, in writing, within 10 calendar days of your knowledge of their occurrence:

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

Note: You can use the **physician and provider demographic change submission form** for demographic changes or to update you NPI information for providers in your office. This form can be located at UHCommunityPlan.com. Click on Health Care Professionals, Select State then select Provider Forms.

Transition Member Care Following Termination of Your Participation

If your network participation terminates for any reason, you are required to participate in the transition of your patient toward timely and effective care. This may include providing service(s) for a reasonable time, at your contracted rate. Provider Services is available to help you and our members with the transition.

Arrange Substitute Coverage

If you are unable to provide care and are arranging for a substitute, we ask that you try to arrange for care from other care providers who participate with UnitedHealthcare.



For the most current listing of network health care professionals, review our professional directory at UHCommunityPlan.com.

In order for services to be covered under the member's in network benefit plan, a non-network care provider or health care professional will need to apply for participation and, if accepted, sign a participation agreement.

After-Hours Care

While true emergencies and life-threatening situations require the immediate services of an emergency department, treatment after hours can be provided quickly and efficiently at an urgent care center where available, and appropriate for conditions such as infections, fever, symptoms of cold or flu. When your office is contacted by one of your patients after hours asking where to

seek urgent care, please refer them to an urgent care center if you are not able to accommodate them in your schedule.

Participate in Quality Initiatives

You must cooperate with our quality assessment and improvement activities, and comply with our clinical guidelines, member safety (risk reduction) efforts, and data confidentiality procedures.

The guidelines upon which UnitedHealthcare clinical quality initiatives are based define optimal delivery of health care for particular diseases and conditions as determined by United States government agencies and professional specialty societies.

Provide Access to Your Records

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

Performance Data

You must allow the plan to use provider performance data.

Comply With Protocols

You will cooperate with, and be bound by, UnitedHealthcare's and Payer's Protocols, including protocols contained in this guide.



You may view all protocols at UHCommunityplan.com>health-professionals.

Office Hours

You must offer office hours of operation to Medicaid members that are no less than those offered to commercial members.

Protect Confidentiality of Member Data

UnitedHealthcare members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a

member requests specific medical record information, we will refer the member to you as the holder of the medical records. You will comply with applicable regulatory requirements, including but not limited to, those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare uses member information for treatment, operations and payment. UnitedHealthcare has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes passwords, screen saver, firewalls and other computer protection, along with shredding of information that includes PHI and all confidential conversations. All personnel are trained on HIPAA and confidentiality requirements.

Follow Medical Record Standards

Please reference Chapter 11 for specific Medical Record Standards.

Inform Members of Advance Directives

The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of 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 also inform members of state laws on advance directives through our member handbooks and other communications. You can locate additional Advanced Directives information at: caringinfo.org.

Resolving Disputes

The terms and conditions of your participation agreement govern the dispute resolution process.

If you have a concern or complaint about your Agreement with us, send a letter containing the details to the address in your contract. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in our Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare procedures, such as the credentialing or Care Management process, you will follow the appeal process as outlined in this provider manual to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, an arbitration proceeding may be filed as described in your Agreement.

If we have a concern or complaint about our Agreement with you, we’ll send you a letter containing the details. If we can’t resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in our Agreement.

Arbitration proceedings will be held at the location described in your Agreement.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member’s benefit contract or handbook.



You can locate the member’s handbook at uhcommunity.plan.com/ne/medicaid/community-plan/member-information.html

Please also reference Chapter 14 of this manual concerning information on Provider Claim Disputes, Appeals and Grievances.

Role of the Primary Care Provider (PCP) and Specialists (i.e., Internal Medicine, Pediatrics, or OB/GYN) Serving in the PCP Role

PCPs are an important partner in the delivery of care and Heritage Health members have the freedom to seek services from any participating care provider. The NE DHHS MLTC program does require members be assigned to PCPs and members are encouraged 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” that they can access to optimize their care.

The Primary Care Provider (PCP) plays a vital role as a physician case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas – access, coordination, continuity, and prevention. The

PCP is responsible for the provision of 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/7-days coverage and backup coverage when he or she is not available.

Care provider types that can be PCPs are medical doctors (M.D.), doctors of osteopathy (DO), nurse practitioners (NPs)*, and physician assistants (PAs)* from any of the following practice areas:

- General Practice
- Internal Medicine
- Family Practice
- Pediatrics
- Obstetrics/Gynecology

Nurse practitioners are allowed to enroll with the state as solo care providers, but physician assistants cannot. Physician assistants must be part of a group practice.

*For services rendered by a nurse practitioner or physician assistant, the claim should be submitted 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 that an M.D. or DO be the ordering care provider type. Per the state of Nebraska Department of Health and Human Services, physician assistants and nurse practitioners cannot be the ordering care provider for these types of services.



Enrollees may change their assigned PCP by contacting Customer Service **800-641-1902** at any time during the month. Customer Service is available 7 a.m. to 7 p.m. CT, Monday through Friday and from 6 a.m. to 6 p.m. MT Monday through Friday.

Enrollees who do not select a PCP at enrollment will be offered the opportunity to select one. However, there are occasions when the UnitedHealthcare Community Plan must auto-assign a PCP in order to complete the enrollment process.

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.

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at UnitedHealthcareOnline.com. The portal requires a unique user name and password combination to gain access.



Sign in to UnitedHealthcareOnline.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.

UnitedHealthcare Community Plan works with members and you to help ensure all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, 7 days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

PCPs and Specialists Serving in the PCP Role (i.e., Internal Medicine, Pediatrics, or OB/GYN) Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of the PCPs include:

- Offer access to office visits on a timely basis, for scheduling Emergency, Urgent Care and Routine care, in compliance with the standards outlined in the Appointment Availability Access Standards section of this Guide. Office hours are no less than those offered to commercial members.
- Conduct a baseline examination during the member's first appointment.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on UHCCommunityPlan.com.
- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with special health care needs.

- Help ensure the integration of clinical and non-clinical disciplines and services in the overall plan of care for special needs members.
- Use any member lists supplied by the Health Plan identifying members who appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- For questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at **866-331-2243**.
- Provide all well baby/well-child services.
- Screen members for behavioral health problems using the Behavioral Health Toolkit for the Health Care Professional found on our website UHCCommunityPlan.com. File the completed screening tool in the patient's medical record.
- Coordinate each member's overall course of care.
- It is an expectation that providers caring for pregnant women and women with dependent children will coordinate referrals to appropriate community programs and services such as the Women, Infants, and Children Program (WIC) services program.
- Be available personally to accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one medical doctor (MD) practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems.
- Recorded messages are not acceptable.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Clinical Request Line (Advanced Outpatient Imaging Procedures), Pharmacy Department, Behavioral Health Unit as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- UnitedHealthcare requires a clean and structurally sound office that meets applicable Occupational Safety and Disabilities (ADA) standards.
- 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 attending care providers.

PCP Checklist

PCPs should take the following steps when providing services to UnitedHealthcare Community Plan members:

- Check member eligibility by going to UHCCommunityPlan.com, contacting Provider Services at **866-331-2243**, or calling Nebraska Medicaid Eligibility System (NMES – **800-642-6092**) to verify eligibility. Failure to verify member enrollment and assignment may result in claim denial.
- Check the member's ID card each time the member presents it for service and verify against photo identification if this is your office practice.

- Obtain prior authorization from UnitedHealthcare, if required. Please visit UHCCommunityPlan.com to view the current notification requirements for Nebraska. To locate, select the Provider Information Tab, Prior Authorization.
- Refer to UnitedHealthcare Community Plan contracted specialists unless otherwise authorized by UnitedHealthcare.
- Identify and appropriately bill other insurance carriers.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 paper claim form. Refer to Chapter 13 of this manual for billing procedures.

- Providing only those covered specialty care services, unless otherwise authorized.
- Complying with the NE DHHS MLTC Access and Availability standards for scheduling Routine care. Appointment Standards are covered in Chapter 2 of this manual.
- Medical Residents in Specialty Practice. Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

Specialist Care Provider Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of specialists include:

- The PCP must coordinate the medical care that UnitedHealthcare enrollees receive. When the treating or consulting specialist determines that a UnitedHealthcare enrollee requires additional treatment or specialist care/services, he/she must contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member's PCP or who self-refer.
- Provide the PCP copies of all medical information, reports, and discharge summaries resulting from the specialist's care.
- Communicate in writing to the PCP all findings and recommendations for continuing patient care and note them in the patient's medical record.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating Hospitals.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Providing covered specialty care services to member in accordance with accepted community standards of care and practices.
- Verifying the eligibility of the member prior to the provision of covered specialty care services.

Specialist Checklist

Specialists should take the following steps when providing services to UnitedHealthcare Community Plan members.

- Verify the member's enrollment prior to initiating services and before rendering subsequent services by going to UHCCommunityPlan.com, calling Provider Services (866-331-2243) or calling Nebraska Medicaid Eligibility System (NMES – 800-642-6092). Failure to verify member enrollment may result in claim denial.
- Check the member's ID card each time the member presents it for service and verify against photo identification if this is your office practice.
- Obtain prior authorization from UnitedHealthcare, if required. Please visit UHCCommunityPlan.com to view the current notification requirements for Nebraska. To locate, select the Provider Information Tab, Prior Authorization.
- Identify and appropriately bill other insurance carriers when appropriate.

Prenatal Care Responsibilities

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



You should notify UnitedHealthcare promptly of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the UnitedHealthcare Healthy First Steps coordinator. Please call **877-813-3417**.

The following information must be provided to UnitedHealthcare when the pregnancy is confirmed:

- Patient's name and member ID number
- Obstetrician's name, phone number, and member ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery
- Any concomitant diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy
- Complying with the NE DHHS MLTC Access and Availability standards for scheduling Prenatal care. Appointment Standards are covered in Chapter 2 of this manual.
- An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures.

Ancillary Care Provider Responsibilities

'Ancillary care providers' include pharmacy, home health, durable medical equipment, infusion care, therapy, vision, and other non-physician care providers. PCPs and specialist care providers are required to use the UnitedHealthcare Ancillary network. UnitedHealthcare contracted Ancillary care providers are responsible for maintaining sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary Care Provider Checklist

Ancillary care providers should take the following steps when providing services to UnitedHealthcare members. Verify the member's enrollment prior to initiating services and before rendering subsequent services by contacting Provider Services at 866-331-2243, UHCCommunityPlan.com or Nebraska Medicaid Eligibility System at NMES 800-642-6092.

- Verify the member's enrollment prior to initiating services and before rendering subsequent services by going

UHCCommunityPlan.com, calling Provider Services (866-331-2243) or calling Nebraska Medicaid Eligibility System (NMES – 800-642-6092). Failure to verify member enrollment may result in claim denial.

- Check the members ID card each time the member presents for service and verify against photo ID if this is your office practice.
- Obtain prior authorization from UnitedHealthcare, if required. Please visit UHCCommunityPlan.com to view the current notification requirements for Nebraska. To locate, select the Provider Information Tab, Prior Authorization.
- Identify and appropriately bill other insurance carriers, when appropriate.

Appointment Availability Access Standards (Nebraska Department of Health and Human Services Access & Availability Standards)

Appointment Type Definitions:

Emergency Services: Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week.

Family planning services: Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

Preventive care: The care you receive to prevent illnesses or diseases. It also includes counseling to prevent health problems. Providing these services is based on the idea that getting preventive care, such as screenings and immunizations, can help you and your family stay healthy.

Routine Care: Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis, chronic low back pain.

Urgent Care: Urgent care is medical care given for a condition which, without timely treatment, could result in deterioration to an emergency, or cause prolonged, temporary impairment of one or more bodily function(s), or development of a chronic illness, or need for a more complex treatment. Examples of urgent conditions include abdominal pain, unremitting new symptoms of dizziness of unknown cause, suspected fracture.

Non-Urgent Sick Care: Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of non-urgent sick visits include cold symptoms, sore throat and nasal congestion.

NOTE: The NE DHHS MLTC Managed Care Access Standards do not differentiate between a new or established patient.

You shall comply with the following appointment availability standards:

Primary Care

PCPs and providers of primary care the following standards must be met:

- Emergency services – available 24 hours a day, 7 days a week.
- Urgent care – same day of request.
- Routine care – within 14 calendar days of request.
- Non-urgent “sick” care within 72 hours, or sooner, as clinically indicated.
- Preventative care within four weeks.

Timely Access-Standards for hours of operation for PCP’s:

1. One-physician practices must have office hours of at least 20 hours per week.
2. Practices with two or more physicians must have office hours of at least 30 hours per week.

Specialty Care

Specialty services the following standards must be met:

- High Volume Specialists; cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedics physicians. Routine care – within 30 calendar days of request/referral.
- Other specialty care, consultation must be available within 30 calendar days of referral or as clinically indicated.

Prenatal Care

The following initial prenatal care appointments must be met:

- First Trimester care – within 14 calendar days of request.
- Second Trimester care – within seven calendar of days of request.
- Third Trimester care – within three calendar days of request.
- High Risk care – within three calendar days of request.

Behavioral Health

The following standards must be met:

- Emergency appointments must be referred within one hour generally and within two hours in designated rural areas.
- Other specialty care, consultation must be available within 30 calendar days of referral or as clinically indicated.

Family Planning Services

The following standard must be met:

- Family Planning services – within seven calendar days

Laboratory and X-rays Services

- Laboratory and X-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

Allowable Office Waiting Times

- Members with appointments should not routinely wait longer than 45 minutes, including time spent in the waiting room and the examining room, unless the care provider is unavailable or delayed because of an emergency. If a care provider is delayed, the member should be notified immediately. If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.

UnitedHealthcare also conducts periodic access and availability surveys to monitor appointment availability and access standards. PCPs, specialists, and obstetricians are required to participate in all activities related to these surveys.

Chapter 3: Care Provider Office Procedures

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled with NE DHHS MLTC, which is Nebraska's Medicaid program. Eligibility for the NE DHHS MLTC program is determined by NE DHHS MLTC. An individual who becomes eligible for the NE DHHS MLTC program either chooses or is assigned to one of the NE DHHS MLTC contracted health plans.

Verifying Member Enrollment

You should verify member eligibility prior to providing services. Determine eligibility through:

- Patient Eligibility & Benefits – access enrollment and benefit information online at UnitedHealthcareOnline.com.
- You may reach the UnitedHealthcare Provider Service Center 7:00 a.m. to 8:00 p.m. CT and 6:00 a.m. to 7:00 p.m. MT Monday through Friday at 866-331-2243.
- Nebraska Medicaid Eligibility System (NMES) Line 800-642-6092.

Member Assignment

Assignment to UnitedHealthcare Community Plan

UnitedHealthcare is assigned Heritage Health eligible members on a daily basis. UnitedHealthcare is responsible for managing the member's care on the date that the member is enrolled with the plan and until the member is disenrolled from UnitedHealthcare. Disenrollment decisions are made by NE DHHS MLTC and are not the responsibility of UnitedHealthcare. Disenrollment usually takes effect at month's end, but at times may occur in the middle of the month.

At the time of assignment to UnitedHealthcare Community Plan, each member receives a member ID card and welcome carrier letter. Followed by a welcome kit includes a new member *Getting Started Guide* that encourages new members to complete health risk screening using our online tool, through the member's PCP/PCMH provider or through direct contact with us. The welcome packet provided to Nebraska Medicaid members includes the *Member Handbook*, information about our *Health4Me* mobile application and a multilingual welcome card, which provides a list of important phone numbers and helpful reminders about member benefits; Medicaid Tip Sheet; and prevention letter.



You may obtain copies of the Member Handbook by calling the UnitedHealthcare Provider Service Center at **866-331-2243** or online at www.uhccommunityplan.com/ne/medicaid/community-plan.html under Member Information.

Immediate Enrollment:

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. In order to avoid delays in claims processing and payment, you should have the payer assignment of newborns checked daily.



Eligibility information is available by calling the NMES line toll free 800-642-6092 or (402) 471-9580 (in the Lincoln area) or the Medicaid Inquiry line toll free 877-255-3092 or (402) 471-9128 (in the Lincoln area) or by using the following link: dhhs.ne.gov > Medicaid > Pages > Med Eligibility



Unborn Enrollment:

Please encourage your patients to notify ACCESSNebraska when they know they are expecting. You or the MCO may use the online change report via the ACCESSNebraska website to report the baby's birth. With that information, ACCESSNebraska will verify the birth through interfaces and from the mother. The MCO and/or your information is taken as a lead. To assist with timely verification, once baby is born, the mother should notify ACCESSNebraska.



Patients can call ACCESSNebraska toll free at **855-632-7633** or **402-473-7000** (in the Lincoln area) or **402-595-1178** (in the Omaha area).

Newborns can get UnitedHealthcare Community Plan covered health services beginning on their date of birth, so it is important eligibility is checked daily until the mother has enrolled her baby in a managed care plan.

PCP Selection:

Although unborns cannot be enrolled with an MCO until birth, please encourage your patients to select and contact a PCP for their baby prior to delivery to 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 provider.

Choosing a Primary Care Provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is automatically assigned to a primary care provider (PCP). The assignment takes into consideration the distance to the PCP, the PCP's capacity, and if the PCP is accepting new patients. UnitedHealthcare's Member Services department will assign members to the closest available and appropriate PCP.

Depending upon the age, medical condition and location of the member, 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 elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare to change his/her PCP at any other time the change will be made effective on the date of the request.

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at UnitedHealthcareOnline.com. The portal requires a unique user name and password combination to gain access.

Sign in to UnitedHealthcareOnline.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.

PCP-Initiated Transfers

A PCP may wish to transfer a member due to an inability to establish or maintain a professional relationship, experiences incompatibility with a member or member is non-compliant. The PCP shall maintain responsibility for providing care for the patient until a transfer is complete.

1. To initiate a transfer of the member, the PCP must contact the health plan in writing via fax at 402-445-5730 or mail with the specific documentation of the event(s) that occurred. (Documentation includes DHHS form MS-24, the date(s) of failed appointments or a detailed accounting of reasons for termination request, patient name, date of birth, Medicaid number, current address, current telephone 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. A summary will be prepared by UnitedHealthcare Community Plan within 10 business days of the request. The health plan will attempt to contact the member, educate and try to resolve the issue to develop a satisfactory PCP member relationship.
3. If the member and health plan are unable to resolve the current PCP member issue, the Health Plan will then work with the member in finding another PCP for continuity of care. The Health Plan will refer the member to care management if necessary.
4. If the Health Plan is unable to reach the member, the Health Plan will send the member a letter (with a copy to the PCP) advising them they have five business days to contact us with a new PCP. If they do not choose a PCP, the Health Plan will choose one for them. A new ID card will be sent to the member with the new PCP information.

Interpreter Services

Free in-office telephonic interpreter services for all UnitedHealthcare Community Plan members.



Contact Member Services at **800-641-1902** for assistance, if language is other than English.

Deductible/Copayments

There are no deductibles or office visit copayments for covered services.

Member ID Card

Be sure to check the member's ID card at each visit – and to copy both sides of the card for your files. You may also take the precaution of verifying 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 any potential fraud, waste and abuse situation, events or circumstances (provider or member) come to your attention, please notify UnitedHealthcare Community Plan in writing per instructions regarding fraud, waste and abuse addressed in Chapter 13 of this manual, or you can call the toll-free Fraud, Waste, and Abuse Hotline at **800-455-4521**.

UnitedHealthcare Community Plan ID cards will reflect the members Group ID number. The members ID cards will also reflect the members PCP assignment on the front of the card. You may view a copy of the members ID card image online at UnitedHealthcareOnline.com while verifying member eligibility.

Member Identification Numbers

Each member receives a nine-digit UnitedHealthcare member identification number. This number is used to communicate with UnitedHealthcare of the Midlands regarding a specific subscriber/member. The NE DHHS MLTC Medicaid Number is also provided on the member ID card.

Sample Health Member ID Card



UnitedHealthcare® Community Plan

Health Plan/Plan de salud (80840) 911-87726-04

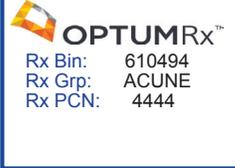
Member ID/ID del Miembro: 999999999 **Group/grupo:** NESHAD

Member/Miembro: SUBSCRIBER BROWN **Payer ID/ID del Pagador:** 87726

Medicaid Number: 99999999999

PCP Name/Nombre del PCP: DR. PROVIDER BROWN

PCP Phone/Teléfono del PCP: (999)999-9999



Rx Bin: 610494
Rx Grp: ACUNE
Rx PCN: 4444

0501 Administered by UnitedHealthcare of the Midlands, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 99/99/99



En caso de emergencia, acuda a la sala de emergencia más cercana o llame al 911. This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.

