2026 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

UnitedHealthcare Community Plan of Kentucky

Doc#: PMG 20251205-142455

United Healthcare® Community Plan

Welcome

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

Click to access different care provider manuals

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**

View the **Medicaid glossary** for definitions of terms commonly used throughout the care provider manuals.

If you have questions about the information or material in this manual, or about our policies, please call UnitedHealthcare **Provider Services** at **1-866-633-4449**.

Important information about the use of this manual

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

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

This manual will be amended as policies change.

Participation agreement

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "provider" refers to any health care professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide
- "Community Plan" refers to the UnitedHealthcare Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to "ID card" includes both a physical or digital card

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-866-633-4449**
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	
UnitedHealthcare Provider Portal support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	
UnitedHealthcare KY Community and State	**UHCprovider.com/kycommunityplan**	
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
Resource library	**UHCprovider.com/resourcelibrary**	

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

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Categorically needy – blind and disabled children and adults who are not eligible for Medicare
- 19–64 years old who are not eligible for another type of Medicaid and who have an income of less than 138% of the federal poverty level
- Medicaid-eligible families

Department of Medicaid Services (DMS) will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-866-633-4449**.

How to join our network

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

For additional questions, you can contact **Provider Services** at **1-866-633-4449** or chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation**.

Approach to health care

Care Model

The Care Model helps to empower UnitedHealthcare Community Plan of Kentucky members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes targeting Kentucky members with complex medical, behavioral and social needs and multiple chronic health conditions. The program helps address their needs holistically. The Care Model examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

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

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plan(s). You may view care plans and assessments from the **Community Care Provider Portal,** if members are enrolled in this program.
  - To view care plans and assessments, go to **UHCprovider.com** > click on UnitedHealthcare Provider Portal > go to the Community Care Provider Portal > and select the Population Health module
  - Our case managers will outreach to you once we engage a member. The manager will introduce themselves and ask you to participate in the member care planning.
- Assistance with appointments with PCP and coordinating appointments. The Community Health Worker (CHW) refers members to a Registered Nurse (RN), Behavioral Health Advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The goals of the Care Model are to:

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

To refer your patient who is a UnitedHealthcare Community Plan member to the care management program, call **Member Services** at **1-866-293-1796**, TTY **711**. You may also call **Provider Services** at **1-866-633-4449**.

Cultural resources

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

UnitedHealthcare Community Plan offers the following support services:

- **Cultural competency training and education**
  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.
- **Translation/interpretation/auxiliary aide and services**
  You must provide language services and auxiliary aide and services, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

  If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

  Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

  Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

  If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to the Virtual Visit.
- **Care for members who are deaf or hard of hearing**
  You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.
- **Language Interpretation Line**
  - We provide interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** TTY **711**
- **I Speak language assistance card**
  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members
- **Materials for limited English-speaking members**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Clinical Guidelines are approved by DMS prior to implementation.

UnitedHealthcare Community Plan uses InterQual Care Guidelines, American Society of Addictive Medicine, CMS or other nationally recognized guidelines for medical care and behavioral health determinations.

If InterQual guidelines are silent on a service requested, then UnitedHealthcare clinical guidelines will allow for appropriate clinical guidance and clinical decision determination.

Online resources

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

Application Programming Interface

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer. This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

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

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

This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

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

Getting started

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

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

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist ™ integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca.**

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling. See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access.

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

Here are the most frequently used portal tools:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility.**
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims.**
- **Prior authorizations and notifications** – Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile** – View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mpp**.
- **Document Library** – Access correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to **UHCprovider.com/documentlibrary**.

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

Direct Connect

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

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

All users will access Direct Connect using the UnitedHealthcare Provider Portal.

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

Privileges

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

Provider Services

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

Provider Services at **1-866-633-4449** can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

How to contact us

*We no longer use fax numbers.