For Members/Para Miembros:	800-641-1902	TTY 711
Vision/Servicios para la vista:	800-879-6901	
NurseLine/Línea de enfermeras:	877-543-4293	
Enrollment Broker/Agent de ventas:	888-255-2605	

For Providers: www.uhccommunityplan.com 866-331-2243

Claims: PO Box 31365, Salt Lake City, UT 84131

For Pharmacist: 1-877-231-0131

Pharmacy Claims: OptumRx PO Box 29044, Hot Springs, AR 71903

Chapter 4: Covered Services

UnitedHealthcare Community Plan provides the basic NE DHHS MLTC Medicaid benefits to eligible UnitedHealthcare Community Plan members consisting of medical, vision, mental health and substance use and pharmacy services. In addition, UnitedHealthcare Community Plan also provides value-added services to our members.

Some of the covered services need prior authorization; therefore, you must contact us before starting the service. Hospitals and facilities must notify us of any admissions or services that need notification. An authorization from us for any out of network services is required.



You can request the prior authorization for medical services by calling **866-604-3267**. For Advanced Outpatient Imaging Procedures providers can call CareCore at **866-889-8054**. You can also visit UHCCommunityPlan.com for information regarding the prior authorization requirements. Click on Health Care Professionals and for state select NE.



Medically Necessary Service

UnitedHealthcare only pays for medically necessary services.

Medically Necessary Definition

Medically necessary health care services or supplies are:

- Medically appropriate
- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service

- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the client of his or her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Of demonstrated value
- No more intense level of service than can be safely provided

Deductibles/Copayments

There are no deductibles or office visit copayments for covered services.

Covered Services

The benefits listed below should not be considered **exhaustive**. The specific services to be delivered to Community Plan members are described in detail on the NE DHHS MLTC website.



For specific services, please reference dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx



Contact the Provider Service Center, **866-331-2243**, with questions as to whether a service is covered.

Benefit	Services Included	Limitations
Ambulance Services	Emergent ground transportation Non-emergent ground transportation – transportation should be made by the member’s care provider directly with the ambulance service.	Covered if medically necessary Prior Authorization not required if participating care provider. Non-participating care provider requires a prior authorization.
	Emergent Air Ambulance Non-emergent air ambulance transportation – transportation should be made by the member’s care provider directly with the air ambulance service.	Covered if medically necessary Prior Authorization required for participating and non participating care providers
	Please refer to additional Ambulance Service information in this Chapter.	

Benefit	Services Included	Limitations
Bariatric Surgery	Inpatient and outpatient bariatric surgery and specific obesity-related service.	Covered. Prior Authorization required.
Behavioral Health- Inpatient and Residential	<ul style="list-style-type: none"> • Psychiatric services • Substance use treatment <p>Please reference Chapter 6 for specific behavioral health coverage information.</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>Please reference Chapter 6 for specific behavioral health coverage information.</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. 	Covered. Potential Prior Authorization required.
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. • Members aged 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 5th 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>	Covered. Prior Authorization required.
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 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 • Gyncomastia 	Potentially Covered. Prior Authorization required.

Benefit	Services Included	Limitations
Dental Services	Routine Dental services are not covered under UnitedHealthcare Community Plan. Care providers will need to contact NE DHHS MLTC – Julie Swenson at 402-471-6287.	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 NE DHHS MLTC – Julie Swenson at 402-471-6287 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 out-patient only and includes: <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 6 months • Chest x-ray every 6 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.
Diabetic Supplies	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 UHCommunityPlan.com for drugs covered under the Pharmacy Program tab. 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 contracted DME pharmacy. Optum Rx for Providers and Pharmacies: 877-231-0131 .	Covered. Prior Authorization Required on all DME codes with a retail purchase or cumulative rental cost of more than \$500 per line item. Outpatient only.

Benefit	Services Included	Limitations
<p>Diagnostic Tests</p>	<p>Radiology: Radiology (Imaging studies) require prior authorization from UnitedHealthcare Clinical</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: 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>Some diagnostic tests require a Prior Authorization and must always be medically necessary.</p> <p>UnitedHealthcare Clinical Request Line for providers: 866-889-8054</p>
<p>Durable Medical Equipment (DME) and Medical Supplies</p>	<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 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>A prior authorization is required on all DME codes with a retail purchase or cumulative rental cost of more than \$500 per line item. Outpatient only.</p>
<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, 7 days a week at any emergency room.</p> <p>Please refer to additional information in this Chapter.</p>	<p>Covered anywhere in the USA.</p>

Benefit	Services Included	Limitations
<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>Please refer to additional information in this Chapter.</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>
<p>Hearing Services</p>	<p>Audiological testing to establish a need for a hearing aid to include:</p> <ul style="list-style-type: none"> • Hearing evaluation (bone conduction & air conduction tests) • Speech audiometry • Hearing aid selection <p>Treatment may include:</p> <ul style="list-style-type: none"> • Auditory training; speech training • Aural rehabilitation (including hearing aid & cochlear implant orientation & fitting adjustments) • Augmentative communication <p>Adults: As part of the adult Health Screening Services audiometry sweeps are covered for once every four years greater than 21 years of age.</p> <p>Hearing aids, necessary accessories are covered services with medical evaluation and items covered include:</p> <ul style="list-style-type: none"> • Hearing aids • Initial care kit • Batteries – There is a 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) 	<p>Covered.</p> <p>Covered.</p> <p>Prior Authorization required for ALL DME codes with a retail purchase or cumulative rental cost of more than \$500 per line item.</p>
<p>Home Health Services</p>	<p>All services in the home:</p> <ul style="list-style-type: none"> • Home Health Agencies • Private duty nursing • PT/OT/ST • Skilled nursing • Social worker • Home Infusion • Physician Home Visit 	<p>Covered. Prior Authorization required.</p> <p>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.</p>

Benefit	Services Included	Limitations
Hospice	In-Home Hospice and Short Stay Inpatient Hospice.	Prior Authorization required.
	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 shall be approved as an exception under the prior authorization provisions. The benefit periods may be used consecutively or at intervals.	
	Residential Inpatient Hospice Services are covered by NE DHHS MLTC.	Not Covered.
Please refer to additional Hospice information in this Chapter.		
Hospital – Inpatient	Inpatient hospital care. Includes medical, surgical, post-stabilization, acute and rehabilitative services.	Covered. Prior Authorization required.
Hospital – Outpatient	Outpatient Professional/Medical Services Professional component (in/outpatient) of surgical services, including: <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 over-night stay • Invasive diagnostic procedures such as endoscopic examinations 	Covered.
	Electroconvulsive therapy (ECT) does not require a prior authorization.	
	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.	Prior Authorization required for non-emergent/non-urgent hospital services.
Immunizations	Immunizations are covered for adults.	Covered.
	Covered for children, birth through 18 years of age, via the Vaccine for Children program (VFC). Provider must file claims using the appropriate CPT and modifier. UnitedHealthcare Community Plan only covers the administration of the VFC program. 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. Providers must report required immunization data to the Nebraska State Immunization Information System.	
Injectable Medications	Rendered on an outpatient basis. Please visit UHCommunityPlan.com to view the current notification requirements for Nebraska for the list of injectable medications requiring a prior authorization. To locate, select the Provider Information Tab/Administrative Guide/Prior Authorization List.	Covered. Prior Authorization required.
Joint Replacement	Outpatient and inpatient joint and total hip and knee replacement procedures.	Covered.
		Prior Authorization required.
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.

Benefit	Services Included	Limitations
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.
	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. 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: <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 \$500.	Prior Authorization required.
Outpatient and Care Provider Visits	Services at a hospital or care center when a member stays less than a day; Doctor, other provider visits, family planning, preventive services, and clinic visits. Specialty care provider visits. Emergency Room visits including both hospital and care provider charges.	Covered.
Out of Network Services	A recommendation to a care provider who is not contracted with UnitedHealthcare.	All out of network services require prior authorization.
Outpatient Surgery	Services include but are not limited to: <ul style="list-style-type: none"> • Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and Hospital ASC) 	Covered.
	Covered when medically necessary and not otherwise excluded.	Some surgeries require Prior Authorization.
Pharmacy Program	Drugs prescribed by a care provider. This includes education about how to take the drugs.	Covered – Some drugs on the state-approved formulary and preferred drug list may require prior authorization.
	See our Drug Formulary on UHCCommunityPlan.com for drugs covered under the Pharmacy Program tab. Please reference Chapter 5 for specific Pharmacy Program benefit information.	

Benefit	Services Included	Limitations
<p>Podiatry Services</p>	<p>Routine/Palliative Foot Care: 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. 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. 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 patient 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 	<p>Covered.</p>
<p>Pregnancy-Related Services</p>	<p>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.</p> <p>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 member is inpatient longer than the federal requirements a prior notification is needed. Please call 866-604-3267.</p> <p>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 pre-natal visits. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit</p> <p>Non-routine newborn care, i.e. care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress).</p> <p>Please refer to additional Maternity and Newborn information in this Chapter.</p>	<p>Covered.</p> <p>Prior authorization required.</p> <p>Prior authorization required.</p>
<p>Rehabilitation Therapies</p>	<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.</p> <p>Maintenance physical therapy is not covered.</p> <p>Massage therapy accumulates toward the visit limit.</p> <p>No limit for members age 20 and younger</p>	<p>Covered.</p> <p>An MD or DO must be the ordering care provider type for physical, occupational or speech therapy. Per NE DHHS MLTC, Physicians Assistants and Nurse Practitioners cannot order these services.</p>

Benefit	Services Included	Limitations
Sexually Transmitted Diseases – Screening, diagnosis, and treatment.		Covered service 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.
Sterilization and Hysterectomies	The plan covers once requirements are met. Requirements include but are not limited to: 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 patient.	Covered. All inpatient services require a Prior authorization in addition to the appropriate State consent form.
	Reversal of Voluntary Sterilization	Not Covered.
	Hysterectomies – Services cannot be reimbursed if performed for sterilization purposes. Patients undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result. 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 client in which she states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility. For additional information see: dhhs.ne.gov/medicaid/Pages/med_phosp.aspx Please refer to additional information in this Chapter. All inpatient services require a prior authorization in addition to the appropriate state consent form	
Synagis	Synagis requires prior authorization from OPTUMRx Phone: 800-310-6826 Fax: 866-940-7328	Covered. Prior authorization required.
	The Season Respiratory Syncytial Virus Enrollment Form needs to be completed and sent to OPTUMTRx. Please go to uhcommunityplan.com - Pharmacy Program tab and select Synagis Enrollment Form.	
Telehealth and Telemonitoring Services	Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a physician or practitioner for patients in rural areas or other places.	Covered benefit for medically necessary services.
	Please refer to additional Telehealth and Telemonitoring information in this Chapter.	

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 in order 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 are provided by the NE DHHS MLTC. NE DHHS MLTC has partnered with IntelliRide to provide non-emergent transportation services to our members.</p> <p>Members must make transportation arrangements at least three calendar days before their medical appointment.</p>	<p>Covered.</p> <p>Prior authorization required via IntelliRide.</p> <p>Non urgent appointments call 844-531-3783, or Omaha local 402-401-6999 6999 (TTY 402-401-6998).</p>
	<p>UnitedHealthcare is responsible for non-emergent ambulance transportation.</p> <p>Please refer to additional information in this Chapter.</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>
Vision Services	<p>Vision exams, prescription lens, and eyeglasses.</p>	<p>Covered.</p>
Superior Vision Benefit Management, Inc.	<p>Eye Exams:</p> <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 <p>Eye glasses (lenses and frame)</p> <ul style="list-style-type: none"> One pair every 12 months if there is significant change in your prescription 	<p>Member must use a participating Superior Vision provider.</p> <p>Superior Vision toll free at 866-819-4298 9 a.m. – 8 p.m. Eastern Time or go online to superiorvision.com.</p>
	<p>Vision therapy/orthoptic training</p> <p>Intraocular Lens</p>	<p>Covered.</p>
Weight Loss Surgery (Bariatric Surgery)	<p>Members must meet several criteria prior to be approved for this procedure, for example documentation of participation and failure in legitimate weight loss program.</p>	<p>Covered.</p>

Ambulance Services

Medically Necessary Definition

Emergency ambulance services (in-network or out-of-network care provider) are a covered benefit and do not require an authorization.

Emergency transports are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Any ambulance transport that does not meet the definition of an emergency transport must be billed as a non-emergency transport. This includes all scheduled runs (regardless of origin and destination) and transports to nursing facilities or to the member's residence.

Non-Emergent Ambulance Transportation:

UnitedHealthcare is responsible for Non-Emergent Ambulance Transportation.

Non-emergency ambulance transports to a care provider or office, clinic or therapy center are covered when -

1. The member is bed confined before, during, and after transport; and
2. The services cannot or cannot reasonably be expected to be provided at the member's residence (including a nursing facility or ICF/MR).

Ambulance services provided to a member receiving inpatient hospital services, where the member is transported to another facility for services (e.g., diagnostic testing) and the member is returned to the originating hospital for continuation of inpatient care, is not included in the payment to the hospital and must be billed by the ambulance care provider.

Non-emergent Ambulance Transportation needs to be scheduled by care provider's office, clinic or therapy center.

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

Air Ambulance:

Air Ambulance is covered only when the services are medically necessary and transportation by ground ambulance is contraindicated and -

1. Great distances or other obstacles are involved in getting the member to the destination;
2. Immediate and rapid admission is essential; or
3. The point of pickup is inaccessible by land vehicle.

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

Emergency/Urgent Care Services

Emergency services are covered for all UnitedHealthcare members; however, you should educate the members regarding appropriate and inappropriate use of the emergency room. Non-emergency services should be treated by the primary care provider (PCP), or in an urgent care setting. Non-emergency services, such as: sprains/strains, stomach aches, ear aches, fever, cough and colds, and sore throats, should be treated by the PCP.

A prior notification is not required for emergency services.

Covered services include, but are not limited to, the following:

- Emergency services based on prudent lay person definition of emergency health condition
- Hospital emergency department room and ancillary services and care provider services 24 hours a day, seven days a week, both by in-network and out-of-network providers
- Medical screening examination
- Stabilization services
- Access to designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services
- Emergency ground, air and water transportation
- Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts

Urgent Care (Non-Emergent)

Services for urgent care are covered.



For a list of Urgent Care Centers, call Provider Services at **866-331-2243**.

Family Planning

Family planning services are covered when provided by care providers or practitioners to members who voluntarily choose to delay or prevent pregnancy. UnitedHealthcare Community Plan members can access family planning services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- A. annual gynecological examination
- B. annual pap smear
- C. laboratory services
- D. contraceptive supplies, devices and medications for specific treatment
- E. contraceptive counseling

Non-covered items include:

- Reversal of Voluntary Sterilization
- Hysterectomies specifically for sterilization infertility treatment
- In-vitro fertilization is not covered Including, but not limited to:
 - GIFT
 - ZIFT
 - Embryo Transport
- Infertility Services – Not covered if the sole purpose of the service is to achieve pregnancy.
Note: Diagnosis of infertility is covered but treatment is not covered.
- Morning after pill – Not Covered

Parenting/Child Birth Education Programs:

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

Voluntary Sterilization

In Network covered with a consent requirement. The member needs to give consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent.

- Tubal Ligation
- Vasectomy

Out of Network: Authorization Required.

Reference Department of Health & Human Services Regulations, in this chapter, for further information on sterilization.

Hospice

UnitedHealthcare is responsible for In-Home Hospice and Short-Stay Inpatient Hospice. These services require a prior authorization.

Home Hospice:

UnitedHealthcare Community Plan covers benefits for routine home care for every day the member is at home, under the care of hospice, and not receiving continuous home care. We cover continuous home care to the hospice care provider to maintain a member at his/her place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

Respite Hospice:

Inpatient Hospital or Nursing Facility Respite Care is covered for the hospice care provider for 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 short-term and restricted to a maximum of five days per month counting the day of admission but not the day of discharge.

Inpatient Hospice:

Inpatient care is a covered benefit for the member to receive inpatient hospice care during a period of acute medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management that cannot be provided in any other setting. Care shall be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and member care. Inpatient care is short-term and restricted to a maximum of 10 days per month.

Inpatient Hospice Services provided for members that are receiving residential services provided by the facility are not covered under Managed Medicaid. Residential Inpatient Hospice Services are covered by DHHS. DHHS will cover benefits to the hospice care provider for both the hospice services care provided and for the residential services provided by the facility.

Immunizations

As a value added service, we cover immunizations for adult members who are identified with IDD/TANIF/ABD this includes pneumonia, flu and shingles shots, and routine vaccinations.

Covered for children, birth through 18 years of age, via the Vaccine for Children program (VFC). Provider must file claims using the appropriate CPT and SL modifier. UnitedHealthcare Community Plan only covers the administration of the VFC program.

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. Providers must report required immunization data to the Nebraska State Immunization Information System.

The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that has been developed to connect and share immunization information among public clinics, private provider offices, local health departments, schools, hospitals, and other health care facilities that administer immunizations. For more information go to dhhs.ne.gov/publichealth/Pages/nesiis_index.aspx.

Laboratory, X-rays, Imaging Procedures

Advanced Outpatient Imaging Procedures

Advanced outpatient imaging procedures must be prior authorized.



A complete list of the imaging procedures can be found on the Radiology tab on UHCCommunityPlan.com. To obtain a prior authorization, call the UnitedHealthcare Clinical Request Line at **866-889-8054** or you can request a prior authorization online at UHCCommunityPlan.com. Click on the Radiology tab and the Online Portal link.



Please reference Chapter 7 for additional information on the Radiology Prior Authorization Program.

Lab Services

UnitedHealthcare Community Plan requires you to use our contracted laboratories when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a primary care provider (PCP) or other care provider or dentist in one of our in-network, contracted laboratories do not require prior authorization except as noted on our Prior Authorization list. Referrals to non-contracted laboratories requires a prior authorization.

When submitting claims, you need to have a CLIA # on file or claims will deny.

Maternity and Newborn

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 member is in-patient longer than the federal requirements a Prior Notification is needed. Please call **866-604-3267**.

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three more consecutive months or had seven or more pre-natal visits. The initial pregnancy visit is not included in the global days and must be billed as a separate office visit.

Non-routine newborn care, i.e., care for sick newborns (for example, unusual jaundice, prematurity, sepsis, respiratory distress) is also covered but require a prior authorization.

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 the licensed care provider or group of care providers with whom there is an arrangement for referral and consultation if complications arise.

Obstetrical Maternity Care medical services must be furnished on an outpatient basis by the physician, nurse practitioner, physician's assistant, or licensed professional nurse under the physician's supervision, and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present when services are provided, the physician must assume professional responsibility for the medical services provided and ensure through approval of the plan of care that the services are medically appropriate.

Telehealth and Telemonitoring Services:

Some telehealth and telemonitoring services, including consultation, diagnosis and treatment by a physician or practitioner for patients in rural areas or other places are a covered benefit for medically necessary services. In-person contact between a health care provider and a patient is not required by Title XIX or XXI of the Social Security Act. 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. Please review our prior authorization list online at

UHCCommunityPlan.com for a complete listing of telehealth and telemonitoring services that require prior authorization.

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

- i. The member has been hospitalized two or more times in the last 12 months for conditions related to the disease. This provision is not required for infant apnea monitoring.
- ii. 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.
- iii. The originating site has space for all program equipment and full transmission capability.
- iv. The 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.

Transportation

Non-Emergent Transportation

Non-emergent transportation services are provided by the NE DHHS MLTC. NE DHHS MLTC has partnered with IntelliRide to provide non-emergent transportation services to our members.

UnitedHealthcare Community Plan enrollees are eligible to receive non-emergent transportation services through IntelliRide for covered services allowed by UnitedHealthcare Community Plan. Modes of transportation covered includes sedan, taxi, wheelchair equipped vehicle, public transit, mileage reimbursement and shared rides.

All trips must be approved in advance through IntelliRide's online system or the call center. The call center is open from 8:00 a.m. to 7:00 p.m. CT and 7:00 a.m. to 6:00 p.m. MT Monday through Friday. Online trip requests can be made 24 hours a day, seven days a week at iridenow.com. Non-emergency trips which are urgent, such as when you are discharged from the hospital, may be made through their call center after 7:00 p.m. CT and 6:00 p.m. MT. Urgent calls are the only calls taken in person by a Reservation Specialist after 7:00 p.m. CT and 6:00 p.m. MT.