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum **providerexpress.com** **1-866-633-4449**	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-866-633-4449**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	We provide members older than 21 with up to 26 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the UnitedHealthcare Provider Portal at **UHCprovider.com/claims** **1-866-633-4449** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal **1-866-633-4449** Mailing address: **UnitedHealthcare Insurance Company** P.O. Box 101760 Atlanta, GA 30392-1760	Ask about claim overpayments.
Clinical care model	Provider Services **1-866-633-4449**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.

Topic	Contact	Information
Dental	**uhcdental.com** **1-877-897-4941**	Find statements, claims and additional information.
Electronic Data Intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	To access eligibility information, go to **UHCprovider.com** then Sign In to the UnitedHealthcare Provider Portal or go to **UHCprovider.com/eligibility.** **1-866-633-4449**	Confirm member eligibility.
Enterprise Voice Portal	**1-866-633-4449**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment integrity information: **UnitedHealthcare Community Plan of Kentucky Homepage** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Hearing services	Call Provider Services at **1-866-633-4449**	Benefit coverage available with no age restriction. Limit is $1,200 per ear every 36 months.
Laboratory services	**UHCprovider.com** > Our Network > **Preferred Lab Network**	The Preferred Lab Network webpage provides a full listing of eligible labs.
Medicaid (Department of Medicaid Services)	chfs.ky.gov/agencies/dms 1-502-564-4321	Contact Kentucky Department of Medicaid Services (DMS) directly.
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** Most care providers in your state must submit reconsideration/appeal requests electronically. For further information on reconsiderations and appeals, see the **Reconsiderations and Appeals interactive guide.**	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.

Topic	Contact	Information
Member services	Benefits: **myuhc.com®** **1-866-293-1796** for members **1-877-542-9239**, TTY **711** for help accessing member account KY Health Plan: **UHCCommunityPlan.com/ky**	Assist members with issues or concerns. Available 7 a.m.–7 p.m. ET, Monday–Friday. Go to the Kentucky health plan website to enroll for benefits or see the member view of benefits.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov **1-800-465-3203**	Apply for a National Provider Identifier (NPI).
Network management support	**1-866-633-4449** Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.
NurseLine	**1-800-985-3856**	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care	Healthy First Steps **1-800-599-5985** **uhchealthyfirststeps.com** Pregnancy Notification Form at **UHCprovider.com**, then the UnitedHealthcare Provider Portal	Complete the appropriate forms and refer all pregnant members to Healthy First Steps.
Oncology prior authorization	**UHCprovider.com/oncology** Optum **1-888-397-8129** Monday–Friday 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat with a live advocate 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**. **1-855-819-5909**	Contact if you have issues with your ID. Available 8 a.m.–10 p.m. ET, Monday–Friday; 7 a.m.–7 p.m. ET, Saturday; and 10 a.m.–7 p.m. ET, Sunday.
Pharmacy services	pharmacy.medimpact.com 1-800-210-7628 (MedImpact)	MedImpact oversees and manages the pharmacy network. Available 24 hours a day, 7 days a week.
Prior authorization/ notification for pharmacy	All prior authorizations will be managed by MedImpact. 1-844-336-2676	Request authorization for medications as required. Available 8 a.m.-7 p.m. ET, 7 days a week. You can also submit your request online through Cover My Meds, Surescripts or CenterX ePA portals.

Topic	Contact	Information
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/priorauth** Provider Services: **1-866-633-4449** Note: Including all medically billed drug (Jcode) PA requests	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status. Information and advance notification / prior authorization lists: **UHCprovider.com/kycommunityplan** > **Prior Authorization and Notification**
Provider Services	**UHCprovider.com/kycommunityplan** **1-866-633-4449**	Available 8 a.m.–6 p.m. ET, Monday–Friday, including Federal holidays
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	**UHCprovider.com/referrals** A formal documented referral is not necessary or needed for submission or verification. Provider Services **1-866-633-4449**	A PCP refers the member to an in-network care provider for specialty service or when medically necessary. **Referrals are not required in Kentucky**.
Reimbursement policy	**UHCprovider.com/kycommunityplan** > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus.** **1-866-209-9320** for Optum support	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	Non-emergent transportation: 1-800-635-2570 1-888-941-7433 If you need assistance with a ride or changes to the reservation, call Ride Assist at 1-866-918-8997. Non-emergent stretcher and ambulance: Kaizen Health at 1-888-259-4773	To arrange non-emergent stretcher transportation, please contact Kaizen Health at least 3 business days in advance. All other types of non-emergent transportation, contact the Kentucky Office of Transportation Delivery.