All non-urgent requests must be made at least three days in advance of the requested appointment time.

Rides can be scheduled up to 30 days in advance.

Call **844-531-3783** (toll free) or Omaha local **402-401-6999** (TTY **402-401-6998**). Online trip requests can be made 24 hours a day, 7 days a week at iridenow.com.

Bus Transportation will also be available as another transportation option if the member:

1. Lives less than half a mile from a bus stop.
2. Their appointment is less than half a mile from the bus stop.

Value-added Services

We offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives. Members are informed of these services through their Value-added services are highlighted in the member newsletter, listed in the member handbook and at UHCCommunityPlan.com. Information about diagnosis-specific services, such as diabetes and pregnancy, are mailed to the member's home.

Members are able to directly access most of the value-added services. Some services require assistance from your office. All are limited to in-network providers.

For the most current information on value-added services available, please visit UHCCommunityPlan.com > For Healthcare Professionals > Nebraska > Billing & Reference Guides > Value Added Services.

You may also call Provider Services at **866-331-2243**.

Vision Services

UnitedHealthcare Community Plan uses Superior Vision Benefit Management as its Medicaid vision vendor. Members may self-refer to any Superior Vision Medicaid network provider for services. To aid members in making a provider selection, please refer them to Superior Vision at superiorvision.com or they may call member services toll-free at **800-879-6901**.

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

For specific information, please refer to the Superior Vision Provider Manual located at UHCCommunityPlan.com For Health Care Professionals > Nebraska > Provider Information > Vision Provider Manual or superiorvision.com.

Department of Health & Human Services Regulations

Pregnancy Termination Services

Pregnancy termination services are not a covered benefit, except in cases to preserve the life of the woman. In this case, you will be required to follow the NE DHHS MLTC and Consent Procedures for abortion.

Allowable pregnancy termination services do not require a referral from the patient's primary care provider. Patients must use the physician and care provider network.

Pregnancy Termination Service Documentation Process

Pregnancy termination services are covered when it is necessary to preserve the life of the woman. Follow the policy and procedures outlined below to qualify for reimbursement by the NE DHHS MLTC. If a pregnancy termination is needed to preserve the life of the mother, you must request prior authorization from the Medicaid Division before performing the pregnancy termination. Should prior authorization be approved using the NE DHHS MLTC guideline, reimbursement will be made upon submission of documentation reflecting NE DHHS MLTC approval of procedure.

Requests must be sent in writing to:

**Department Health & Human Services
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026 Fax 402-471-9092**

Sterilization and Hysterectomy Procedures

Payment can only be made for sterilization procedures performed pursuant to the person's documented voluntary request for such service. The intent of this policy is to assure that individuals considering sterilization are fully aware of the consequences, the available alternatives to sterilization and have had ample time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the requirements for making payment for Sterilization have been met. The regulations require that a written consent form 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 patient.

The individual must not be mentally incompetent or a resident of an institution such as a mental hospital or other facility for the treatment of mental disorders. An individual may consent to be sterilized at the time of premature delivery or emergency

abdominal surgery if at least 72 hours have passed since the individual has signed the Medical Assistance Consent Form. However, in the case of premature delivery, the Medical Assistance Consent Form must have been signed at least 30 days before the normally expected date of delivery. In the absence of compliance with the requirement outlined in this policy both for sterilization procedures and hysterectomies, no payment can be made to any of the parties concerned, i.e., physician, anesthetist or hospital.

Hysterectomies

Hysterectomy services cannot be reimbursed if performed for sterilization purposes. Patients undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result.

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 client in which she states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility. Refer to Chapter 17 for a copy of the form.



The form can also be found on the NE DHHS MLTC website dhhs.ne.gov/medicaid/Pages/med_phosp.aspx

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

1. The individual was already sterile before the Hysterectomy and you, who performs the hysterectomy, certifies in writing the individual was already sterile before the hysterectomy and states the cause of the sterility; or
2. The individual requires a hysterectomy because of a life-threatening emergency situation in which you determine prior acknowledgment is not possible, and
3. The hysterectomy was performed under a life-threatening emergency situation in which she determined prior acknowledgment was not possible. You must also include a description of the emergency.

UnitedHealthcare Community Plan will require along with your claim for services, a copy of the signed medical assistance hysterectomy statement. The claim, with documentation attached, should be mailed to Claims Administration identified on the back of the enrollee's ID card. Reimbursement will be made upon completion

of documentation requirements and UnitedHealthcare Community Plan review. The enrollee may not be billed if consent forms are not submitted.

Sterilization Informed Consent

An individual is considered as having provided Informed consent only if the Medical Assistance Consent Form for Sterilization procedures developed by the Department of Health and Human Services (DHHS) is properly executed. Any other already existing consent forms you use do not preclude the use of the Medical Assistance Consent Form developed by DHHS. It is your responsibility to be sure the individual fully understands, to the best of his or her ability, the planned sterilization procedure, has been advised of available alternative, non-permanent methods of family planning and has had an opportunity to have any questions answered. Informed consent may not be obtained while the individual is in labor for childbirth, is seeking to obtain or is obtaining an abortion or is under the influence of alcohol or other substances that affect the individual's state of awareness. The consent form must be signed and dated by the individual to be sterilized, and by the physician who performed the sterilization procedure. A copy of the signed Consent Form must be given to the patient, a copy must be submitted together with the Request for Payment form and the physician should retain a copy.

Sterilization Consent Form

Federal CMS regulations must be followed when completing the sterilization consent form. Refer to Chapter 17 for a copy of the form.



The form can also be found on the NE DHHS MLTC website dhhs.ne.gov/medicaid/Pages/med_phhosp.aspx

- 1. All applicable sections of the form must be complete.**
CMS has ruled that for a sterilization form to be considered valid, all applicable items on the form must be completed before payment is made. All applicable sections of the consent form must be completed before submitting it together with the billing form for payment. The Nebraska Medical Assistance Program cannot make payment for sterilization procedures until all applicable items on the consent form have been completed and are accurate and are in conformance with sterilization regulation requirements.
2. The physician's statement section of the form should be completed after the sterilization is performed. CMS policy is the physician should sign and date the form after the sterilization is performed. This may be the same date of the sterilization procedure or some date after the date of the procedure. If a physician signs and dates the consent form prior to performing the sterilization, the form is invalid.

3. Definition of the term "shortly before" as used in the physician statement section of the form. The state's definition of "shortly before" is not more than 30 days prior to the procedure. That means explain the procedure to the patient within that time frame. However, it is most important to note while the explanation can be given up to 30 days prior to the procedure, the physician should not sign and date the form until after the procedure is performed.

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 Native American Access to Care, emergency treatment and family planning services), including services received outside of the United States.
- Any care not covered by Nebraska Medicaid
- Any care covered by Medicaid but not through Managed Care, such as:
 - A. Institutional Long Term Care Nursing Facility services at a custodial level of care.
 - B. Intermediate Care Facilities for Persons intellectually/developmentally disabled (I/DD)
 - C. Home and Community Based Waiver Services
 - D. Dental Services. Exception: dental services performed in an outpatient setting. UnitedHealthcare Community Plan will cover the facility and anesthesia services when deemed medical necessary. Facility utilization requires a prior authorization.
 - E. Residential Inpatient Hospice Service
 - F. School-based services
 - G. Home and community based waiver services
 - H. Medicaid State plan personal assistance services
 - I. 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
- Infertility services

Chapter 5: Pharmacy Services

Preferred Drug List (PDL)

UnitedHealthcare Community Plan Pharmacy Program adheres to the state-approved preferred drug list. UnitedHealthcare Community Plan also provides coverage for additional drugs not found on the preferred drug list. You may access the list of covered drugs from our website at [UHCCommunityPlan.com](https://www.uhccommunityplan.com) > For Healthcare Professionals > Nebraska > Pharmacy Program.

Prior Authorization

Some drugs on the state-approved formulary and preferred drug list may require prior authorization. Pharmacists receiving prescriptions for drugs 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 be instructed to contact the UnitedHealthcare Pharmacy Department at **800-310-6826** with questions concerning the prior authorization process. The drugs preferred and those that require prior authorization will be designated in the list of drugs at [UHCCommunityPlan.com](https://www.uhccommunityplan.com).

Day Supply Dispensing Limitations

Members may receive up to a one-month supply (31 days) of medication per prescription order or prescription refill. You may reorder or refill a medication when 90% of the medication has been used. If a claim is submitted before 75% of the medication has been used, based on the original day supply submitted on the claim, the claim will reject with a “refill too soon” message.

Quantity Limitations

UnitedHealthcare places quantity limitations on medications. The following describes the quality 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 is designed to consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and also promote the efficient use of health care dollars.

- The limits for the program are established 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 the 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 from time to time and providers notified accordingly. Also, we recognize a number of patient-specific variables must be taken into consideration when drug therapy is prescribed, and therefore overrides will be available through the medical exception (prior authorization) process.

Find more information regarding drug-specific quantity limits at [UHCCommunityPlan.com](https://www.uhccommunityplan.com). Please call the UnitedHealthcare Pharmacy Department at **800-310-6826** with questions.

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 a 72-hour emergency supply. You will receive a response by telephone or other telecommunication device within twenty-four hours of a prior authorization request.

Restricted Services

UnitedHealthcare Community Plan Restricted Services is a program to control misuse and abuse of Medical Assistance services. Our Restricted Services Program is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider, this is also known as a lock in. Claims will not be paid if a member uses another pharmacy without prior authorization. We have the ability to communicate information related to our Restricted Services Program to notify both members and care providers. Restrictions does not apply to emergency services. Members are allowed to change care providers with cause.

Medication Therapy Management Program (MTMP)

Through our Medication Therapy Management Program, we will assist our members in understanding their prescriptions and engage them in education about their medication and efforts to improve their compliance with prescribed medication regimens. The focus of the program is to educate members about how to effectively communicate about their preferences and needs with their prescribers to promote shared decision-making.

Pharmacy Claims Processing Information

Obtain information pertaining to claims processing information from UHCCommunityPlan.com > For Healthcare Professionals > Nebraska > Provider Information > Pharmacy Provider Manual or learn.optumrx.com/pharmacymanual/index.html

- 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

Pharmacy Contact Information – Claims Assistance

Pharmacy - OptumRx Pharmacy Benefit Manager Technical Help Desk (pharmacies call): **877-231-0131**

Monday through Friday 8:00 a.m. to 8:00 p.m. CT and 7:00 a.m. to 7:00 p.m. MT.

Prescriber Prior Authorization Contact Information – Pharmacy Benefit Management

Pharmacy Services Call Center: **800-310-6826**

Monday through Friday 8:00 a.m. to 8:00 p.m. CT and 7:00 a.m. to 7:00 p.m. MT.

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

Prior Authorization request fax forms can also be found at UHCCommunityPlan.com > For Health Care Professionals > Nebraska > Pharmacy Program tab.

Provider Services Call Center

Provider Services Call Center: **866-331-2243**

Monday through Friday 7:00 a.m. to 8:00 p.m. CT and 7:00 a.m. to 7:00 p.m. MT

This is an automated system. Please have your Tax ID and NPI number ready.

You may obtain assistance on a wide variety of topics such as: covered services, fee schedules, member eligibility verification; prior authorization and referral procedures; provider credentialing/recredentialing status; filing provider complaints, grievances and appeals; claims payment and dispute procedures; verifying member assignment to the provider's panel; referrals to the fraud and abuse hotline as necessary; pharmacy formularies/Preferred Drug List (PDL); and coordinating the administration of out-of-network services.

Chapter 6: Mental Health and Substance Use

United Behavioral Health operating under the brand Optum is the administrator of mental health and substance use disorder benefits for UnitedHealthcare Community Plan members. The national Optum Network Manual generally applies to all types of business. There are some sections where differences may apply based on state law. This chapter does not replace the national Optum Network Manual; rather, it supplements the national manual by focusing on the core services and procedures specific to the Nebraska Heritage Health membership.

As a care provider, you must have a National Provider Identification (NPI) number and an Nebraska Medicaid provider identification number to render services for a Nebraska Heritage Health plan member and receive payment from the health plan. To request an ID number, go to the Nebraska Department of Health and Human Services website, dhhs.ne.gov/medicaid/Pages/med_providerenrollment.aspx, to the section titled, How to Enroll in the Nebraska Medicaid Program.

NOTE: Atypical 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.

Covered Services

Behavioral Health covered services are for the treatment of mental, emotional and substance use disorders. UnitedHealthcare Community Plan service coordinators have an integrated Care Management program with medical and behavioral health providers of the health plan that include Behavioral Health to assist members and Primary Care Providers (PCPs) in using and receiving services. Our Behavioral Health program utilizes Optum clinician center with patient resources accessible from the provider website, providerexpress.com, see Live and Work Well (LAWW) clinician center. Health Condition Centers can be located at the Clinical Resources tab at providerexpress.com. These centers provide information and instruments for several mental health and substance abuse diagnoses, symptoms, treatment options, prevention and other resources in one, easy-to-access area to both behavioral clinicians and PCPs to share with patients. They are available to both behavioral clinicians and medical care providers to share with patients. The Provider Express Recovery and Resiliency page also includes tools to use when working with individuals who are addressing mental health and substance use issues.

The benefits available for Nebraska Heritage Health members who seek services for mental health or substance use disorders are the following:

Services for individuals younger than 20 years old, unless otherwise indicated.

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility (age 19 and under)
- Outpatient assessment and treatment:
 - Partial hospitalization.
 - Day Treatment
 - Intensive Outpatient
 - Medication management.
 - Outpatient therapy (individual, family, or group)
 - Injectable psychotropic medications.
 - Substance use disorder treatment.
 - Psychological evaluation and testing.
 - Initial diagnostic interviews.
 - Sex offender risk assessment.
 - Community treatment aide (CTA) services.
 - Hospital observation room services (up to 23 hours and 59 minutes in duration).
 - Parent child interaction therapy.
 - Child-parent psychotherapy.
 - Applied behavioral analysis.
 - Multi-systemic therapy.
 - Functional family therapy.
- Rehabilitation services
 - Day treatment/intensive outpatient.
 - CTA services.
 - Professional resource family care.
 - Therapeutic group home.

Services for adults older than 21 years old:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- 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 treatment.
 - Psychological evaluation and testing.
 - Electroconvulsive therapy.
 - Initial diagnostic interviews.
 - In-home psychiatric nursing
- Rehabilitation services
 - Dual-disorder residential.
 - Intermediate residential (SUD).
 - Short-term residential.
 - Halfway house.
 - Therapeutic community (SUD only).
 - Community support.
 - Psychiatric residential rehabilitation.
 - Secure residential rehabilitation.
 - Assertive community treatment (ACT) and Alternative (Alt) ACT.
 - Community support.
 - Day rehabilitation.

Eligibility

It is your responsibility to verify the member's Medicaid eligibility each month prior to rendering service to a Nebraska Heritage Health Plan member.

View eligibility online at UnitedHealthcareOnline.com.

Authorizations

Members shall be able to access all behavioral health outpatient services (mental health and substance use) without a referral.

Prior authorization may be required for services more intensive than standard outpatient, such as Intensive Outpatient Program, Day Treatment, Partial, Inpatient or Residential. You must ensure the prior authorizations are in place before rendering non-emergent services.

Prior authorization requests can be obtained by calling: **866-604-3267**.

Prior authorization request forms specific to Autism services are available at providerexpress.com.

Portal Access

Website: UnitedHealthcareOnline.com

This site will give you access to Link, the new gateway to UnitedHealthcare's online tools. Use the tools to do eligibility and benefit verification, electronic claim submission, view claim status, and submit notifications/ prior authorizations.

Website: UHCCommunityPlan.com

This site should be used view the Prior Authorization list, access forms, and access to the Provider Manual.

Customer Service Center phone number: **866-331-2243** to verify eligibility and benefit information (available 7 a.m. to 8 p.m. Central time, Monday through Friday).

Website: providerexpress.com

This site should be used to update provider practice information, review guidelines and policies, and to view the national Optum Network Manual.

Provider Service phone number: **877-614-0484**
(Available 7 a.m. to 7 p.m. Central time)

Appeals and Grievances

Call 866-556-8166 and a Customer Service representative will assist with the Appeals and Grievances process. The care provider may file an appeal or grievance within 90 calendar days of the notice of action.

Written requests can be sent to:

United Behavioral Health
Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 855-312-1470

Claims

Providers shall submit claims using the current 1500 Claim Form (v 02/12) or UB-04 form, (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to, ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Effective October 1, 2015, in compliance with federal regulations.

Providers shall include all data elements necessary to process a complete claim including: the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number, National Provider Identifier (NPI), code modifiers and/or other identifiers requested.

In addition, Providers are responsible for billing of all services in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the CMS website for additional information on CCI billing standards.

Although claims are reimbursed based on the network fee schedule or facility contracted rate, Providers claims should be billed with the providers usual and customary charges indicated on the claim.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor. You may choose any clearinghouse vendor to submit claims through this route. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For all UnitedHealthcare Community Plan claims use Payer ID 87726.

Clinician Claim Forms: Paper claims can be submitted using the CMS 1500 Claim Form (v 02/12) the UB-04 claim form or their successor forms in accordance with your Agreement. The claims should include all itemized information such as diagnosis (ICD-10-CM code as listed in DSM-5), length of session, Member and subscriber names, Member and subscriber dates of birth, Member identification number, dates of service, type and duration of service, name of the rendering clinician (i.e., individual who actually provided the service), credentials, Tax ID and NPI numbers.

Facility Claim Forms: Paper claims should be submitted using the UB-04 billing format, or its successor, which includes all itemized information such as diagnosis (ICD-10-CM code as listed in DSM-5), member name, member date of birth, member identification number, dates of service, procedure or revenue codes, name of facility and Federal Tax ID number of the facility, NPI of the facility and admitting care provider, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility's agreement. Facilities may file claims through an EDI vendor.

Paper claims can be submitted to the following address:

UnitedHealthcare
P.O. Box 31365
Salt Lake City, UT 84131

For Claims/Customer Service, toll-free line:
866-331-2243

Chapter 7: Medical Management

Referral Guidelines

You are responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of your practice. You are expected to monitor the progress of referred members' care and help ensure members are returned to their care as soon as medically appropriate. We require prior authorization of all out-of-network referrals. The request is generally processed like any other authorization request. 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 generally approved for, but not limited, to the following circumstances:

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

Out-of-network referrals are monitored on an individual basis and trends related to individual care providers or geographical locations are reported to Network Management to assess root causes for action planning and if contracting opportunities exist.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.



Emergency care should be rendered at once, with notification of any admission to the Prior Authorization Department at **866-604-3267** or fax your Prior Authorization Form by 5 p.m. the next business day to 866-622-1428. Prior Authorization Form can be located at UHCCCommunityPlan.com. Click on Health Care Professionals, Select State and select Provider Forms.

Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare uses evidence based, nationally accredited, clinical criteria for determinations of appropriateness of care. If medical necessity does not appear to be met, the request will be sent to a physician for review. UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage under-utilization.



The clinical criteria is available in writing upon request or by calling **866-604-3267**.

Admission to inpatient starts at the time you write that a member's condition has been determined to meet an acute inpatient level of stay.

Care in the Emergency Room

Prior authorization is not required for the medical screening. UnitedHealthcare provides coverage for these services without regard to the emergency care provider's contractual relationship with UnitedHealthcare. Emergency services, i.e. physician and outpatient services furnished by a qualified care provider necessary to treat an emergency condition, are covered both within and outside UnitedHealthcare's service area.

An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, perceived as placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Admission Authorization and Prior Authorization Guidelines

All UnitedHealthcare Community Plan admission authorizations must contain the following information:

- Patient name and ID number;
- Facility name and Tax Identification Number (TIN) or National Provider Identification (NPI);
- Admitting/attending care provider name and TIN/NPI;
- Description for admitting diagnosis of ICD CM code; and
- Admission date.

NOTE: You can use the [UnitedHealthcare ICD-10-CM Code Lookup Tool](#) to determine a diagnosis code from ICD-9 leading issue ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare claim platforms. Please utilize this link: icd10codelookup.smartbaselink.com/

All UnitedHealthcare Community Plan prior authorizations must contain the following information:

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



If you have questions, please call Prior Authorization Intake at **866-604-3267**. The Prior Authorization Fax Request Form can be located at UHCCommunityPlan.com. Click on Health Care Professionals, Select State and select Provider Forms.



For Mental Health and Substance Use Disorder authorizations, please reference Chapter 6 for specific information.

Services Requiring Prior Authorization



For a list of services that require prior authorization, please go to UHCCommunityPlan.com. Click on Health Care Professionals, select State, Provider Information Tab, Prior Authorization.

Direct Access Services – Native Americans

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

Seek Prior Authorization/Notify UnitedHealthcare

Within the Following Time Frames:

Emergency Facility Admission

Notify UnitedHealthcare one business day of an emergency or urgent admission.

Inpatient Admissions After Ambulatory Surgery

Notify UnitedHealthcare one business day of an inpatient admission.

Non-Emergency Admissions and/or Outpatient Services (Except Maternity)

Seek prior authorization at least 14 business days prior to non-emergent, non-urgent facility admissions and/or outpatient services; in cases in which the admission is scheduled less than five business days in advance, notify at the time the admission is scheduled.

Responding to Prior Authorization Requests

The UnitedHealthcare Community Plan Pre-Service Review Team will make determinations on authorization request and will notify requesters of approval or denial of the requested authorization.

- **STANDARD** Request (aka Elective/Routine/Non-Urgent)
 - A decision and notification will be made no later than fourteen calendar days following the receipt of the request, with a possible extension of up to 14 days if the member or you requests an extension, or if there is justification for additional information and the delay is the member's best interest. 42 C.F.R. 438.210.
- **EXPEDITED** Request (aka Urgent/STAT)
 - These requests should ONLY be made when the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. A decision and notification will be made no later than 72 hours following the receipt of the request, with a possible extension of up to 14 days if the member or provider requests an extension or if there is justification for additional information and the delay is in the member's best interest. 42 C.F.R. 438.210.

Radiology Prior Authorization Program

Under the Radiology Prior Authorization Program CT, MRI, MRA, PET scan Nuclear Medicine, Select Nuclear Medicine Studies, and Nuclear Cardiology require prior authorization. To improve compliance with evidence-based and professional society guidance in the use of Radiology procedures

UnitedHealthcare Community Plan utilizes a Radiology Prior Authorization Program.

The program includes: Magnetic Resonance Image (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CT), Positron-Emission Tomography (PET), Nuclear Medicine, and select nuclear medicine studies, including nuclear cardiology.

Failure to complete the Radiology Prior Authorization protocol will result in an administrative denial. Claims denied for failure to request prior authorization may not be balance-billed to the patient.

You may obtain and verify a Prior Authorization number through the UnitedHealthcare Radiology Program.

- Online: UHCommunityPlan.com
- Phone: **866-889-8054**

The phone service is available from 7 a.m. to 7 p.m. CT and 6:00 a.m. to 6:00 p.m. MT, Monday through Friday. Call centers are closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the Friday following, and Christmas Day.

All calls received outside of normal business hours will be routed to a registered professional nurse or physician that will be available by phone seven days a week, 24 hours a day, to render utilization management determinations for you. If you order MRI/MRA, CT, PET scans, nuclear medicine, and nuclear cardiology studies, you are required to obtain a prior authorization for services prior to the services rendered in an outpatient setting.

Imaging studies ordered through an emergency room treatment visit, while in an observation unit, when performed at an urgent care facility or during an inpatient stay do not require a prior authorization. For claims to be processed correctly, the place of service must indicate an inpatient, emergency room, observation or urgent care setting.

If initiating the prior authorization by telephone, the caller should have the medical record available. An authorization number is required for each individual CPT code and each authorization number is CPT-code specific. Please note that an authorization number is not needed for an intravenous (IV) drug in a contrast study. Authorization numbers are only required for advanced imaging studies.



Please refer to UHCommunityPlan.com under the Radiology section for a current listing of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk table as well as the link to the Online Notifications and Prior Authorizations portal.

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 requirements related to the Provider Preventable Conditions initiative which includes: 1) adjustment of reimbursement for Health Care Acquired Conditions (HCAC), 2) POA indicator requirement 3) no reimbursement for Never Events and 4) Other Provider Preventable Conditions (OPPC) as defined by any additional State Regulations that are in place that expand or further define the CMS regulations.

Healthcare Acquired Conditions

Hospital reimbursement will be adjusted cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present. CMS has identified the following to be Health Care Acquired Conditions (HCAC) because they:

- (a) Are high cost or high volume or both,
- (b) Result a higher payment when present as a secondary diagnosis
 - Payment may be adjusted based on the assignment of a case to an MS-DRG of a higher value as a result of the secondary diagnosis
 - For non-DRG reimbursement methodologies, payment may be adjusted if the health plan can reasonably isolate for nonpayment the portion of the payment directly related treatment for, and related to, the provider-preventable conditions,

AND

- (c) Could reasonably have been prevented through the application of evidence-based guidelines.

UnitedHealthcare Community Plan will consider the following to be Health Care Acquired Conditions (HCAC) if not Present on Admission (POA) based on the list of diagnoses provided in the CMS Regulations:

- Foreign Object Retained After Surgery

- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma causing:
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Electric Shock
- Manifestations of Poor Glycemic Control causing:
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG)—Mediastinitis
 - Cardiac Implantable Electronic Device (CIED)
 - Bariatric Surgery
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
 - Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following: **
 - Total Knee Replacement
 - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

**NOTE: Obstetric and pediatric patients are excluded from the Deep Vein Thrombosis/Pulmonary Embolism component only.

There will be no reduction in payment if the condition is indicated to be Present on Admission (POA) by utilizing the appropriate POA indicator on the submitted claim. UnitedHealthcare Community Plan will identify HCAC claims based on the appropriate use of the POA indicator. Claims that do not have the POA indicator included may be subject to denials and required to re-submit. POA indicator is not required on SNF (Skilled Nursing Facility) claims.

Other Provider Preventable Conditions

1. Also included in the Medicaid Payment Adjustments for Provider-Preventable Conditions including Health Care Acquired Conditions regulations is the “Never Events” noncoverage component. Consistent with CMS, UnitedHealthcare Community Plan will not reimburse for a surgical or other invasive procedure, or for services related to a particular surgical or other invasive procedure when any of the following are erroneously performed:
 - A different procedure altogether
 - The correct procedure but on the wrong body part
 - The correct procedure by on the wrong patient

Please refer to the “Wrong Surgical or Other Invasive Procedures Policy” for further details.

2. UnitedHealthcare Community Plan will align with any state-specific initiatives as they are approved by CMS and implemented by the individual states.

Present on Admission (POA)

The POA indicator is required on all inpatient claims submitted on a UB04 form, its electronic equivalent or its successor form. A POA indicator is required on any diagnosis that is not exempt from the requirement per CMS. All facilities are required to use the appropriate POA indicators unless a particular state has requested and received an exception from CMS to exclude certain types of facilities.

Appropriate POA indicators are:		
Y	Diagnosis was present at time of inpatient admission.	Payment made for condition
N	Diagnosis was not present at time of inpatient admission.	No payment made for condition
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment made for condition
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment made for condition
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable.	Exempt from POA reporting



Additional information can be found at [medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/PPCFAQ-41012.pdf](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/PPCFAQ-41012.pdf)

Reimbursement

Authorization by UnitedHealthcare Community Plan does not ensure reimbursement for all services provided. You should:

- Determine that the member is eligible on the date of service by using UHCCommunityPlan.com, contacting UnitedHealthcare Community Plan’s Provider Services Department **866-331-2243**, or the Nebraska Medicaid Eligibility System (NMES) by calling **800-642-6092**.
- Submit appropriate and requested documentation to support the medical necessity of the requested procedure.
- Be aware that the services provided may be outside the scope of what was authorized by UnitedHealthcare Community Plan.
- Determine if the member has other insurance that should be billed first.

Even with a valid prior authorization number, you will be reimbursed only for covered services as designated by your contract with UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will not reimburse:

- Services not determined by UnitedHealthcare to be medically necessary.
- Non-covered services
- Services provided to members who are not enrolled on the date(s) of service

Determination of Medical Necessity

UnitedHealthcare evaluates medical necessity according to the following standard.

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, 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 or causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition;
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capabilities that are appropriate for individuals of the same age;
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member.

Case Management

UnitedHealthcare Community Plan provides case 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 Case 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 candidates for case management by contacting Care Management at **877-856-6351**. Additionally,



UnitedHealthcare provides the Healthy First Steps program which proactively manages pregnant women. They can be reached at **877-813-3417**.

Evidence-based Clinical Guidelines

UnitedHealthcare has adopted evidence-based clinical guidelines to guide our quality and health management programs.



You may request a copy of our guidelines by logging on to UHCCommunityPlan.com.

Utilization Management Guidelines

UnitedHealthcare uses MCG Care Guidelines as our Utilization Management Guidelines.



If you have any questions about the guidelines or would like a copy of a specific guideline, please contact the UnitedHealthcare Community Plan Medical Management Department at **877-856-6351**.

You are offered an opportunity to discuss the requested services with the physician who will make the decision by contacting **877-856-6351**.

Utilization Management is based on a member's medical condition and is no way influenced by financial incentive of any kind. UnitedHealthcare pays its contracted PCPs and specialists on a fee-for-service basis. We also pay contracted hospitals and all other types of providers in the UnitedHealthcare network on a fee-for-service basis. The Plan's Utilization Management staff works with you to help ensure members receive the most appropriate care in the place best suited for the needed services. The providers and staff are expected to encourage appropriate utilization and to discourage under utilization. The Utilization Management staff does not receive incentives for any utilization management decisions they make.

Utilization Management (UM) Appeals

These appeals contest UnitedHealthcare's utilization management decisions. They are appeals of UnitedHealthcare's determination that an admission, extension of stay, level of care, or other health care services, based on review of the information available to UnitedHealthcare, is not medically necessary or is considered experimental or investigational. There also can be appeals of denials of any admission, extension of stay or other healthcare service due to reasons such as late notification or lack of complete or accurate information. Any

member, member's designee, physician, or care provider who is dissatisfied with any aspect of UnitedHealthcare's utilization management decisions, has a right to file a UM appeal.

The care provider may file an appeal within 90 calendar days of the notice of action. The request and a copy of the medical record should be mailed to:

**UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131**

Resolution of a standard appeal is 45 calendar days.

You may request an expedited 72-hour appeal if a delay would seriously jeopardize the life, health, or ability to attain, maintain or regain maximum function. Resolution of an expedited appeal is 72 hours.

You may request an expedited appeal by calling



866-331-2243.

Use the expedited appeal when the appeal involves, but is not limited to:

- Continued or extended health care services, procedures, or treatments;
- Additional services for a member undergoing a course of continued treatment;
- A denial in which you believe an immediate appeal is warranted; or
- When the standard time frame could seriously jeopardize the life, health, or ability to attain, maintain or regain maximum function.

A request for a Nebraska State Fair Hearing may be made within 90 calendar days from the appeal decision notice by writing to:

**Department Health and Human Services
Legal Services-Hearing Section
P.O. Box 98914
Lincoln, NE 68509-8914**

A copy of the medical record should accompany the hearing request. Note: UnitedHealthcare appeals do not have to be exhausted prior to requesting a State Fair Hearing. A copy of the Clinical Criteria used in making utilization management decisions may be obtained by contacting the UnitedHealthcare Community Plan Utilization Management.

Concurrent Review Guidelines

Review is conducted on-site at the facility or telephonically for each day of the stay using MCG Care Guidelines criteria. You must cooperate with all requests for information, documents or discussions from the Health Plan for purposes of concurrent review including, but not limited to, clinical information on patients status and discharge planning. When criteria are not met, the case is referred to a Medical director for determination. The Health Plan will deny payment for hospital days that do not have a documented need for acute care services. The Health Plan requires that your progress notes be charted for each day of the stay. Failure to document will result in denial of payment.

Emergency/Urgent Care

In the event of an emergency, the enrollee should seek immediate care at the closest Emergency Room (ER). If the enrollee needs assistance in getting to the ER, they may call 911. Enrollees do not need a referral from their PCP to use the ER. The enrollee can expect to be seen within an hour to determine the extent of their illness or injury. Enrollees have been instructed to contact their PCP as soon as they can after receiving emergency care. There is no cost to the enrollee for ER services or emergency ambulance services.

After the enrollee has received emergency care, the hospital must request approval within one hour for pre approval for additional care to make sure the enrollee remains in stable condition. If the Health 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 enrollees care, the Health Plan must give the treating care provider the opportunity to talk with the Health Plan's Medical Director. You may continue with care until the Health Plan's care provider is reached or one of the approved guidelines are met:

1. A plan care provider with privileges at the treating hospital assumes responsibility for the enrollee's care.
2. A plan care provider assumes responsibility for the enrollee's care through transfer to another place of service.
3. An MCO representative and the treating care provider reach an agreement concerning the enrollee's care.
4. The enrollee is discharged.

Depending on the need, the enrollee may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services. Enrollees are not financially responsible for these services.

Should an enrollee require emergency services outside of his or her service area, the same applies as above.

Restrictive Services (Lock-In) Program

Restricted Services is a method used by UnitedHealthcare Community Plan to limit the medical services of a member who has been determined to be over-utilizing services provided by Nebraska Medicaid without infringing on the client care provider choice.

A UnitedHealthcare Community Plan member may be referred to restricted services by the care provider, pharmacy, hospital facility or Managed Care Plan. Requests of restricted services and documentation can be submitted to UnitedHealthcare Community Plan for review.

**UnitedHealthcare Community Plan
Restrictive Services
2717 North 118th Street Suite 300
Omaha, NE 68164
1-800-284-0626**

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 Provider
- **Category 9:** All Medical Services

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 accepting new patients. The member will identify the care provider(s) or facility they agree to receive restricted services from.

The health plan will review information provided related to claims data, clinical notes, and medication history. The medical director, in conjunction with the NE DHHS MLTC State Pharmacist to review the member's file, and the medical director submits his recommendation.

Neonatal Resource Services (NICU Case Management)

Our Neonatal Resource Services program manages NICU cases inpatient and post-discharge to reduce costs and improve outcomes.

Our dedicated team of NICU nurse case managers, social workers and medical directors collaborate to provide education and family support.

Neonatal Resource Services (NRS)

Neonatal Resource Services (NRS) Program helps to ensure quality of care and efficiency in treatment of NICU babies. The NRS Program Eligible Member is defined as a newborn who has been admitted to the NICU upon birth (including babies that get transferred from PICU to NICU) and/or any baby previously in a NICU who is readmitted within 30 days of NICU discharge. All babies admitted to the NICU will be followed by NRS (detained babies will also be eligible for the program for the initial inpatient hospitalization only).

NRS Neonatologists and NICU nurses proactively manage NICU patients through evidence-based medicine and the use of care plans.

The NRS nurse case manager will:

- Collaborate with the family, care provider and Discharge Planner on a coordinated discharge to ensure timely provision of care and delivery of services
- Develop alternate strategies for care management Interventions (as needed)
- Facilitate the discharge
- Coordinate services post-discharge as required

The NRS program includes a multidisciplinary approach to case management in the 30 day post discharge period. The NRS nurse case manager's role is comprehensive and includes:

- Discharge planning and facilitation of timely release
- Coordination of alternative care options, including home care, equipment and skilled nursing
- Post-discharge Support for 30 days, except detained babies
- Educating parents and families on local community resources and support services available
- Case managers provide benefit solutions to families in order to ensure appropriate services for the neonate

Home Care and All Prior Authorization Services



Home Care should be pre-certified by the agency or the hospital Discharge Planner ordering the home care by calling the Prior Authorization Department at **866-604-3267** or sending a fax to **866-622-1428**.

Healthy First Steps

Healthy First Steps™ (HFS) is a program aimed at improving birth outcomes that is focused on managing pre-natal and post partum care of pregnant members.

HFS-Maternal Care Model

The objective of the HFS-Maternal care model is to create a structure that consistently:

- Increases early identification and enrollment of expectant mothers
- Assesses the risk level of each member and directs them to proper care
- Increases the member's understanding of pregnancy and newborn care
- Encourages pregnancy and lifestyle self-management
- Encourages appropriate pregnancy, postpartum and infant care provider visits
- Fosters a care provider-member partnership for care in non-emergent settings

Access to Care Providers in Key Specialties

Medical support for the Healthy First Steps Model is provided by care providers who are Board Certified in Maternal and Neonatal Medicine. These care providers are providing clinical supervision and education to our staff, as well as conducting peer-to-peer discussions with care providers. The HFS program is responsible for helping ensure members receive the services and education they need at the right time, in the right place and according to specific member needs.

Please note these Provider OB Referral Numbers:

Phone: **800-599-5985**

Fax: 877-353-6913

Healthy First Steps (Maternity Case Management)

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, the Healthy First Steps program uses early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother's self-efficacy by identifying and building the mother's support system;
- The Women, Infants, and Children Program (WIC) services program;
- Ensure appropriate postpartum and newborn care;
- Develop the care provider/member partnership and relationship before and after delivery.

It is an expectation that providers caring for pregnant women and women with dependent children will coordinate referrals to appropriate community programs and services such as the Women, Infants, and Children Program (WIC) services program.

Baby Blocks™ Program

Baby Blocks™ is a web-based, mobile tool to remind and reward pregnant women and new mothers to receive prenatal, postpartum and well-child care. Baby Blocks™ is available to UnitedHealthcare Community Plan members who are either pregnant or newborn.

Baby Blocks™ Benefit

Baby Blocks engages patients with a personalized, interactive tool that provides appointment reminders by text or email message. Members who enroll early in their pregnancy can earn up to eight rewards by adhering to prenatal and postpartum recommendations of the American Congress of Obstetricians and Gynecologists and well-baby recommendations by the American Academy of Pediatrics.

How it Works

1. UnitedHealthcare Community Plan members are invited by care provider, mail, and phone call to enroll in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointment at UHCBabyBlocks.com.
3. Members are reminded of upcoming appointments and are prompted to 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 discuss the benefits of the program
3. Encourage the member to enroll at UHCBabyBlocks.com.



Members must self-enroll on a smartphone or computer by going to UHCBabyBlocks.com and clicking on "Sign Up Here."

Early Intervention Program

Early Intervention promotes the development of infants and toddlers with developmental challenges, delays and certain disabling conditions. The program provides service to eligible children from birth to three years of age, and their families.

If you believe 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**.

Lead Screening/Treatment



Children with an excess of 15 mg/dl lead blood level must be referred to the Department of Health Lead Program at **888-242-1100**. Care management services are available to children with high lead levels. Call **877-856-6351** to refer the child to our Lead RN.

Second Opinion Benefit

If a UnitedHealthcare Community Plan member for whom a treatment or surgical procedure is being recommended, requests a second opinion, the cost of the second opinion will be covered by UnitedHealthcare Community Plan. Scheduling the appointment for the second opinion should adhere to the access standards established by the NE DHHS MLTC. These access standards are defined in Chapter 2. The care provider or surgeon rendering the second opinion must not be affiliated with the attending care provider.

Criteria:

- A. The member's primary PCP is responsible for referring the member to a network care provider for a second opinion. Care providers will forward a copy of all relevant records concerning the first opinion to the second opinion care provider prior to the appointment date. The care provider furnishing the second opinion will then forward his or her report to the enrollee's PCP and treating care provider, if different. The member is allowed to participate with the PCP in selecting the care provider.
- B. If a network care provider is not available, UnitedHealthcare will arrange for a consultation with a non-participating care provider. Network care provider should contact the health plan at **800-641-1902**.
- C. Once the second opinion has been given, the member and his/her PCP discuss information gathered from both evaluations.
- D. If follow up care is recommended, the member consults with his/her PCP prior to receiving treatment for appropriate referrals and/or approvals.

NurseLine

NurseLine is available at no cost to our members, 24 hours a day, seven days per week (**877-543-4293**). Members may call NurseLine to determine if they need to go to the urgent care center, the emergency room, or to schedule an appointment with their primary care provider. Our nurses also help members with education and information about staying healthy.

Chapter 8: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)

Primary care providers are expected to adhere to the EPSDT periodicity schedule adopted by Nebraska Medicaid for all enrollees (including women who are pregnant) under age 21. EPSDT screening includes immunizations; hearing, vision, and speech screening; nutritional assessment; dental screening; growth and development tracking.



Below is the link to NE DHHS MLTC for the criteria regarding Health Checks and Treatment Services for Conditions disclosed during Health Checks (EPSDT). Please reference Chapter 33.
dhhs.ne.gov/Pages/reg_t471.aspx

Physician and Care Provider Coding

UnitedHealthcare Community Plan is required to report compliance with EPSDT standards to the State and will do so based upon claims data and chart review. **Appropriate ICD CM Code and CPT coding are crucial to this effort.** You can utilize the [UnitedHealthcare ICD-10-CM Code Lookup Tool](#) to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare claim platforms. Please utilize: icd10codelookup.smartbaselink.com/

Procedure and ICD CM Codes

If an enrollee presents for a preventive or well visit, the codes are as follows:

- **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 the enrollee also has a medical diagnosis addressed at the visit, use the appropriate ICD CM Code in addition to one of the above-noted “Z” codes.