Topic	Contact	Information
Utilization management	Provider Services **1-866-633-4449**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com** > Resources > **Health Plans, Policies, Protocols and Guides**. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	chfs.ky.gov 1-800-219-3224	UnitedHealthcare Community Plan of Kentucky, with the Department of Medicaid Services, encourages and coordinates the enrollment of primary care providers in the Department for Public Health and the Department for Medicaid Services Vaccines for Children Program.
Vision services MARCH Vision Care	Reference guides: marchvisioncare.com > Provider Reference Guides Contact information: eyesynergy.com MARCH Vision Care 1-844-516-2724	Contact MARCH Vision Care's provider relations department for information on benefits, lab order submissions, and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers, and federal tax identification numbers. Attend a training session on eyeSynergy®. The web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
Website for Kentucky Community Plan	**UHCprovider.com/kycommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-866-633-4449**
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	
Provider Directory	**UHCprovider.com/findprovider**	

General care provider responsibilities

Nondiscrimination

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

Communication between care providers and members

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

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

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

Provide official notice

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

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

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. **Provider Services** at **1-866-633-4449** is available to help you and our members with the transition.

Arrange substitute coverage

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

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

You can update your practice information through the UnitedHealthcare Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- For general provider assistance, connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**

After-hours care

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

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

UHCprovider.com/findprovider

Participate in quality initiatives

Your contract states you must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

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

Provide access to your records

Your contract states you must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement.

Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

View protocols at **UHCprovider.com**.

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations.

In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

Please reference **Chapter 9** for Medical Record Standards.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before an incapacitating illness or injury through an advance directive. Under the PSDA, providers must give adult members written information at the time of admission, initial receipt of care, or enrollment about:

- State laws regarding advance treatment directives
- Members' rights to accept or refuse medical treatment
- The provider's own policies on advance directives

To comply with this requirement, we inform members of Kentucky state laws on advance directives through member handbooks and other communications provided at enrollment and during the initial care process.

Value based payments

UnitedHealthcare Community Plan of Kentucky will use a Value Based Payment (VBP) model. Value-based care is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards you for both efficiency and effectiveness. This is an alternative to fee-for-service reimbursement, which pays you retrospectively for services delivered based on billed charges or annual fee schedules.

Value-based care models center on patient outcomes and specific measures of quality of care, such as reducing hospital readmissions, using certified health IT and improving preventative care. Value-based reimbursements are calculated by using numerous measures of quality and determining the overall health of populations.

Unlike the traditional model, the VBP model is driven by data because you must report to payers on specific metrics and demonstrate improvement. When patients receive more coordinated, appropriate and effective care, you are rewarded.

Your Agreement

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

After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the member handbook at **UHCCommunityPlan.com/ky** > Medicaid > **View Plan Details**.

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

Care provider rights

You have the right to:

- Review, upon request, information submitted to support your credentialing application to the UnitedHealthcare Community Plan Credentialing department. We keep all submitted information secured and confidential. Access to electronic credentialing information is password-protected and limited to staff requiring access for business purposes.
- Correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department before presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, you are notified and given the opportunity to correct information before presentation to the Credentialing committee.
- Be informed of their credentialing or recredentialing application status on written request to the Credentialing department

Appointment standards (Kentucky Department of Medicaid Services access and appointment availability standards)

Comply with the following KY Department of Medicaid Services (DMS) access and appointment availability standards:

Primary care

PCPs should arrange appointments for:

- Routine and preventive services, not to exceed 30 days from date of enrollee's request
- Urgent care services, available and accessible within 48 hours of request
- Emergency medical and behavioral health services, available and accessible to enrollees 24 hours a day, 7 days a week
- Both adults and pediatrics
- General and pediatric dental services
- General vision services
- Laboratory and radiology services

Specialty care

Specialists are designated by DMS to meet the specific needs of enrollees 21 years of age and older. Pediatric specialists meet the needs of enrollees under age 21. Specialists should arrange appointments for routine appointments within 30 days of request/referral and within 48 hours for urgent care needs.

A written referral is not necessary; however, when medically necessary, the PCP refers the member to in-network care providers for specialty services and when care is beyond their scope of practice.

Emergency care

Emergency medical and behavioral health services should be made available and accessible to members 24 hours a day, 7 days a week.

Provider Directory

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

To report an inaccuracy in the directory, please visit **UHCprovider.com** > Our Network > **Demographics and Profiles**.

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

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

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

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

To help ensure we have your most current information:

- Delegated care providers – submit changes to your designated submission pathway
- Nondelegated care providers – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider**.

Provider attestation

Confirm your provider data every quarter through our UnitedHealthcare Provider Portal at **UHCprovider.com** or by calling **Provider Services** at **1-866-633-4449**. If you have received the upgraded My Practice Profile and have editing rights, access the My Practice Profile in the UnitedHealthcare Provider Portal to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

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

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

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

- Verify eligibility using the UnitedHealthcare Provider Portal at **UHCprovider.com/eligibility** or by calling **Provider Services** at **1-866-633-4449**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.

- Get prior authorization:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then click Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.
  4. Check **clinical and/or reimbursement policies**, if applicable.
- Identify and bill other insurance carriers when appropriate.

If you have questions about the UnitedHealthcare Provider Portal, for chat options and contact information, visit **UHCprovider.com/contactus**, 8 a.m.–10 p.m. ET, Monday–Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- **Urgent** – 24 hours
- **Nonurgent** – 10 business days

Definition of a primary care provider

Primary care provider (PCP) means a licensed or certified health care practitioner that functions within the provider's scope of licensure or certification, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner [NP], nurse midwife and clinical specialist), physician assistant [PA], or health clinic (including a federally qualified health center [FQHC], FQHC look-alike). There is a referral agreement with a care provider who has admitting privileges. The care provider agrees to offer 24 hours a day, 7 days a week primary health care services to members, which includes patients who have gynecological or obstetrical health care needs, disability or chronic illness. A PCP can also be a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

PCP means primary care physician/practitioner and always includes:

- Family practice
- Geriatrics
- Internal medicine
- Pediatric general practice
- General practice physicians

Requirements for primary care provider and specialists serving in primary care provider role

Specialists include internal medicine, pediatrics or obstetrics/gynecology

The Kentucky DMS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

Medical doctors (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and physician assistants (P.A.s) from any of the following practice areas can be PCPs:

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

N.P.s may enroll with the state as solo care providers, but P.A.s cannot. P.A.s must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at **1-866-293-1796** at any time during the month. Customer service is available 7 a.m.–7 p.m., Monday–Friday.

UnitedHealthcare Community Plan will auto-assign a PCP to a member who does not select a PCP during enrollment.

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week.

During non-office hours, access must be available through either an after-hours answering service that can contact the PCP or another designated medical practitioner for a return call, a recording directing the member to call another number to reach the PCP or a designated medical practitioner for a return call or a call transfer to another office location for a return call by the PCP or designated medical practitioner. For all acceptable methods of access, member calls must be returned within a maximum of 30 minutes by the PCP or designated medical practitioner.