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

Childhood immunizations are provided through the Vaccines for Children program (VFC). Claims for administered vaccines should be billed with the correct vaccine-specific CPT codes. Vaccine administration fees are reimbursable when submitted with an appropriate modifier, UnitedHealthcare Community Plan is unable to reimburse for private stock vaccines when they are available through VFC.



For questions about the VFC Program, please call DHHS public health at **800-798-1696** or visit



dhhs.ne.gov/publichealth/Immunization/Pages/Home.aspx for further information.

Correct Referral Indicator Listed on the Claim:

- **AV:** Patient refused referral;
- **S2:** Patient 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.

If a referral indicator is not listed the claim will be denied.

Immunization Data – Required State Reporting

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 has been developed to connect and share immunization information among public clinics, private provider offices, local health departments, schools, hospitals, and other health care facilities that administer immunizations. For more information go to dhhs.ne.gov/publichealth/Pages/nesiis_index.aspx.

Chapter 9: Dental Services

Covered Dental Services

For dental services performed in an outpatient setting, UnitedHealthcare Community Plan will cover the facility and anesthesia services when deemed as medically necessary. Facility charges require a prior authorization.



Facility services require a prior authorization.
Call: **866-604-3267** or Fax: **866-622-1428**.

Non-Covered Dental Services

Routine dental services are not covered by UnitedHealthcare Community Plan but under NE DHHS MLTC.



You will contact NE DHHS MLTC - Julie Swenson at **402-471-6287** for assistance with dental services.

Chapter 10: Member Rights and Responsibilities

UnitedHealthcare Community Plan's member handbook contains a section regarding the member rights and responsibilities when accessing services. UnitedHealthcare members are asked to treat you and your staff with respect and courtesy.

Privacy Regulations

HIPAA privacy regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The privacy regulations also create certain individual patient rights.

Access to Protected Health Information

UnitedHealthcare members have the right to access health information maintained in a designated record set held at your office or at the health plan. Members may make a request to see and obtain a copy of certain health information UnitedHealthcare maintains electronically, such as medical records and billing records. They may also make a request of you to obtain copies of their health information maintained electronically. If members health information is maintained electronically, members may request the health plan or you send a copy of their electronic health information in an electronic format. They may also request that a copy of their health information be provided to a third party they identify.

Amendment of PHI

UnitedHealthcare members have the right to request information held by you or health plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be in writing and provide reasons for the requested amendment. The request must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member. If the request is denied, members may have a statement of disagreement added to members health information.

Accounting of Disclosures

UnitedHealthcare members have the right to request an Accounting of Certain Disclosures of his or her PHI made by you or the health plan during six years prior to the request. This accounting must include disclosures by business associates. The accounting will not include disclosures of information made: (i) for treatment, payment and health care operations purposes; (ii) to members or pursuant to members authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require UnitedHealthcare to provide an accounting.

Right to Request Restrictions

Members have the right to request restrictions on their PHI uses and disclosures for treatment payment and health care operations. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented. You and the health plan must agree to the individual's request to restrict disclosure. Members have the right to request restriction on uses or disclosures of their information for treatment, payment, or health care operations.

In addition, members may request to restrict disclosures to family members or to others who are involved in their healthcare or payment for their health care.

Members have a right to request confidential communications from the care provider or health plan to be received at an alternative location or by alternative means. You will accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A health plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

Right to Request Confidential Communications

Members have the right to request that communications from you or the health plan be received at an alternative location or by alternative means. You will accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A health plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

Native American Access to Care

Native American members can access care to tribal clinics and Indian Hospitals without prior authorization. Native American Access and Member Rights and Responsibilities can be found in the member handbook at the web link below and found under "Learn More, UnitedHealthcare Community Plan. Select Member information".



uhcommunityplan.com/ne/medicaid

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

Member Rights and Responsibilities

Member Rights

Members have the right to the following:

- Request information on Advance Directives.
- Be treated with respect, dignity and privacy.
- Courtesy and prompt treatment.
- Receive culturally competent assistance including having interpreter services during appointments and procedures.
- Receive information about UnitedHealthcare Community Plan, your rights and responsibilities, your benefit plan and which services are not covered.
- Know the qualifications of your health care providers.
- Give your consent for treatment unless you are unable to do so because your life or health is in immediate danger.
- Discuss any and all treatment options with your provider without interference from us.
- Refuse treatment through an Advance Directive or withhold your consent for treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, retaliation, convenience or to force you to do something you don't want to do.
- Obtain available and accessible health care services covered by the health plan.
- Receive information about our network providers and practitioners, and choose a provider from our network.
- Change your provider at any time for any reason.
- Tell us if you are not satisfied with your treatment or with UnitedHealthcare Community Plan; when you tell us, you can expect a timely response from us.
- Appeal any payment or benefit decision we make.
- Request and review your medical records maintained by your provider and request changes and/or additions to any area you feel is needed.
- Be given information about your illness or condition, understand your treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand the information, regardless of cost or whether such services are covered by UnitedHealthcare Community Plan, and participate with your providers in making decisions about your health care including the right to refuse treatment.

- Get a second opinion with a network provider.
- Expect that health care professionals are not prohibited or otherwise restricted from advising you about your health status, medical care or treatment regardless of benefit coverage.
- Make suggestions about UnitedHealthcare Community Plan's member rights and responsibilities policies.
- You have the right to additional information upon request, such as information on how your Health Plan works and a provider's incentive plan, if they apply.

Member Responsibilities

- Understand your benefit plan and follow it to obtain the most benefits.
- Show your ID card to providers; prevent others from using your ID card.
- Give health care providers true and complete information; ask questions about your treatment so that you understand.
- Work with your provider to set treatment goals and follow the treatment plan you and your provider agree upon.
- Get to know care provider before they are sick
- Keep appointments or tell you when they cannot keep the appointment
- Treat UnitedHealthcare Community Plan staff, care providers and their staff with respect and courtesy
- Tell us their opinions, concerns and complaint
- Get any approvals needed before receiving treatment
- Use the emergency room only when there is a serious threat to life or health
- Notify us of any change in address or family status
- Make sure each care provider is in the network
- Follow the advice of care providers and understand possible results if they do not follow your advice
- Give care providers and us information that could help improve their health

We tell our members they have certain rights and responsibilities, all of which are intended to 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 Insurance (NCQA) are:

1. A responsibility to supply information (to the extent possible) that the organization and its care providers need in order to provide care.
2. A responsibility to follow plans and instructions for care that they have agreed to with their care providers.
3. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Chapter 11: Medical Records

Medical Records

A member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers, as well as but not limited to, those kept in placement settings such as nursing facilities, assisted living facilities, and other home and community based providers.

Each member is entitled to a copy of his or her medical record at no cost.

A medical record (hard copy or electronic) is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

The medical record must include at a minimum, the following:

- Member-identifying information, including name, member ID number, date of birth, gender, and legal guardianship (if applicable)
- Primary language spoken by the member and any translation needs
- Services provided, date of service, service site, and name of service provider
- Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by treating provider
- Referrals including follow-up and outcome of referrals.
- Documentation of emergency or after-hours encounters and follow-up.
- Signed and dated consent forms (as applicable).
- Documentation of immunization status.
- Documentation of advance directives, as appropriate.
- Documentation of each visit must include:
 - Date and begin and end times of service
 - Chief complaint or purpose of the visit
 - Diagnoses or medical impression
 - Objective findings
 - Patient assessment findings
 - Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG)
- Medications prescribed
- Health education provided
- Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider. Initials of providers must be identified with correlating signatures
- Documentation of EPSDT requirements including but not limited to:
 - Comprehensive health history
 - Developmental history
 - Unclothed physical exam
 - Vision, hearing and dental screening
 - Immunizations
 - Lab testing including mandatory lead screening
 - Health education and anticipatory guidance

The medical records must be maintained in a manner to ensure that records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and facilitates an adequate system for follow-up treatment.

When a member changes PCPs, his/her medical records or copies of medical records must be forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

MLTC is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. UHCCP may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the Nebraska Medicaid program.

MLTC must be afforded access to all members' medical records, whether electronic or paper, within 20 business days of receipt of the request or more quickly if necessary in MLTC's sole determination.

Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in State statute, and substance use disorder information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR.

Medical Record Charting Standards

All participating primary care UnitedHealthcare Community and State providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating care providers are subject to UnitedHealthcare Community and State's periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Confidentiality of Record	<p>Office policies and procedures exist for the following</p> <ul style="list-style-type: none"> • Confidentiality of the patient medical record • Initial and periodic training of office staff concerning medical record confidentiality • Release of information • Record retention • Availability of medical record when housed in a different office location (as applicable)
Record Organization	<ul style="list-style-type: none"> • An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations. • Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of: <ul style="list-style-type: none"> • Identifiable order to the chart assembly • Papers are fastened in the chart • Each patient has a separate medical record • Medical records are: <ul style="list-style-type: none"> • Filed in a manner for easy retrieval • Readily available to the treating care provider where the member generally receives care • Promptly sent to specialty care providers upon patient request and within 48 hours in urgent situations. • Medical records are: <ul style="list-style-type: none"> • Stored in a manner that ensures protection of confidentiality • Released only to entities as designated consistent with federal requirements. • Kept in a secure area accessible only to authorized personnel
Procedural Elements	<p>Medical records are legible*</p> <ul style="list-style-type: none"> • All entries are signed and dated • Patient name/identification number is located on each page of the record • Linguistic or cultural needs are documented as appropriate • 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 patient's first language is something other than English • Mechanism for monitoring and handling missed appointments is evident • An executed 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 regarding advance directives. • A problem list includes a list of all significant illnesses and active medical conditions • A medication list includes prescribed and over the counter medications and is reviewed annually* • Documentation of the presence or absence of allergies or adverse reactions is clearly documented*
History	<p>An initial history (for patients seen three or more times) and physical is present to include:</p> <ul style="list-style-type: none"> • Medical and surgical history* • A family history that minimally includes pertinent medical history of parents and/or siblings • A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, 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; and if present, advise to quit • Medicare patients for functional status assessment and pain • Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Problem Evaluation and Management

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

*Critical element

Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Clinical and Provider Advisory Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

Medical Record Review

Annually, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. You are expected to achieve a passing score of 85% or better.

UnitedHealthCare Community and State Medical Record Review Tool

Provide Name:	ID:	Specialty:	Review Date:			Original Score:		
Member Initials:	DOB:		Reviewer Name:			Second Score (if applicable):		
Member ID#:			1			2		
						3		
Confidentiality & Record Organization & Office Procedures								
			Yes	No	N/A	Yes	No	N/A
1. The office has a policy regarding record confidentiality addressing staff training on confidentiality; release of information; record retention and availability of medical records housed in different locations (as applicable).								
2. Staff are trained in medical record confidentiality								
3. The office uses a Release of Information form that requires patient signature								
4. There is a policy for timely transfer of medical records to other locations/Providers								
5. There is an identified order to the record assembly								
6. Pages are fastened in the medical record								
7. Each patient 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.								

Attestation:

By signing below, I attest that the above questions are accurate and true to the best of my knowledge.

Provider Representative Name and Title: _____

Date and Time: _____

UnitedHealthCare Community and State Medical Record Review Tool

<u>Procedural Elements</u>	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The medical record is legible. *									
2. All entries are signed and dated and include services provided, service site, and name of services provider									
3. Patient name/identification number is located on each page of the record									
4. Medical records contain patient demographic information (date of birth, gender, and legal guardianship if applicable)									
5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable and translation needs if known									
6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record.									
6 a. <i>If the answer to the above # 6 is No, then adults 18 and older, emancipated minors, and minors with children are given information about advance directives which is noted in a prominent part of the medical record</i>									
7. A problem list includes significant illnesses and active medical conditions									
8. A medication list includes prescribed and over-the-counter medications and is reviewed annually									
9. The presence or absence of allergies or adverse reactions is clearly displayed									
10. Documentation of emergency or after-hours encounters and follow-up									
<u>History</u>	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.									
<u>Preventative Services</u>	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 & tobacco use, sexual activity, exercise and nutrition counseling									
6. Evidence that Medicare patients are screened for functional status and pain									
7. Evidence of tracking and referral of age and gender appropriate preventive health services including EPSDT required services age 0-20									
8. Use of flow sheets or tools to promote adherence to Clinical Practice Guidelines/Preventative Screenings									

Chapter 12: Quality Assurance and Performance Improvement (QAPI) Program

Care Provider Participation in Quality Management

UnitedHealthcare has a Quality Assurance and Performance Improvement Committee (QAPIC) chaired by the Chief Medical Officer (CMO), which meets four times a year at a minimum and has oversight responsibility for issues affecting the quality of care and services provided to members.

It is the decision-making body ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QAPIC is composed of UnitedHealthcare management staff, leadership, and care providers that serve the membership, and members and reports its recommendations and actions to the UnitedHealthcare Board of Directors. The QAPIC has three standing sub-committees:

- **Clinical and Provider Advisory Committee (CPAC)** reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and performance of all participating care providers. Participating care providers give UnitedHealthcare advice and expert counsel in medical policy, quality management, and quality improvement. The health plan CMO chairs the CPAC.
- **Healthcare Quality and Utilization Management Committee (HQUM)** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical care.
- **Member Advisory Committee (MAC)** seeks input from members, care givers, providers, and community groups to make recommendations for improvement to plan services and communication materials.

Cooperation With Quality Improvement Activities

All participating care providers must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;

- Participation in quality audits, including site visits and medical record standards reviews, and annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax.

Quality Improvement Program

The Quality Improvement program at UnitedHealthcare is a comprehensive program under the leadership of the Chief Executive Officer and the Chief Medical Officer. A copy of our Quality Improvement program is available upon request. The Quality Improvement program consists of the following components:

- Quality improvement measures and studies
- Clinical practice guidelines
- Health promotion activities
- Service measures and monitoring
- Ongoing monitoring of key indicators (e.g., over and under utilization, continuity of care)
- Health Plan performance information analysis and auditing (e.g., HEDIS®)
- Care CoordinationSM
- Educating members and care providers
- Risk management
- Compliance with all external regulatory agencies

Your participation is an integral component of UnitedHealthcare's Quality Improvement program.

As a participating care provider, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback via your Network Account Manager. We require your cooperation and compliance to:

- Participate in quality assessment and improvement activities.
- Allow the use of care provider performance to conduct quality activities.

- Provide feedback on our Care CoordinationSM guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
- Advise us of any concerns or issues related to patient safety.
- Share information and follow-up on other care providers and UnitedHealthcare to provide seamless, cohesive care to patients.
- Use the Physician Data Sharing information we provide you to help improve delivery of services to your patients.
- It is required you allow the plan to use performance data.
- You will offer Medicaid members the same number of office hours as you do to commercial members, or will not restrict the number of office hours you offer Medicaid patients.

Care Provider Satisfaction

On an annual basis, UnitedHealthcare conducts ongoing assessments of your satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of your satisfaction include:

- Annual Provider Satisfaction Surveys;
- Regular visits to providers;
- Provider town hall meetings.

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare engages independent market research firms Center for the Study of Services (CSS) to field the survey and Market Strategies International to analyze and report findings. UnitedHealthcare provides CSS lists of eligible care providers for each Community Plan from which CSS draws random samples for fielding.

Survey results are reported to our Quality Assurance and Performance Improvement (QAPIC) committee and Clinical and Provider Advisory Committee (CPAC). The results are compared by the Health Plan year over year and also in comparison to other UnitedHealthcare plans across the country. The survey results include key strengths and key improvement targets. Additionally, improvement plans are implemented as a result of the targets identified.

Credentialing Standards

UnitedHealthcare will credential and re-credential all participating providers according to applicable Nebraska statutes and regulations and the NCQA. The following key elements are required to begin the credentialing process:

- A completed Credentialing Application including Attestation Statement;
- Current Medical License;
- Current DEA Certificate;
- Current Professional Liability Insurance

Information from primary sources regarding Licensure, education and training, board certification, and malpractice claims history will be verified as part of the credentialing process.

Medicaid ID and Disclosure of Ownership Form are requirements of enrollment.

The MCO must notify the Medicaid Agency of any disclosures made by you on information 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 any action it takes on your application for participation in the program. The Medicaid Agency is responsible for notifying the Inspector General within 20 working days of notification by the MCO.

Credentialing and Re-credentialing Process

UnitedHealthcare's credentialing and recredentialing process is to determine your competence and suitability for initial and continued inclusion in UnitedHealthcare's care provider network. All individual contracted care providers are subject to the credentialing and recredentialing process before evaluating and treating UnitedHealthcare members.

Types of Care Providers Subject to Credentialing and Recredentialing

UnitedHealthcare credentials and re-credentials the following types of care providers:

- 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 the credentialing and recredentialing process are care providers who:

- Practice exclusively within an inpatient setting
- Hospitalists who are employed solely by the facility; and/or
- Nurse Practitioners and Physician Assistants who practice under the auspices and supervision of a credentialed UnitedHealthcare care provider

UnitedHealthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which you specialize. Credentialing and Recredentialing activities are completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website.



First time applicants will need to contact the National Credentialing Center (VETTS line) at **877-842-3210** to obtain a CAQH number in order to complete the application online.

Peer Review

Credentialing Process

All applicants are reviewed by the Clinical and Provider Advisory Committee (CPAC). Decisions are final and binding and not subject to appeal if they relate to mandatory participation criteria at the time of initial credentialing. You are notified in writing of the credentialing determination within 60 calendar days of the committee decision.

Recredentialing Process

UnitedHealthcare recredentials you every three years to assure time-limited documentation is updated, changes in health and legal status are identified, and you comply with UnitedHealthcare's guidelines, processes, and care provider performance standards. You are notified prior to your next credentialing cycle to complete an application on the CAQH website. Failure to respond to UnitedHealthcare's request for recredentialing information will result in administrative termination of privileges as a UnitedHealthcare participating care provider. You will be afforded three opportunities to respond to UnitedHealthcare's request for recredentialing information before action is taken to terminate participation privileges.

Care Provider Performance Review

As part of the recredentialing process, UnitedHealthcare queries its Quality Management database for information regarding your performance. This includes, but is not limited to:

- Member complaints
- Quality of care issues

Applicant Rights and Notification

You have the right to review the information in support of credentialing/recredentialing applications and to request the status of your application. This review is at your request and is facilitated by the credentialing staff. The credentialing staff notifies you of any information obtained during the credentialing or recredentialing process that varies significantly from the information you gave to UnitedHealthcare. You have the right to correct erroneous information of the request for clarification by the credentialing staff.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Resolving Disputes

Contract Concern or Complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to:

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

A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your applicable Provider Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, please follow the dispute resolution provisions of your applicable Provider Agreement.

If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, please follow the dispute resolution provisions of your applicable Provider Agreement.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the Member Handbook, and this provider manual.

HIPAA Compliance – Care Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare is a “covered entity” under the regulations as are all health care providers who conduct business electronically.

Transactions and Code Sets

These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. If you conduct business electronically, you are required to do so using the standard formats adopted under HIPAA or to use a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare.

Unique Identifier

HIPAA also requires the development of unique identifiers for employers, health care providers, Health Plans and individuals for use in standard transactions.

NPI National Provider Identifier (NPI)

The National Provider Identifier (NPI) is the standard unique identifier for health care providers. The NPI is a 10-digit number with no embedded intelligence which covered entities must accept and use in standard transactions. While the HIPAA regulation only requires that the NPI be used in electronic transactions, many state agencies require the identifier on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared with all impacted trading partners, such as care providers to whom you refer patients, billing companies, and health plans.

Privacy of Individually Identifiable Health Information

The privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that Health Plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information and to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

Security

The Security Regulations require covered entities to meet basic security objectives.

1. Ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Ensure compliance with the Security Regulations by the covered entity's workforce.

UnitedHealthcare expects you to be in compliance with the HIPAA regulations that apply to your practice or facility within the established deadlines.



Additional information on HIPAA regulations can be obtained at [cms.hhs.gov](https://www.cms.hhs.gov).

Ethics & Integrity

Introduction

UnitedHealthcare is dedicated to conducting business honestly and ethically with members, care providers, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators and others has never been greater. It's not only the right thing to do, it is necessary for our continued success and that of our business associates.