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1 MD practice and at least 30 hours per week for a 2 or more MD practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members
- Recommend or arrange for all necessary preventive health care, including EPSDT, for persons younger than 21 years old

Responsibilities of primary care providers and specialists serving in primary care provider role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to **Provider Services** at **1-866-633-4449**, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate medical care during hospitalization.
- Refer a member to a behavioral health service provider if the desired treatment is out of scope for the PCP
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form

- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards
- Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments
- Provide copies of medical records to members upon request at no charge. Transfer medical records to new providers within 10 days of request and with a release of medical records signed by the member.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the Kentucky DMS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-866-633-4449**.
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic, federally qualified health clinic and primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic or FQHC as their PCP.

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

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.

- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the Kentucky DHHS Access and Availability standards for scheduling routine visits. Appointment standards are covered within this chapter.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week, or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Ancillary care provider responsibilities

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

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

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-866-633-4449**.
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

Interacting with capitated/ delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare ("capitated organization"). If your patient is assigned to one of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

Capitation is a payment model in which providers receive a fixed per-member, per-period payment, regardless of services rendered. Common capitated entities include Independent Practice Associations (IPAs), medical groups, and occasionally hospital systems or ancillary providers.

What is delegation?

Delegation is the transfer of authority to perform specific functions on our behalf.

We may delegate:

- Medical management
- Credentialing
- Utilization management
- Claims processing and payment
- Complex case management
- Other clinical and administrative functions

When responsibilities are delegated to a provider, they become a "delegated entity" or "delegate." UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other providers, but those agreements must follow UnitedHealthcare's product-specific regulations. To obtain and maintain delegation, providers must comply with our standards and best practices. Non-compliance may result in revocation of delegated responsibilities.

Capitated organizations are often also delegated entities, making them responsible for both delivering care and administering delegated functions, such as processing and paying claims for other providers.

What does it mean for you if you are not a capitated/delegated provider?

You may enter into direct agreements with capitated or delegated organizations. These agreements may differ from your Participation Agreement with UnitedHealthcare and should clearly define applicable protocols and procedures.

Key principles:

- **If you participate with both UnitedHealthcare and a capitated organization, and provide designated covered services to a capitated member:** The capitated organization is solely responsible for payment, based on your agreement with them.
- **If you participate with UnitedHealthcare but not with the capitated organization, and provide designated covered services to a capitated member:** The capitated organization remains solely responsible for payment. Reimbursement follows your UnitedHealthcare Participation Agreement.
- **If you participate with both UnitedHealthcare and a capitated organization, and provide services to a non-capitated member:** UnitedHealthcare (or the financially responsible entity) is solely responsible for payment, per your UnitedHealthcare Participation Agreement.

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/ky**	Check the number on the back of the member's ID card
Member handbook	**UHCCommunityPlan.com/ky** > Go to Plan Details, then Member Resources, View Available Resource	Go to Plan Details, then Member Resources, View Available Resources
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-866-633-4449**
Prior authorization	**UHCprovider.com/priorauth**	
D-SNP	**UHCprovider.com/ky** > Medicare > **Dual Complete Special Needs Plan**	**1-844-855-9774**

Click **UHCCommunityPlan.com/ky** > **Eligibility** to view a member's eligibility.

Member benefits

Website for members: **UHCCommunityPlan.com/ky**.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com** then Sign In. Each month, we monitor PCP panel sizes via PCP-to-member ratio reports. When a PCP's panel nears the max limit, we remove it from auto-assignment.

1. Go to **UHCprovider.com**.
2. Select Sign In on the top right.
3. Log in.
4. Select Clinical & Pharmacy tab.
5. Select UnitedHealthcare Community Care.

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

You may also use **Report Center** for member contact information in a PDF at the individual practitioner level.

View the **Report Center Interactive User Guide** to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the PCP assignment, the effective date will occur no later than the first day of the second month following the month of the request.

Copayments

Kentucky Medicaid members do not have copays for covered medical services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Covered services that are medically necessary as defined under 907 KAR 3:130. They meet national standards, if applicable, and are provided based on 42 C.F.R. § 440.230. They include children's services pursuant to 42 U.S.C.1396d(r).