Compliance Program

As a business segment of UnitedHealth Group, UnitedHealthcare is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Compliance program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealthcare 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 education of employees;
- Assessing compliance by monitoring and auditing;
- Responding to allegations or information regarding violations;
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for employees, managers and others to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare has a Compliance Officers for each Health Plan. In addition, each Health Plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the Health Plan.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare employee which comes to your attention should be reported to a UnitedHealthcare senior manager in the Health Plan or directly to the Compliance Office.

UnitedHealthcare's Special Investigations Unit (SIU) is an important component of the Compliance program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities.

To facilitate the reporting process of any questionable incidents involving plan members or care providers, call 866-242-7727.

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

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare operations and implementing reviews and audits to help ensure compliance with law, regulations, and policies/contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our care providers, UnitedHealthcare will conduct an appropriate investigation. You are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by your applicable Provider Agreement and this manual) and access to care provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If you become the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to your operations (other than a routine request for documentation from a regulatory agency), you must advise the UnitedHealthcare plan of the details of the investigation.

Extrapolation Audits of Corporate-wide Care Provider Billing

UnitedHealthcare Community Plan will work with the State of Nebraska to perform "individual and corporate extrapolation audits" and 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 agree to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Records must be maintained for a period of not less than 10 years from the close of the Nebraska program agreement between the state and UnitedHealthcare, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. United Healthcare and its affiliated entities (including OptumHealth) will request and obtain prior approval from all care providers under review or inspection.

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

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

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

All reviews and audits shall be performed in such a manner that will not unduly delay your work. If you refuse to allow access to all documents, papers, letters, or other materials, this will constitute a breach of your applicable Provider Agreement.

You must keep records for a period of ten years following the close of the agreement between the state and UnitedHealthcare, unless the state authorizes in writing their earlier disposition. You agree to refund to the state any overpayment disclosed by any such audit.

However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 10-year period, you agree to retain the records until completion of the action and resolution of all issues which arise from it and for one year thereafter. The state shall also retain the right to perform financial, performance, and other special audits on such records maintained by you during regular business hours throughout the term of your applicable Provider Agreement.

Delegating and Subcontracting

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

Care Provider Office Site Quality

United Healthcare and affiliates monitor complaints or quality of services (QOS) concerning participating care providers and facilities. Complaints about a care provider's office site and facilities are recorded, investigated, and appropriate follow-up is conducted to assure that members receive care in a safe, clean, accessible and appropriate environment. For this reason, UnitedHealthcare has set Clinical Site Standards for all Primary Care Provider office sites to help ensure the quality of the facility in which the care is provided.

UnitedHealthcare requires that all clinic facilities meet the following minimum site standards:

- Overall appearance is clean and orderly
- Handicapped parking is available
- Facility is handicapped accessible
- Adequate waiting room space
- Exam room(s) are adequate for providing patient care
- Exam room(s) allow for privacy

Criteria for Site Visits

The table below outlines the criteria that are used to require a site visit. When the threshold is met, a site visit is conducted according to UnitedHealthcare Community and State policy and procedure.

QOS Issue	Criteria	Threshold
Issue that may pose a substantive threat to patient's safety	Access to facility in poor repair as 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	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

Chapter 13: Billing and Encounter Submission

As a care provider, you must have a National Provider Identification (NPI) number and an Nebraska Medicaid provider identification number to render services for a Nebraska Heritage Health plan member and receive payment from the health plan.

NE DHHS MLTC Medicaid ID

You must receive a NE DHHS MLTC Medicaid ID prior to claims payment for UnitedHealthcare Community Plan members. This ID is assigned by the NE DHHS MLTC.



To apply for a NE DHHS MLTC Medicaid ID, please utilize the link provided below for access to the MC-19 form and Provider Screening and Enrollment information: dhhs.ne.gov/medicaid/Pages/Provider-Screening-and-Enrollment.aspx



National Provider Identifier (NPI)

A requirement of HIPAA legislation is that all health care providers be assigned a unique (NPI). Beginning May 23, 2007, the health care industry is to use the NPI to identify itself in all standard transactions.



If you have not applied for assignment of an NPI, please call **800-465-3203** to begin the process.



You may also access the online application at nppes.cms.hhs.gov

Once you have been assigned an NPI, report the new identifier to UnitedHealthcare Community Plan.



Please call the UHG VETSS line at **877-842-3210** or your Provider Service Center at **866-331-2243**

Effective March 1, 2007, all laboratory claims must include the Unique Physician Identification Number (UPIN) or NPI number of the referring care provider, in addition to the elements of a Clean Claim. This requirement is consistent with current CMS policy. Like CMS, the Health Plan will also require that, effective May 23, 2007, all laboratory claims include the NPI of the referring care provider.

A current Federal Tax Identification Number and NPI are required on all claims.

Clinical Laboratory Improvements Amendments (CLIA)

You may submit your claims with your Clinical Laboratory Improvements Amendments (CLIA) number. In block 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. Any additional conditions should be reported on a separate CMS 1500 Form.

If you bill electronically, the CLIA number is reported in Loop 2300 or 2400, REF/X4,02.

Acceptable Claim Forms

UnitedHealthcare Community Plan requires you to use one of two forms when billing for services.

- Effective April 1, 2014, submit all paper claims on the new 02/12 1500 Claim Form. Use the 02/12 1500 Claim Form for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a hospital and other care providers.
- Use a UB-04 form to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

UnitedHealthcare Community Plan will not process claims received on any other type of claim form.

Billing Multiple Units

Reminder when billing multiple units:

- If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate number of units.
- The unit's field is used to specify the number of times the procedure was performed on the date of service.
- The total bill charge is the unit charge multiplied by the number of units.

Ambulance Claims (Emergency)

Ambulance claims must include **both** the ambulance point of origin and destination address, city, state, and zip in box 32 of the HCFA form. 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 NDC and unit of measurement for the drug billed, HCPCS/CPT code and units of service for the drug billed and actual metric decimal quantity administered.

You must submit the National Drug Code (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. You are required to submit claims with the exact NDC that appears on the product administered. Do not bill for one manufacturer's product and dispense another. It is considered a fraudulent billing practice to bill using an NDC other than the one administered. You must enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and actual metric decimal quantity administered. HCPCS/CPT code must also be included.

Clean Claims and Timely Claim Submission Requirements

Whether you use an electronic or a paper form, complete a CMS 1500 or UB-04 form. A complete claim includes the following information (additional information may be required by us for particular types of services or based on particular circumstances or state requirements).

For services rendered by a nurse practitioner or physician assistant, the claim should be submitted under the nurse practitioner or physician assistant, and not the supervising care provider.

A clean claim has no defect or impropriety and meets the following criteria:

- The claim is an eligible claim for a health service provided by an eligible health care provider to a UnitedHealthcare Community Plan member under the agreement.
- The claim does not lack any of the required substantiating documentation.
- The claim contains correct coding of diagnosis, procedure, or other required information.
- There is no dispute regarding the amount claimed.
- UnitedHealthcare has no reason to believe the claim has been submitted fraudulently.

- The claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the agreement.

Please refer to your contract for your timely filing guidelines.

Mail initial claims and encounters to:

**UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131**

Claim Resubmissions and Care Provider Claim Disputes

All claim resubmissions and/or Claim Disputes (Claims Administrative Appeals) challenging claim payments, denials or recoupments must be filed with UnitedHealthcare Community Plan within the time frames specified in your contract.

Electronic Claims Submission

UnitedHealthcare offers the option of submitting claims to UnitedHealthcare by electronic data interchange (EDI). EDI offers you several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turn-around.



For information on a variety of EDI transactions and documents, please see our webpage at UHCCommunityPlan.com under the Electronic Data Interchange EDI section.

Please share this information with your software vendor. Your software vendor can help in establishing electronic connectivity.

Please note the following:

- Clearinghouse connectivity is OptumInsight at enshealth.com for our Payer ID 87726. Your software vendor is responsible for establishing your connectivity via a clearinghouse or entity that utilizes OptumInsight if you are not a direct OptumInsight client.
- All claims are set up as "commercial" through the clearinghouse.
- Our Payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer specific Acknowledgment Reports identifying claims failing to successfully transmit electronically.

- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for placement of data for both HCFA 1500 & UB04.



Questions can be addressed to EDI Customer Service at **800-210-8315**.



If you are interested in billing electronically, obtaining information on a variety of EDI transactions, or information on training, please visit the UnitedHealthcare Care Provider Portal at **UHCCommunityPlan.com**, your Physician Advocate or contact the Provider Service Center at **866-331-2243**.

Importance & Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show the claim left your office and either was accepted or rejected by the vendor. Your software vendor report **does not** confirm claims have been received or accepted at clearinghouse or by the Health Plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the Health Plan for payment or if claim(s) have been rejected for an error or additional information.

You **MUST** review **reports, clearinghouse acknowledgment reports** and the Health Plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the Health Plan.

How do I get these reports?



Your software vendor is responsible for establishing your connectivity to our clearinghouse OptumInsight at enshelath.com.

If you are not already a direct OptumInsight client, we will instruct you in how your office will receive Clearinghouse Acknowledgment Reports.

How do I correct errors?

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing late.

IMPORTANT: If a claim is rejected and corrections are not received by the Health Plan within timely filing requirements from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing. Please reference your contract for timely filing limits.

EDI Companion Documents

The Health Plan's Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides (IG) adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted.



The Companion Documents are located on our website at **UHCCommunityPlan.com**.

The Health Plan utilizes the Companion Guides to:

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

The companion guide 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.

As the Health Plan makes information available on various transactions, we will identify our requirements for those transactions in the Companion Guide. Changes will be included in Change Summary located in each section of the Companion Document.

e-Business Support

UnitedHealthcare offices will be staffed and open during normal business hours 8 a.m. to 5 p.m., Monday through Friday.

- ERA – To enroll for 835 Electronic Remittance Advice (ERA), you **MUST** enroll via a clearinghouse or entity that utilizes OptumInsight if you are not a direct OptumInsight client.
- EFT – EFT enrollment forms are located at UHCCommunityPlan.com.

e-Business support is available for the following EDI issues:

EDI Claims Issues 800-210-8315 ac_edi_ops@uhc.com	EDI Log-on Issues 800-842-1109 UnitedHealthcareOnline.com
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Contacting your software vendor and/or clearinghouse prior to contacting UnitedHealthcare should be considered.

Important EDI Payer Information

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

General Billing Guidelines

Claims will be considered for reimbursement only if billing requirements are met and are a covered benefit for the enrolled member. If prior authorization was required, the prior authorization number must be entered in box 23 of the 1500 claim form. Submitting a referral with the claim does not guarantee reimbursement. Reimbursement for services depends on the member's enrollment on the date(s) of service, medical necessity, and limitations and exclusions as stated in rules governing the plan, and UnitedHealthcare policies and procedures. Exclusions include excessive, inappropriate or non-covered charges. We may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, state and federal law. We may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

Prompt Pay Requirements

UnitedHealth Community Plan is required to comply with the requirements of the Health Care Prompt Payment Act found in the Nebraska Revised Statutes, 44-8001 through 8010. The Act requires a clean claim shall be paid, denied, or settled within 30 calendar days after receipt by the insurer if submitted electronically and within 45 calendar days after receipt if submitted in a form other than electronically. If the claim resolution requires additional information, the insurer shall, within 30 calendar days after receipt of the claim, give the health care provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.

Medical Necessity Definition

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

- Necessary to meet the basic health needs of the client;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
- Consistent with the diagnosis of the condition;
- Required for means other than convenience of the client or his or her care provider;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value; and
- No more intense level of service than can be safely provided.

NOTE: UnitedHealthcare only pays for medically necessary services.

Correct Coding Initiative (CCI)

The Health Plan performs coding edit procedures, based primarily on the Correct Coding Initiative (CCI) and other nationally recognized and validated sources.

The edits basically fall into one of two categories:

1. Comprehensive and Component Codes

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.

- Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or Multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same care provider. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and ICD CM Code vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technical Information Service, or NTIS

New CMS 02/12 1500 Claim Form Effective April 1, 2014

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500. Claims submitted on/after April 1, 2014 will need to be submitted on the new 02/12 1500 Claim Form.

- CPT and HCPCS procedure codes must be used to identify all services
- ICD-10 procedure and condition codes (ICD-9 prior to 10/01/1015).

This section applies to paper CMS 1500 claims submitted to UnitedHealthcare Community Plan. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide.



Companion documents for 837 transactions are available on UHCommunityPlan.com in the Electronic Data Interchange (EDI) section.

The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transactions.

ICD-10 CM Codes Effective 10/1/2015

UnitedHealthcare ICD-10-CM Code Lookup Tool to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare claim platforms. Please use this link: icd10codelookup.smartbaseline.com/.

Completing the CMS 02/12 1500

Find instructions to completing the paper CMS 1500 claim form and determining whether a field is required at the National Claim Form Committee website.



nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42

Claim Form

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

1. Program Block – Required

Check the second box labeled "Medicaid."

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input checked="" type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK (LUNG) <input type="checkbox"/> (ID#)
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1a. Insured's ID Number Required – Required

Enter the member's UnitedHealthcare Community Plan Member ID or their Nebraska DHHS ID number. If there are questions about eligibility, contact the Provider Service Center at 866-331-2243.

1a. INSURED'S ID, NUMBER (For Program in Item 1)
999999999

2. Patient's Name – Required

Enter member's last name, first name, and middle initial a shown on the ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holiday, John H.

3. Patient's Date of Birth and Sex – Required

Enter the member's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE	SEX
MM DD YY	M <input type="checkbox"/> F <input type="checkbox"/>

- 4. **Insured's Name – Not required**
- 5. **Patient Address – Required**
(can be used for member verification)
- 6. **Patient Relationship to Insured – Not required**
- 7. **Insured's Address – Required (if applicable)**
- 8. **Reserved for NUCC use – Not required**
- 9. **Other Insured's Name – Required (if applicable)**
If the recipient has no coverage other than UnitedHealthcare Community Plan, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

- 9a. **Other Insured's Policy or Group Number – Required (if applicable)**
Enter the group number of the other insurance.
- 9b. **Reserved for NUCC Use – Not required**
- 9c. **Reserved for NUCC Use – Not required**
- 9d. **Insurance Plan Name or Program Name – Required (if applicable)**
Enter name of insurance company or program name that provides the insurance coverage.

- 10. **Is Patient's Condition Related to – Required (if applicable)**
Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)
 YES NO

b. AUTO ACCIDENT? PLACE (State)
 YES NO

c. OTHER ACCIDENT?
 YES NO

10d. CLAIM CODES (Designated by NUCC)

- 10d. **Claim Codes (Designated by NUCC) – Required (if applicable)**
- 11. **Insured's Policy Group or FECA Number – Required (if applicable)**
- 11a. **Insured's Date of Birth and Sex – Required (if applicable)**
- 11b. **Other Claim ID (Designated by NUCC) – Required (if applicable)**
- 11c. **Insurance Plan Name or Program Name – Required (if applicable)**

- 11d. **Is There Another Health Benefit Plan – Required (if applicable)**
Check the appropriate box to indicate coverage other than UnitedHealthcare Community Plan. If "Yes" is checked, you must complete Fields 9a-d.
- 12. **Patient or Authorized Person's Signature – Required**
- 13. **Insured's or Authorized Person's Signature – Required**
- 14. **Date of Current Illness, Injury or Pregnancy (LMP) – Required (if applicable)**
- 15. **Other date – Required (if applicable)**
- 16. **Dates Patient Unable to Work in Current Occupation – Required (if applicable)**
- 17. **Name of Ordering/Referring Provider or Other Source – Required (if applicable)**
Enter name of referring, ordering, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim
- 17a. **The Other ID Number of the Referring/Ordering/Supervising provider – Required (if applicable)**
The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.
- 17b. **NPI # of Ordering/Referring/Supervising Provider – Required (if applicable)**
- 18. **Hospitalization Dates Related to Current Services – Required (if applicable)**
- 19. **Additional Claim Information (Designated by NUCC) – Required (if applicable)**
- 20. **Outside Lab and (\$) Charges – Required (if applicable)**
- 21. **Diagnosis Or Nature Of Illness or Injury – Required**
Enter at least one ICD CM Code diagnosis code describing the recipient's condition. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY *Relate A-L to service line below (24E) ICD Ind. |

A. 998.59	B. _____	C. _____	D. _____
E. _____	F. _____	G. _____	H. _____
I. _____	J. _____	K. _____	L. _____

- 22. **Resubmission Code – Required (if applicable)**
Enter the appropriate code ("7" or "8") to indicate whether this claim is a replacement of prior claim or a void/cancel of a prior claim. Enter the Claim Reference Number (CRN) of the prior claim being resubmitted or the paid claim being adjusted or voided/canceled in the field labeled "Original Reference No."

22. RESUBMISSION CODE ORIGINAL REF. NO.

7 ABC1111111111

23. Prior Authorization Number – Required

Also used to enter the 10 digit CLIA certification number

24a. Date(s) of Service and NDC –Required

In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 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. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

24. A. DATE(S) OF SERVICE		3. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS			
From	To	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY
N4000741	5278	ML	10										
10	01	14	01	10	13	14	J1642						

The beginning and ending service dates must be entered in the non-shaded area.

24b. Place of Service (POS) – Required

Enter the two-digit code that describes the place of service. (reference chapter 10 for POS list).

24c. EMG – Emergency Indicator – Required (if applicable)

Mark this box with an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

24. A. DATE(S) OF SERVICE		3. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS			
From	To	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY

24d. Procedures, Services, or Supplies – Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

24e. Diagnosis Pointer – Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the number of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), not the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

24f. \$ Charges – Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

24g. Units – Required

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

24h. EPSDT/Family Planning – Required (if applicable)

Enter referral indicator codes using CPT well-child preventive codes 99381-99395.

- AV – Patient;
- S2 – Patient is currently under treatment for diagnostic or corrective health problem;
- NU – No referral given; or
- ST – Referral to another provider for diagnostic or corrective treatment.

24i. ID Qualified – Required (if applicable)

24j. (NON SHADED AREA) – RENDERING PROVIDER ID # – Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI #.

F. \$ CHARGES	G. DAYS OR UNITS	H. POS	I. EMG	J. RENDERING PROVIDER ID #
				NPI ID #

25. Federal Tax ID Number – Required

Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

26. Patient Account Number – Not required

This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. UnitedHealthcare Community Plan will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the UnitedHealthcare Community Plan Claim Reference Number and the provider’s own accounting or tracking system.

27. Accept Assignment – Required

28. Total Charge – Required

Enter the total for all charges for all lines on the claim.

29. Amount Paid – Required (if applicable)

Enter the total amount that the provider has been paid for this claim by all sources *other than* UnitedHealthcare Community Plan. Do *not* enter any amounts expected to be paid by UnitedHealthcare Community Plan.

- 30. **Rsvd for NUCC Use – Required** (if applicable)
- 31. **Signature and Date – Required**
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

- 32. **Service Facility Location Information – Required**
Ambulance claims must include point of origin, and destination; Address, city, state and zip.

- 32a. **Service Facility NPI # – Required** (if applicable)

- 32b. **Service Facility (Shaded Area) – Not required**

32. SERVICE FACILITY LOCATION INFORMATION	
Nebraska Hospital 123 Main Street Omaha, NE 68105	
a.	NPI

- 33. **Billing Provider Name, Address and Phone # – Required**
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

- 33a. **Billing Provider NPI # – Required** (if applicable)

- 33b. **Other ID (shaded area) – Required** (if applicable)

33. BILLING PROVIDER INFO & PH # ()	
a.	NPI

UB-04

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services.

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
- ICD CM Code diagnosis codes are required.
- ICD CM Code procedure codes must be used to identify surgical procedures billed on the UB-04.
- CPT/HCPCS and modifiers must be used to identify other services rendered.

This section applies to paper claims submitted to UnitedHealthcare Community Plan. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide.



Companion documents for 837 transactions are available on our website at UHCommunityPlan.com.

The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

ICD-10 CM Code Effective 10/1/2015

You can utilize the [UnitedHealthcare ICD-10-CM Code Lookup Tool](#) to determine a diagnosis code from ICD-9 to ICD-10 and vice versa. The tool was developed using the Centers for Medicare and Medicaid Services (CMS) General Equivalence Mappings (GEMs) as a baseline, focusing on the high volume codes most frequently submitted to UnitedHealthcare claim platforms. Please utilize this link: <https://icd10codelookup.smartbaselink.com/>

Completing the UB-04 Claim Form

The following instructions explain how to complete the UB-04 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

1. **Provider Name, Address & Telephone Number – Required**
Enter the name, address, and phone number of the provider rendering service. P.O. Boxes or lockboxes are not allowed.
2. **Pay to Name and Address – Required** (if applicable)
- 3a. **Patient Control No. – Required**
This is a number that the facility assigns to uniquely identify a claim in the facility's records. UnitedHealthcare Community Plan will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Claim Reference Number and the facility's accounting or tracking system.
- 3b. **Medical/Health Record – Required** (if applicable)
4. **Bill Type – Required**
Facility type (first digit), bill classification (second digit and frequency (third digit).