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

Download a copy of the Member Handbook online at **UHCCommunityPlan.com/ky**. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

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

Get eligibility information by calling **Provider Services** at **1-866-633-4449**.

Unborn enrollment changes

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

Members may call Kentucky DMS at **1-502-564-4321**.

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

Primary care provider selection

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

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

Member eligibility

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

Member ID card

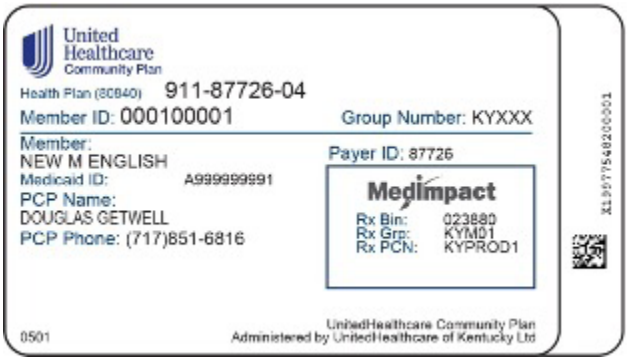
Check the member's ID card at each visit and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice. If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the Fraud, waste and abuse hotline

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-866-633-4449**. Also document the call in the member's chart.

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Kentucky DMS Medicaid number is also on the member ID card.

Sample health member ID card



Primary care provider-initiated transfers

Primary care providers (PCPs) can request a member's disenrollment and reassignment to a new PCP if there is an incompatibility in the PCP/patient relationship, if the member has not used any services within a year and the PCP has made at least 6 unsuccessful contact attempts, or if the PCP is unable to meet the medical needs of the member. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, call **Provider Services** at **1-866-633-4449**, or mail with specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   P.O. Box 5270
   Kingston, NY 12402-5270

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- UnitedHealthcare Provider Portal: access through **UHCprovider.com/eligibility**
- **Provider Services** at **1-866-633-4449** available from 7 a.m.–5 p.m. CT, Monday–Friday
- Kentucky Medicaid Management Information System (KYMMIS)

UnitedHealthcare Dual Complete

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

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

For Kentucky-specific D-SNP information, go to: **UHCprovider.com/en/health-plans-by-state/kentucky-health-plans/kymedicare-plans/ky-dual-complete-snp-plans.html.**

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-866-633-4449**
Prior authorization	**UHCprovider.com/priorauth**	**1-844-336-2676**
Pharmacy	**UHCprovider.com/pharmacy**	**1-800-210-7628**
Dental	**uhcproviders.com**	**1-877-897-4941**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

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

Ambulance services

Air ambulance

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

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

For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-866-633-4449**.

Emergency ambulance transportation

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

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

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

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

Non-emergent ambulance transportation

UnitedHealthcare Community Plan provides non-emergent stretcher/ambulance transportation services through Kaizen Health for covered services. Covered transportation includes stretcher ambulance services. Members may receive this level of transportation when:

- They are bed-confined before, during and after transport
- The member must be moved only by stretcher to receive medically necessary Medicaid-covered medical services
- Non-emergent stretcher/ambulance transportation must be requested at least 3 business days in advance

Schedule nonemergent ambulance or stretcher rides up to 30 days in advance.

Non-emergent stretcher/ambulance requests are accepted between 7 a.m.–7 p.m. ET, Monday–Friday.

Starting Jan. 1, 2024, for non-emergent ambulance services, ambulance providers must complete the Department for Medicaid Services (DMS)-approved Physician Certified Statement form, available on chfs.ky.gov, and attach it to the claim for complete reimbursement. If this is form is not present with the claim, then the payment may be denied.

Questions? Chat with a live advocate 7 a.m.–7 p.m. CT from the **UnitedHealthcare Provider Portal**. You can also contact UnitedHealthcare **Provider Services** at **1-866-633-4449**, TTY/RTT **711**, 7 a.m.–5 p.m. CT, Monday–Friday.

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) is a primary care referral may be required for transportation outside of a member's medical service area or for specialty care.

Requesting services

Non-emergency medical transportation services are available through the Kentucky Office of Transportation program, a regional brokerage system. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

To find your regional Kentucky Office of Transportation broker, click on the Human Service Transportation Delivery (HSTD) Brokerage Listing. For program policies and complaints, contact the Office of Transportation Delivery at 1-888-941-7433.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Echocardiograms
- Stress echocardiograms

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

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

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

Request prior authorization online or by phone:

- **Online** – **UHCprovider.com/cardiology** > Sign in
- **Phone** – **1-866-889-8054**, 7 a.m. - 7 p.m. local time, Monday–Friday

Make sure the medical record is available.

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

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

Durable medical equipment

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

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

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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

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

Emergency room care

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

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

Urgent care (nonemergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-866-633-4449**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal at **UHCprovider.com/portal**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-866-633-4449**.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting **Provider Services** at **1-866-633-4449**.

The criteria are available in writing upon request or by calling UnitedHealthcare **Provider Services** at **1-866-633-4449**. For policies and protocols, go to **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans**.

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

Facility admission notification requirements

Facilities are responsible for admission notification within 24 hours for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral.

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

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

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

Noncovered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  - Morning-after pill. Contact the state of Kentucky to verify state coverage.

Voluntary sterilization

In-network treatment with consent is covered. Before a member can get a tubal ligation or vasectomy, they first must give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent.

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DMS Regulations for more information on sterilization.

Find the sterilization consent form at chfs.ky.gov.

All information should be considered confidential. Adolescents need to be assured that family planning services are confidential and that any necessary follow-up will ensure privacy.

You may not restrict a member's choice of provider for family planning services. You must ensure access to any qualified provider of family planning services without requiring a referral from the PCP.

Care coordination/health education

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve members' quality of care, quality of life and health outcomes

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

If the member has specific conditions (e.g., history of preterm birth, hypertension, SUD/OUD, depression, co-morbidities, diabetes) they may qualify for care coordination.

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

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

Hearing services

Monaural and binaural hearing aids are covered, including ear molds, fitting, follow-up care, batteries and repair for members age 20 years or younger, not to exceed $800 per ear every 36 months.

Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered for members 20 years or younger. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger.

Hospice

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

Home hospice

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

Serious mental illness

UnitedHealthcare Community Plan of Kentucky Behavioral Health Case Management helps transition and coordinate care for members with serious mental illness (SMI) who are moving from licensed personal care homes, psychiatric hospitals or other institutional settings to integrated, community-based housing. This process begins once the Department of Behavioral Health and Intellectual Disabilities and/or Optum's Utilization Management team are notified about admissions to psychiatric hospitals. A case manager is assigned to these members and reach out to them within 3 days of notification to support coordination and continuity of care.

Community-based housing

Utilization Management and Complex Care Management program help support members transitioning to community-based housing. UnitedHealthcare Community Plan of Kentucky Behavioral Health Complex Case Management complete appropriate assessments (e.g., Adult and Pediatric Health Risk Assessments, Adult and Pediatric Enrollee Needs Assessments) to help ensure the successful transitions to community-based housing.

When Utilization Management notifies the case management team that a member is moving to community-based housing, the assigned case manager reviews the member's and develops a plan of care within 14 days. The case manager works with the provider agency to develop the person-centered recovery plan before helping the member identify areas of focus for services based on the person-centered recovery plan.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

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

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office.

Medically necessary laboratory services ordered by PCPs, other care providers or dentists in one of these laboratories do not require prior authorization except as noted on our prior authorization list. For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all care providers rendering clinical laboratory and certain other diagnostic services. See the **Billing and Submission** chapter for more information.

Maternity/pregnancy/well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Access the digital Notification of Pregnancy through our UnitedHealthcare Provider Portal at **UHCprovider.com**. You may also call Healthy First Steps at **1-800-599-5985**.