3a. PAT. CNTRL. #	4. TYPE OF BILL
	111

5. **Fed Tax No. – Required**
Enter the facility's federal tax identification number.
6. **Statement Covers Period – Required**
Enter the beginning and ending dates of the billing period.

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
	09/15/14	09/20/14

OR

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD		7
	FROM	THROUGH	
	09/15/2014	09/20/2014	

8. **Administrative Necessary Days – Not Required**

8. **Patient Name/Identified – Required**

Enter the recipient's last name, first name, and middle initial as they appear on the UnitedHealthcare Community Plan ID card.

9. **Patient Address – Required**

10. **Patient Birth Date – Required**

11. **Patient Sex – Required**

12. **Admission/Start of care date – Required**

13. **Admission hour – Required** (if applicable)

14. **Priority (type) of Admission/Visit – Required**

Required for all claims. Enter the code that best describes the recipient's status for this billing period. An Admit Type of "1" is required for emergency inpatient and outpatient claims.

1. Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
2. Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
3. Elective: Patient's condition permits time to schedule services.
4. Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.
5. Trauma Center: Visit to a trauma center/ hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

15. **Point of Origin for Admission or Visit – Required**

16. **Discharge Hour – Required** (if applicable)

Enter the code which best indicates the recipient's time of discharge. Required for inpatient claims when the recipient has been discharged. See UB Editor for code structure.

17. **Patient discharge status – Required**

Required for all claims. Enter the code that best describes the recipient's status for this billing period

- 01 Discharged to home or self-care (routine discharge)
- 02 Discharged/Transferred to a short-term general hospital for inpatient care

03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled car

04 Discharge/Transferred to a facility that provides custodial or supportive care

05 Discharge/Transferred to a designated cancer center or children's hospital

06 Discharge/Transferred to home under care an organized home health service organization in anticipation of covered skilled care

07 Left against medical advice or discontinued care

09 Admitted as an inpatient to this hospital

20 Expired

21 Discharged/Transferred to Court/Law Enforcement

30 Still a patient

40 Expired at home

41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice

42 Expired, place unknown (hospice only)

43 Discharged/Transferred to a federal health care facility

50 Discharged to Hospice home

51 Discharged to Hospice medical facility (certified) providing hospice level of care

61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed

62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)

64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital

66 Discharges/Transfers to a Critical Access Hospital

70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18-28. **Condition Codes – Required** (if applicable)

Enter the appropriate condition codes that apply to this b

29. **Accident State – Required** (if applicable)

30. **Accident Date – Required** (if applicable)

31-34. Occurrence Codes and Dates – Required (if applicable)

NOTE: Nebraska Hospital claims require that at least one UB Occurrence Code be a number from 01-06 when the RSS Diagnosis code in the Primary Diagnosis field only indicates Trauma ICD10 S02.0XXA - T88.51XA). In addition the Hospital must also submit a valid External Cause of Injury Code (E-code) on the Claim. Since correct Provider billing should have the required occurrence code and E Diagnosis code on hospital claims when a Trauma diagnosis is present. Claims will deny when correct coding is not submitted.

- 01 Accident/Medical Coverage – Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
- 02 No-Fault Insurance Involved – Including Auto Accident/Other - Date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
- 03 Accident/Tort Liability - Date of an accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
- 04 Accident/Employment Related – Date of an accident that relates to the patient's employment.
- 05 Accident/No Medical or Liability Coverage – Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
- 06 Crime Victim – Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

35-36. Occurrence Span codes and dates – Required (if applicable)

37. Reserved (assignment by the NUBC)

38. Responsible Party Name and Address – Required (if applicable)

39-41. Value Codes and Amounts – Required (if applicable)

42. Revenue Code – Required

Enter the appropriate revenue code(s) that describe the service(s) provided. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

42. Revenue Code – Required

Enter the appropriate revenue code(s) that describe the service(s) provided. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

43. Revenue Code Description/NDC code – Required (if applicable)

Enter the description of the revenue code billed in Field. To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualified (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

44. HCPCS/Rates – Required (if applicable)

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

- Form locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC

45. Service Date – Required (if required)

The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46. Service Units – Required

Number of units for ALL services must be indicated. If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22 and statement covers period (Field 6). If the recipient has been discharged, UnitedHealthcare Community Plan covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, UnitedHealthcare Community Plan covers the admission date through last date billed.

- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered
47. **Total Charges – Required**
Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to \$999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed \$999,999,999.99.
 48. **Non-covered Charges – Required** (if applicable)
 49. **Reserved (assignment by the NUBC)**
 50. **(A–C) Payer – Required** (if applicable)
Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are other payers, UnitedHealthcare Community Plan should be the last entry. If there are no payers, UnitedHealthcare Community Plan will be the only entry.
 51. **(A–C) Healthplan Identification No. – Required** (if applicable)
Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C.
 52. **(A–C) Release of Information – Required**
 53. **(A–C) Assignment of Benefits – Required**
 54. **(A–C) Prior Payments – Required** (if applicable)
Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the explanation of Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.
 55. **(A–C) Amount due – Not required**
 56. **National Provider Identifier (NPI) Billing Provider – Required**
 57. **Other (Billing) Provider Identifier – Required** (if applicable)
 58. **(A–C) Insured's Name – Not Required**
Enter the name of insured covered by the payer(s) in Field 50.
 59. **(A–C) Patient's Relationship To Insured – Not Required**
 60. **(A–C) Insured's Unique Identification – Required**
Enter the Medicaid members complete eleven-digit identification number or UnitedHealthcare Community Plan seven-digit identification number.
 61. **(A–C) Group Name – Required** (if applicable)
 62. **(A–C) Insurance Group Number – Required** (if applicable)
 63. **(A–C) Treatment Authorization – Required** (if applicable)
Enter the authorization number for services provided.
 64. **Document Control Number – Required** (if applicable)
 65. **(A–C) Employer Name – Not required**
 66. **Diagnosis and Procedure Code Qualified – Required**
 67. **Principal Diagnosis Code – Required**
Enter the principal ICD CM Code diagnosis code.
 67. **(A – Q) Other Diagnosis Codes – Required** (if applicable)
Enter when other condition(s) coexist or develop(s) subsequently during the patients treatment.
 68. **Reserved (assignment by the NUBC)**
 69. **Admitting Diagnosis – Required**
Required for inpatient bills. Enter the ICD CM Code diagnosis code that represents the significant reason for admission.
 70. **(A - C) Patient's Reason for Visit —Required** (if applicable)
 71. **Prospective Payment System (PPS) Code – Not Required**
 72. **External Cause of Injury (ECI) Codes – Required** (if applicable)
Enter trauma diagnosis code, if applicable.
 73. **Reserved (assignment by the NUBC)**
 74. **Principal Procedure Code and Dates – Required** (if applicable)
Enter the principal ICD CM Code procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which require the highest skill level.
 74. **(A-E) Other Procedures and Dates - Required** (if applicable)
Enter other ICD codes identifying all significant procedures performed. Enter the date of that procedure.
 75. **Reserved (assignment by the NUBC)**
 76. **Attending Provider name and identifiers – Required**
 77. **Operating Physician Name and Identifier – Required** (if applicable)
 - 78-79. **Other Physician – Required** (if applicable)
 80. **Remarks –Required** (if applicable)

81. **Code-Code (CC) Field – Required** (if applicable)
Enter other procedure codes in descending order of importance.

Electronic Claims and Encounter Submission

UnitedHealthcare offers many of our providers the option of submitting claims and encounters to UnitedHealthcare by electronic data interchange (EDI). EDI offers providers several advantages, including less paperwork, reduced postage, less time spent handling claims and faster turn-around. UnitedHealthcare Community Plan can accept claims electronically when UnitedHealthcare Community Plan is secondary and there is no need to send a paper claim as backup.



If you are interested in billing electronically, visit the UnitedHealthcare Provider Portal at UHCCommunityPlan.com or contact the Provider Service Center at 866-331-2243.

Reminders

- Indicate the Attending Provider Name and Identifiers for the patient's medical care and treatment on institutional claims for any services other than non-scheduled transportation claims.
- Also send the Referring Provider NPI and name on outpatient claims when the Referring Provider for the services is different than the Attending Provider.
- As of Jan. 1, 2013, claims must include the NPI of the attending provider in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims. That NPI must not be your billing NPI or an organizational NPI; it must be an individual provider NPI.
- **For Behavioral Health providers**, currently, our systems have been updated to receive more than one NPI per agency. Providers can now bill using multiple **site-specific** NPIs.

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.

Overpayment

Overpayment Identified by the Provider

A provider must notify UnitedHealthcare Community Plan of an overpayment on a claim. A request to have an adjustment completed can be requested or a refund check can be sent with the following information:

- A statement of authorization for Community Plan to recover the funds in question from a person in your office or company who has the authority to, for example, sign checks or approve financial decisions
- The name and contact information for the person mentioned above.
- The overpayment amount and the reason for the request.
- If you are sending a check, the amount for the check you are sending must be included with the written request along with the check number.

A list of claims must accompany the letter and needs to include the following information:

- Member ID as applicable for UnitedHealthcare Community Plan.
- Date of service.
- Date of payment.
- Original claim number (if known).

- Amount paid.
- Amount of Overpayment.
- Overpayment reason.

Please reference Sample Overpayment Report on next page.

Mail Adjustment Request to:
UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131

Mail Refund Check to:
UnitedHealthcare
P.O. Box 5230
Kingston, NY 12401

Overpayment Identified by UnitedHealthcare Community Plan

Refunds requested by UnitedHealthcare Community Plan should be sent with an Overpayment Notification Letter to:

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

Helpful Hints:

- Make sure the letter is authorized by an individual in your office or company authorized to sign checks and financial documents, such as an office or principal.
- Include the contact information for the person mentioned above.



Provider Service Telephone Number: If you have any questions or problems, please call **866-331-2243**.

Sample Overpayment Report

*The information provided below 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	03/15/14	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

Billing Guidelines for Obstetrical Services

The reporting procedure below must be followed when submitting OB delivery claims to UnitedHealthcare. These procedures must be followed or the claim will be denied by UnitedHealthcare.

- Utilize CPT Evaluation and Management codes (99201-99215*) or OB visits (59425-59426) to report prenatal visits
 - 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
 - Use one unit with the appropriate charge should be entered in the charge column
- *Only use CPT Evaluation and Management (E/M) codes 99201-99215, when three or less prenatal visits are performed
- Use global delivery code (59400, 59519, 59610 and 59618).

Hospital and Clinic Method of Billing Professional Services

UnitedHealthcare Community Plan billing policy requires hospital and clinics to bill on a CMS 1500 with the servicing care provider's name in box 31 and the servicing care provider's group NPI number in box 33a.

UnitedHealthcare Community Plan Provider Remittance Advice

All online transactions for members enrolled in Medicaid are accessible on UnitedHealthcareOnline.com. The Electronic Provider Remittance Advice can be found under the tab Claims & Payments/Electronic Payments & Statements (EPS).

If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. The following is an explanation of fields found on the UnitedHealthcare paper claim provider remittance advice

1. **Patient** – first and last name of the member.
2. **Subscriber ID** – the UnitedHealthcare Community Plan ID number assigned to the member.
3. **Subscriber Name** – first and last name of the member.
4. **Prompt Pay Disc** – payment reduction offered by the provider for payment prior to the due date.
5. **Claim Number** – claim number generated by UnitedHealthcare.
6. **Patient Account**
7. **Member ID** – the State Medicaid ID number assigned to the member.
8. **Interest Amount** – calculated penalty applied to qualified claims.
9. **PCP Number** – the UnitedHealthcare Community Plan provider ID number assigned to the provider.
10. **Remit Detail** – type of claim
11. **Product Desc** – Nebraska UnitedHealthcare Community Plan.
12. **Servicing Provider NPI** – NPI of the provider who performed the service.
13. **Servicing Prov Name** – provider billing the service
14. **PCP Name** – member's primary care provider
15. **Billing NPI** – billing providers NPI number
16. **Carrier ID**
17. **Date/s Of Service**
18. **Description of Service** – lists billing code (procedure/revenue code for service rendered), NDC, and POS (place of service)/bill type
19. **Units** – units submitted for service.
20. **Billed Amt** – amount billed by Provider
21. **Disallow Amt** – amount disallowed by UnitedHealthcare Community Plan. Need to reference Reason Code for denial reason.
22. **Discount Amt** – amount deducted or subtracted from the billed amount.
23. **Allowed Amt** – amount allowed per UnitedHealthcare provider agreement or non-participating rate.
24. **Deduct Amt** – amount for which the member is responsible (if applicable).
25. **Copay/Coins Amt** – amount for which the member is responsible (if applicable).
26. **COB Amt** – co-ordination of benefit is payment made by other insurers amount paid my other insurance.
27. **Withhold Amt** – amount withheld, if any, according to the contract.
28. **Paid To Provider Amt** – amount paid for service.
29. **Patient Resp Amt** – amount patient owes provider.
30. **Auth #** – authorization number for the service covered by this claim.

31. **RMK CD** – remark code provides an additional explanation already described by a Reason Code. Further explains why the procedure allowed differently than the billed amount.
32. **GRP CD/RSN CD** – GRP CD (Group Coded) assigns financial responsibility for non-paid amount and is reported in conjunction with applicable claim adjustment reason codes that explain full or partial denials of services allowed differently than the billed amount. RSN CD (Reason Code) explains why the procedure was allowed differently than the billed amount.
33. **Claim Number** – generated by UnitedHealthcare.
34. **Subtotal** – amount of that claim.

Resubmitting a Claim

If you feel a claim has not been properly processed, UnitedHealthcare has provided several options for you. If you met the initial submission requirements as stated in your contract, then you have up to twelve months from the date of service to resubmit a clean claim. Please see Timely Filing Guidelines within this chapter for additional timely filing guidelines for resubmitting a claim.

Resubmission of Claims

You must use the following steps to resubmit a claim or submit a corrected claim:

- Submit a copy of the claim.
- Submit a copy of the remittance advice.
- Submit with a cover letter or completed Reconsideration Form with the reason for resubmitting the claim, and any correction(s) that were made. Sign and date the cover letter and provide UnitedHealthcare with a contact telephone number. The Reconsideration Form is available online at UHCCommunityPlan.com. Choose the Health Care Professionals tab. Select the appropriate state and select the Provider Forms tab.

Mail the claim with cover letter to:

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

All online transactions for members is accessible on UnitedHealthcareOnline.com.

If you are not already registered on UnitedHealthcareOnline.com, you may do so directly on the website. The website allows you to:

- Verify member eligibility
- Check claim status
- Submit claims
- Request an adjustment
- Review a remittance advice
- Review or download a PCP Panel roster

Care Provider Service Center

This is the primary point of contact if you require assistance. The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare.



The Provider Service Center can assist you with questions on Medicaid benefits, eligibility, claims resolution; forms required to report specific services, billing questions, etc. and can be reached at **866-331-2243**.

The Provider Service Center works closely with all departments in UnitedHealthcare.

How to Submit Your Corrected Claims Electronically

Institutional Claims:

You may submit a corrected claim electronically through their claim clearinghouse.

- Update the 3rd digit in the bill type to a:
 - “7” for a replacement request
 - “8” for a void request
- The change in bill type will flag the claim as a corrected claim

Professional Claims:

You may submit an adjustment or void claim request electronically through claim clearinghouse using resubmission codes in box 22 on the CMS 1500 claim titled Resubmission Code

- Resubmission code “7” for replacement request
- Resubmission code “8” for void request
- Include Original Claim Number in the Original Reference number

Inquiring About a Claim

UnitedHealthcare has developed multiple options to help you when inquiring about claims: the UnitedHealthcare Provider Service Center, and the UnitedHealthcare Provider Portal.

Care Provider Service Center

The Provider Service Center is the primary point of contact if you require assistance with claims.



The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare and can be reached at **866-331-2243**.

They work closely with all departments in UnitedHealthcare to resolve issues. By following a few guidelines, you can help UnitedHealthcare provide you with prompt, efficient service. Please have all applicable information ready before you call:

- Provide the Member's ID number, date of service, procedure code, amount billed, provider's ID Number and claim number (if known).
- Allow 45 days from date of submission prior to inquiring about a claim.
- Limit telephone inquiries to a maximum of five claims per call.

Link: Your New Gateway to UnitedHealthcare's Online Care Provider Tools and Resources

Link includes many of the same applications as Optum Cloud Dashboard, but with a new interface that can help make your work measurably faster and easier. Link users can quickly move between applications and even customize the screen to put common tasks just one click away.

Use Link applications to help simplify daily administrative tasks for your practice:

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

Registration is required to access Link.

To access Link, please sign in to UnitedHealthcareOnline.com using your Optum ID.

- **If you have a UnitedHealthcareOnline.com user ID** but do not yet have an Optum ID, go to UnitedHealthcareOnline.com, click "Sign In," then "Register" to create your Optum ID.
- **If you don't have a UnitedHealthcareOnline.com user ID**, go to UnitedHealthcareOnline.com and select "New User" to begin registration.

LINK applications:

LINK contains the following information:

- General Information
- Information for Website Administrators
- Billing Services
- Claims Management
- Claim Reconsideration
- Provider Data Management
- Eligibility & Benefits Center

Learn more: To learn more about Link and view answers to frequently asked questions, please visit UnitedHealthcareOnline.com > Tools & Resources > Health Information Technology > Link. If you have other questions, please call UnitedHealthcare Connectivity Help Desk at 866-842-3278, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Resolving Claim Issues



To resolve claim issues, you should first contact the Provider Service Center at **866-331-2243**, use the online Provider Portal, or resubmit the claim via mail.

You should allow up to 30 days for UnitedHealthcare to receive payment for initial claims and 30 days to receive a response to adjustment requests.

Care Provider Service Center

The Provider Service Center provides assistance for you to resolve escalated issues, including complex and large volume issues involving UnitedHealthcare claims. A Provider Service Center representative will track each issue until agreement that it is resolved, even if it is referred to an outside expert or adjuster for resolution. When calling the Provider Service Center, you should be prepared to provide the representative a detailed explanation of specific issues and what was expected under the terms of the contract.



To contact the Provider Service Center, call **866-331-2243**.

Valid Proof of Timely Filing Documentation

Timely filing denials are often upheld due to incomplete or invalid documentation submitted with reconsideration requests. The following information has been compiled to help clarify the documentation required as valid proof of timely filing documentation. When submitting a request for reconsideration of a claim to substantiate timely filing, please follow the appropriate instructions below.

For electronic claims:

- Electronic Claims – Acceptance Report must include:
 - Universal Electronic Data Interchange (EDI) acceptance code **A1:19** coding and an acceptance date within the timely filing period, or
 - A combination of a version of the words **accepted by payer, acknowledged by payer or received by UnitedHealthcare**

For paper claims:

Submit a screen shot from accounting software that shows the date the claim was submitted. The screen shot must show:

- Correct patient name
- Correct date of service
- Submission date of claim
- The submission date must be within the timely filing period.

Please reference your contract for timely filing limits.

Other valid proof of timely filing documentation

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/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
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim
- All of the above must include documentation that the claim is for the correct patient and the correct date of service.

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

In order to be considered timely, the claim must be received by UnitedHealthcare 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.

Tips for successful claims resolution

- Do not allow claim issues to accumulate or go unresolved.
- Provider contracts only allow a limited time to request an adjustment.
- If you cannot verify that a claim is on file, then call the Provider Service Center at **866-331-2243**.
- You should not resubmit claims that have been validated as on file unless submitting a corrected claim
- File claims disputes within contractual time requirements.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid, and why.
- Claim/service denied for exceeding the maximum daily frequency allowed for the procedure. If exceeding the maximum daily frequency is required, please submit the medical records justifying medical necessity. If you have any questions about the maximum daily frequency of a CPT/HCPCS, please contact the Provider Service Center at 866-331-2243.

Third Party Resources

UnitedHealthcare is, by law, the payer of last resort for eligible members. Therefore, providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing UnitedHealthcare, as required by contract.

You should refer to your contract for submission deadlines concerning third party claims. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare. Please attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason.

Medicare Crossover Claims

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



Please visit [Unitedhealthcareonline.com](https://www.unitedhealthcareonline.com) > Tools & Resources > EDI Education for Electronic Transactions > Quick Tips for Electronic Claims > Secondary/COB or Tertiary Claims > Medicare Crossover for further information. Or you can call the Provider Service Center at **866-331-2243** for further assistance.



- If you wish to bill the member for non-covered services, you must discuss this with the member prior to rendering the services and obtain a signed waiver of liability from that member that specifies the service and specific amount in question.
- When claims are pending review by UnitedHealthcare

If you have any questions regarding balance billing a member, please contact your provider advocate.



If you do not know whom your provider advocate is, please send an email to Nebraska_PR_Team@uhc.com with your question. A provider advocate will get back with you.

Subrogation and Coordination

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

1. **Subrogation** – We reserve the legal right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness.
2. **COB** – Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations.

UnitedHealthcare Community Plan is considered the payer of last resort. Providers should identify and verify any other insurance coverage for the member. Other coverage that is identified should be billed as the primary carrier. When billing

UnitedHealthcare as the final payee, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Billing Members

Please be aware you must not balance-bill members for any of the following reasons:

- If there is a difference between the charge amount and the UnitedHealthcare fee schedule.
- If a claim has been denied for late submission, unauthorized service, or as not medically necessary.
- If a member requests a service that is not covered by UnitedHealthcare Community Plan.

Chapter 14: Care Provider Claim Disputes, Appeals and Grievances

Appeals and Grievances Definitions

Grievance

Grievance is a written or verbal expression of dissatisfaction about any matter other than an action. A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.

The member may file a grievance by calling UnitedHealthcare Community Plan at **800-641-1902, 711** (TTY for the hearing impaired), OR

Writing to:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

We will try to get an answer in 15 working days. If that is not possible, an answer should be received no longer than 90 calendar days from the date the complaint/grievance was filed.

Appeals

You play an integral role in the appeal process for UnitedHealthcare Community Plan members. This includes you acting on the member's behalf with written consent, and providing medical records and certification of the emergent nature of appeals as appropriate.

Appeal is a request for review of an action.

Action is when the plan:

- Makes an adverse determination or limits authorization of requested service(s) including the type or level of service;
- Reduces, suspends or terminates a previously authorized service;
- Refuses or denies, in whole or part, payment for services;
- Fails to provide services in a timely manner, as defined by the state or CMS; or
- Fails to act within the time frames required by state or CMS.

CMS allows UnitedHealthcare Community Plan members the right to appeal any decision regarding provision of services or claim payment whether the decision is made by UnitedHealthcare Community Plan or you. Whenever you deny a service, you are obligated, under CMS's requirements, to provide that patient with his or her UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Appeal the decision by calling or writing to the Customer Service Center within 90 calendar days of the notice of action.

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

800-641-1902 (toll-free)

TTY: 711 for the hearing impaired

(available 7:00 a.m. to 7:00 p.m. CT and 6:00 a.m. to 6:00 p.m. MT Monday through Friday.)

- Member has the right to present the Appeal in person Monday through Friday, 8:00 a.m. to 5:00 p.m. CT at:

UnitedHealthcare Community Plan
2717 N. 118th Street Suite #300
Omaha, NE 68164

- Receive a copy of the rule used to make the decision
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help with the appeal. The member has the right to present evidence, and allegations of fact or law, in person as well as 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 enrollee or representative may review the case file, including medical records and any other documents or records, before and during the appeal process.
- Send written comments or documents to be considered in deciding the appeal.

- Ask for an expedited appeal if waiting for this health service would increase the risk to the patient's health. The member or care provider has limited time (72 hours) to represent evidence and allegations of fact or law, in person and in writing.
- Ask for continuation of services during the appeal. However, the patient may be required to pay for the Health service if the service is continued and it is decided that the patient should not have received the service.
- Time frame that the health plan has to resolve standard appeal is 45 calendar days from the day the Health Plan receives the appeal.
- Time frame that the health plan has to resolve an expedited appeal is 72 hours from the day the Health Plan receives the appeal. The Health Plan may extend the expedited appeal response up to 14 calendar days if any other below conditions apply:
 1. Member request
 2. The Health plan shows to the satisfaction of DHHS upon its request that there is need for additional information and how the delay is in the enrollee's interest.

- The patient may have someone else such as a family member, friend, healthcare provider, or lawyer attend with them.

Note: A member or member representative may request a State Fair Hearing only after receiving notice the health plan is upholding the adverse benefit determination.

You have the same appeal rights as members.

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

Claims Administrative Appeals (Claim Reconsiderations)

Claims administrative appeals (claim reconsiderations) are appeals of any payment decision made after the health care service was rendered. Some of the common reasons for claims administrative appeals include, but are not limited to, disputes concerning the following reasons:

- Failure to obtain required prior notification
- Untimely submission of claim
- Reimbursement disputes

Claims administrative appeals may be made for claims that are:

- Denied in entirety
- Denied in part
- Paid at a rate alleged to be inconsistent with contracted rates

Claims administrative appeals must be filed within the time frames specified in your contract. **Failure to file a claims administrative appeal within the required time frame shall be a waiver of your right to appeal in this or any other forum.** You acknowledge it will not be paid for any services provided to UnitedHealthcare members regardless of the merits of the underlying claim if no appeal is filed in a timely manner. Any decision by UnitedHealthcare will be final and binding and not subject to arbitration or any adjudication in a court of law or other administrative, executive or judicial proceeding if you fail to appeal the decision.

State Fair Hearings

State Fair Hearing is a request by a member or physician to appeal a decision made by the health plan, addressed to the state.

The member or his/her 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. Write to the state within 90 calendar days from the appeal decision notice at:

**Department of Health and Human Services
Legal Services – Hearing Section
P.O. Box 98914
Lincoln, NE 68509-8914**

- The patient can call UnitedHealthcare Community Plan Customer Service for assistance in writing the letter as necessary
- The patient may call the NE DHHS MLTC Legal Services at **402-471-7237**.

Non-Par Providers: Claims must be received within 365 days of the date services were rendered.

To file a claims administrative appeal (claim reconsideration), you should send a written appeal via regular mail to:

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

The cover letter should state that a claims administrative appeal is being made. Several claims with the same reasons for appeal may be combined in a single appeal letter, with an attached list of claims.

State the specific reason for denial as stated on the remittance. UnitedHealthcare does not accept appeals that fail to address the reason for the denial as stated on the remittance.

For appeals of payment rates, state the basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules

Claims Adjustment

If you believe you were underpaid by UnitedHealthcare, you can simplify the submission of requests for claim adjustments and receive more efficient resolution of claim issues by using [UnitedHealthcareOnline.com](https://www.uhc.com).



You can submit the claim for review by completing the Claim Reconsideration Form found on [UnitedHealthcareOnline.com](https://www.uhc.com) > Tools & Resources > Forms > Claim Section > Paper Claim Reconsideration Form. Or you can call the Provider Service Center at **866-331-2243** to request an adjustment.

If you identify a claim where you were overpaid or if we identify an overpaid claim that you do not dispute, you must send us the overpayment within the time frames 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.

All overpayments received from us or credit balances existing on your records should be sent to:

**UnitedHealthcare Community Plan
P.O. Box 740804
Atlanta, GA 30374-0800**

Please include appropriate documentation that outlines the overpayment including patient ID and number, date of service and amount paid.

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 or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see Claim Administrative Appeals).

Claims Adjustment Appeals

If you disagree with a claim payment adjustment, send a letter of appeal to the claim office identified on the back of the member's ID card or call the Provider Services number listed on the EOB, Provider Remittance Advice (PRA) or member's ID card. Your appeal must be submitted to us within 12 months from the date of payment shown on the EOB or PRA.

If you are appealing a claim that was denied because filing was not timely, for:

1. **Electronic claims** – include confirmation that UnitedHealthcare or one of its affiliates received an accepted your claim.
2. **Paper claims** – include a copy of a screen print from your accounting software to show the date you submitted the claim.

If you disagree with an overpayment refund request, send a letter of appeal to the address noted on the refund request letter. Your appeal must be received within 30 days of the refund request letter in order to allow sufficient time for processing the appeal and avoid possible offset of the overpayment against future claim payments to you. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe the refund request is in error.

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

Chapter 15: Fraud, Waste and Abuse

UnitedHealthcare's Anti-Fraud, Waste and Abuse Program focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and plan members.



A toll-free Fraud, Waste and Abuse Hotline has been set up at **800-455-4521** to facilitate reporting of any questionable incidents involving plan members or care providers.

The mission of the Anti-Fraud, Waste, and Abuse Program is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money UnitedHealthcare has paid for such claims. UnitedHealthcare will also appropriately refer suspected fraud, waste and abuse cases to law enforcement, regulatory, and administrative agencies pursuant to state and federal law. UnitedHealthcare seeks to protect the ethical and fiscal integrity of the company and its employees, members, care providers, government programs, and the public, as well as safeguard the health and well-being of its members.

UnitedHealthcare incorporates applicable federal and state regulatory requirements in to its Anti-Fraud, Waste and Abuse Program. UnitedHealthcare recognizes that state and federal health plans are particularly vulnerable to fraud, waste and abuse and strives to tailor its efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

Whether contracted or non-contracted, you must make available to the Medicaid Fraud and Patient Abuse Unit (MFP AU), on request or as required by UnitedHealthcare Community Plan contract with the division of Medicaid and Long Term Care, or State or Federal law, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

Suspected instances of fraud, waste and abuse are thoroughly investigated. In appropriate cases, the matter is reported to law enforcement and/or regulatory authorities, in accordance with federal and state requirements. UnitedHealthcare cooperates with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse. An important aspect of the Compliance Program is assessing high-risk areas of UnitedHealthcare's operations and implementing periodic reviews and audits to ensure compliance with law, regulations, and contracts. Care providers are contractually obligated to cooperate with the company and government authorities. The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are

aimed at reducing fraud within the health care programs funded by the federal government. Under Section 6032 of the DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted provider with UnitedHealthcare, you and your staff are subject to these provisions.



The UnitedHealth Group policy, titled "Integrity of Claims, Reports and Representations to Government Entities," can be found at UHCommunityPlan.com, located in the Provider Information tab.

This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

Chapter 16: Care Provider Communications & Outreach

The UnitedHealthcare care provider education and training program is built on years of experience with care providers and state managed care program and includes the following care provider components:

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

Care Provider Website

UnitedHealthcare promotes the use of Web-based functionality among its care provider population. UnitedHealthcare's Web-based care provider portal (UHCCommunityPlan.com) facilitates administrative functions. Our interactive website enables care providers to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare has implemented an internet based prior authorization system on UHCCommunityPlan.com, which allows you to request a medical and advanced outpatient imaging procedures online rather than telephonically. The UnitedHealthcare website also contains an online version of the provider manual, access to the Nebraska Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, electronic data interchange, quality and utilization requirements and educational materials such as newsletters, bulletins and other care provider information.

A website is also available to members including access to the Member Handbook, newsletters, provider search tool and other important plan information UHCCommunityPlan.com.

Care Provider Office Visits

Provider advocates visit primary care providers (PCP), specialist and ancillary provider offices on a regular basis. Each provider advocate is assigned to a geographic territory to deliver face-to-face support to our care providers across the state. The prioritization and quantity of care provider office visits by staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography, and other special needs. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and minimize health care disparities.

Care Provider Newsletters and Bulletins

UnitedHealthcare produces and distributes a care provider newsletter to the Nebraska network three times a year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance. The newsletters also include notifications regarding changes in laws and regulations. UnitedHealthcare uses electronic bulletins, posted on the UHCCommunityPlan.com website, to rapidly disseminate urgent information that impacts the entire network.

Care Provider Manual

UnitedHealthcare publishes this guide online, which includes an overview of the program, toll free number to our care provider services hotline, a removable quick reference guide, and a list of additional care provider resources. If you do not have Internet access, you may request a hard copy of this guide by contacting Provider Services.

Care Provider Marketing Guidelines

The Nebraska Health Plan will fully comply with the care provider marketing guidelines requirements :

- When conducting any form of marketing in a care provider's office, UnitedHealthcare of the Midlands, Inc., must obtain and keep on file the written consent of the care provider.
- The health plan shall not require its care providers to distribute health plan-prepared marketing communications to their patients.
- The health plan shall not provide incentives or giveaways to care providers to distribute them to health plan members or potential health plan members.
- The health plan shall not allow care providers to solicit enrollment or disenrollment in a health plan, or distribute health plan-specific materials at a marketing activity.
- The health plan shall not provide printed materials to care providers with instructions detailing how to change health plans to members of other health plans.
- The health plan must instruct participating care providers regarding the following communication requirements:

- Participating care providers who wish to let their patients know of their affiliation with one or more health plans must list each health plan with whom they contract.
- Participating care providers may display or distribute health education materials for all contracted health plans or they may choose not to display and distribute for any contracted health plan. Health education materials must adhere to the following guidelines:
 - Health education posters cannot be larger than 16 x 24 inches.
 - Children’s books, donated by health plan, must be in common areas.
 - Materials may include the health plan’s name, logo, telephone number and website address.
 - Care providers are not required to distribute and/or display all health education materials provided by each health plan with whom they contract. Care providers can choose which items to display as long as they distribute items from each contracted health plan and that the distribution and quantity of items displayed are equitable.
- Care providers may display marketing materials for Managed Care Organizations (MCOs) provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all health plans with whom/which the provider has a contract.
- Care providers may display health plan participation stickers, but if they do they must display stickers for all contracted health plans or choose not to display stickers for any contracted health plans.
- Health plan stickers indicating that the care provider participates 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”.
- Care providers may inform their patients of the benefits, services and specialty care services offered through the health plans in which they participate. However, care providers 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.
- On actual termination of a contract with the health plan, a care provider who/that has contracts with other health plans may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Care providers must continue to see current patients enrolled in the health plan through the termination date, according to all terms and conditions specified between the care provider and the health plan.
- The health plan must not produce branded materials instructing members about how to change to a different health plan. They must use MLTC-provided or approved materials and refer members directly to the enrollment broker for needed assistance.

Chapter 17: Care Provider Forms Appendix

NE DHHS MLTC forms are not on UHCommunityPlan.com.

You can locate these forms on the State's website at dhhs.ne.gov/medicaid/Pages/med_phosp.aspx

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form

Client Name _____
Medicaid ID # _____

STERILIZATION CONSENT FORM (Tubal Ligation and Vasectomy)



NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ The discomforts, risks and benefits asso-

ciated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services System or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Client Signature _____ Date (Month/Day/Year) _____

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- American Indian or Alaska Native Black (not of Hispanic origin)
- Asian or Pacific Islander Hispanic
- White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature _____ Date (Month/Day/Year) _____

Nebraska Health and Human Services System
Department of Finance and Support
c/o Hospital Unit
P.O. Box 95026
Lincoln, Nebraska 68509-5026
(402) 471-3121

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the consent form, I explained to him/her the nature of the sterilization operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent _____ Date (Month/Day/Year) _____

Facility _____

Address _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____

on _____ I explained to him/her the nature of the sterilization operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery:
- Individual's expected delivery date _____ (Month/Day/Year)

Emergency abdominal surgery:
(Describe Circumstances): _____

Physician's Signature _____ Date (Month/Day/Year) _____

Distribution of Copies: WHITE - Physician, Mail to Nebraska Health and Human Services System Department of Finance and Support; YELLOW - Client.



MMS-100 Rev. 6/98 (14001)
(Previous version 4/97 should be used first)

Informed Consent for Hysterectomy

Nebraska Health and Human Services System



Prior to submitting to a hysterectomy, (surgical removal of my uterus), I have been informed that this surgical procedure will result in permanent sterility and I will be incapable of reproducing children.

Sign Here

(Patient)

(Date)

(Patient's Medicaid I.D. Number)

Sign Here

(Witness)

(Date)

One copy of this completed form must be submitted by the physician performing the hysterectomy to Nebraska Health and Human Services Finance and Support, c/o Hospital Claims Payment Unit, P.O. Box 95026, Lincoln, Nebraska 68509-5026. This form should be completed prior to surgery.

DISTRIBUTION: WHITE - Claim Form Copy; YELLOW - Client



MMS-101 Rev 9/97 (02001)
(Previous version 10/96 should be used first)

Chapter 18: Glossary

AABD

Assistance to the Aged, Blind, and Disabled

Action

The denial or limited authorization of a requested service, including the type, level or service care provider reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care

Care provided to persons sufficiently ill or disabled requiring

1. Constant availability of medical supervision by attending care provider or other medical staff
2. Constant availability of licensed nursing personnel
3. 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

Ambulatory Care

Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term “ambulatory care” usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility

A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Care Provider Services

Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, pharmacy and physical therapy.

Appeal

An oral or written request by a member or member’s personal representative received by UnitedHealthcare Community Plan for review of an action.

Authorization

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

Auto Assignment

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

Centers for Medicare & Medicaid Services (CMS)

A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

CHIP

Children’s Health Insurance Program is Kids Connection.

Clean Claim

A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

CMS

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

Contracted Health Professionals

Refers to those primary care providers, physician specialists, medical facilities, allied health professionals and ancillary service care providers under contract with UnitedHealthcare who provide specific covered services to members, and represent those individuals and entities to be used through the UnitedHealthcare prior authorization and referral policies and procedures.

Covered Services

Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing

The verification of applicable licenses, certifications, an experience to assure the care provider status is extended only to professional, competent care providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.

Current Procedural Terminology (CPT) Codes

American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Delivery System

The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, care provider offices, pharmacies and home health care.

Disallow Amt

Medical charges for which the network care provider is not permitted to receive payment from the health plan and cannot bill the member. Examples are:

- the difference between billed charges and contracted rates; and
- charges for services that are bundled or unbundled as detected by Correct Coding Initiative edits.

Discharge Planning

Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Disenrollment

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

Durable Medical Equipment (DME)

Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a care provider.

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). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Electronic Data Interchange (EDI)

The electronic exchange of information between two or more organizations.

Emergency Care

The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Expedited Appeal

An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to

severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

FQHC

FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (i) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (ii) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (iii) is determined by the Secretary of DHHS to meet the requirements for receiving such a grant (look-alike) based on the recommendation of HRSA within PHS; or, (iv) was treated by the Secretary of the Department of Health and Human Services (DHHS) as a Federally Funded Health Center (FFHC) for purposes of Part B Medicare as of January 1, 1990.

Grievance

An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan. Health Plan Employer Data and Information Set (HEDIS) Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA

Health Insurance Portability and Accountability Act

Home Health Care (Home Health Services)

Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

KB

Katie Beckett – a program that provides home health nursing and other medical services to children under 18 years old who otherwise would be hospitalized because of their high level of health care needs.

Medicaid

The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Medically Necessary

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

- Medically appropriate
- Necessary to meet the basic health needs of the member;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
- Consistent with the diagnosis of the condition;
- Required for means other than convenience of the client or his or her care provider;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- Of demonstrated value
- No more intense level of service than can be safely provided.

Member

Refers to an individual who has been determined UnitedHealthcare Community Plan eligible and enrolled with UnitedHealthcare Community Plan to receive services pursuant to the Agreement.

NCQA

National Committee for Quality Assurance

Out-Of-Area Care

Care received by a UnitedHealthcare enrollee 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.

Preventative Health Care

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

Primary Care Provider (PCP)

A care provider, such as a family practitioner, pediatrician, internist, general practitioner, physician assistants (under the supervision of a care provider), advanced registered nurse practitioner or obstetrician who serves as a gatekeeper for their assigned members' care.

Prior Authorization (Notification)

A unit under the direction of the UnitedHealthcare Health Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare policy.

Provider Group

A partnership, association, corporation, or other group of care providers.

Quality Improvement Program (QIP)

A formal set of activities provided to assure 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 used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of 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 are entitled to receive enhanced payments for services provided to enrolled members.

Service Area

A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by NE DHHS MLTC.

Specialist

A care provider duly licensed in the State of Nebraska and has completed a residency or fellowship in his or her specialty and has been approved to sit for the board examination for the specialty.

State Fair Hearing

An administrative hearing requested if the member, member's authorized representative, or care provider does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Appeals and Claim Dispute Department. A State Fair Hearing cannot be requested until after a notice of appeal resolution is received.

TANF

Temporary Assistance to Needy Families.

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 will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title XIX

Section of Social Security Act which describes the Medicaid program coverage for eligible persons.

Utilization Management (UM)

The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.