Healthy First Steps-Maternal care model

The Healthy First Steps (HFS)-Maternal care model strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care, such as WIC, SNAP and breastfeeding
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits

- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs

Program staff act as a liaison between members, care providers, and UnitedHealthcare for care coordination.

Pregnancy/maternity

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

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

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-866-633-4449** or go to or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/kycommunityplan** > **Prior Authorization and Notification**.

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

1. The member was in their second or third trimester of pregnancy when they became a UnitedHealthcare Community Plan member and
2. If she has an established relationship with a nonparticipating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for Caesarean section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/portal**, or by calling **1-866-633-4449**.

Provide the following information within 1 business day of the admission:

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

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

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

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

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

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

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

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

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. Post-discharge care is based on accepted maternal and neonatal physical assessments and consists of a minimum of 2 visits. At least 1 visit is in the home. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for postpartum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

A newborn infant whose mom is on Medicaid is automatically Medicaid eligible and enrolled for 60 days. The hospital should request newborn enrollment at the time of birth. The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). That information is used to auto enroll the newborn within 24 hours of birth.

UnitedHealthcare Community Plan is required to use the newborn's Medicaid ID for any costs associated with child.

Bright Futures assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics. It is supported by the U.S. DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines informs all preventive care screenings and well-child visits.

You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Settings for Bright Futures implementation include:

- Private practices
- Hospital-based or hospital-affiliated clinics
- Resident continuity clinics
- School-based health centers
- Public health clinics
- Community health centers
- Indian Health Service clinics
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

The discharge planner ordering home care should call **Provider Services** at **1-866-633-4449** to arrange for home care.

Hysterectomies

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

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

Find the form on the Kentucky Department of Medicaid Services website at chfs.ky.gov.

See "Sterilization consent form" section below for more information.

See the following "Sterilization consent form" section for more information. Exception: Kentucky DMS does not require informed consent if:

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

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

Pregnancy termination services

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

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

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment.

The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

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

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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

Find the consent form on the Kentucky Department of Medicaid Services website at chfs.ky.gov.

Have 3 copies of the consent form:

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

Neonatal intensive care unit case management

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

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

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

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy."

Oncology

Prior authorization

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

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

Pharmacy

Pharmacy preferred drug list

A single KY formulary and Preferred Drug List (PDL) managed by MedImpact cover all outpatient drugs, including over-the-counter (OTC) drugs. This list applies to all UnitedHealthcare Community Plan of Kentucky members.

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

If a member requires a nonpreferred medication, call MedImpact clinical prior authorization help desk at 1-844-336-2676 (available 8 a.m.- 7 p.m. ET, 7 days a week) or use the online Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal.

Pharmacy providers needing assistance or support to submit pharmacy claims to MedImpact on behalf of UnitedHealthcare Community Plan members of Kentucky can call MedImpact's Pharmacy Help Desk at 1-800-210-7628 (available 24/7). Pharmacy providers can find information for MedImpact at pharmacy.medimpact.com.

Pharmacy prior authorization

Pharmacies may dispense medications as an emergency 3 day supply when drug therapy must start right away and prior authorization isn't immediately available.

Follow these policies:

- Only one 3-day supply per member per drug may be dispensed
- For medications that can't be dispensed as an exact 3 day supply, such as metered-dose inhalers, nasal sprays, topical preparations and powders for reconstitution, dispense the minimum quantity as a 5 day supply.

To request pharmacy prior authorization, call MedImpact Clinical Call Center at 1-844-336-2676, fax 1-858-357-2612 or submit your request online through Cover My Meds, Surescripts or CenterX ePA portals. MedImpact will provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

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

Radiology

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

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

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

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

- Emergency room
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- **Online** – **UHCprovider.com/radiology** > Sign in
- **Phone** – **1-866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday. Make sure the medical record is available.

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

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (FDA)-approved medications for OUD include Buprenorphine, Methadone and Naltrexone.

To prescribe Buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services.

If you need help finding a behavioral health provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT provider in Kentucky:

1. Go to **UHCprovider.com/findprovider**.
2. Select the care provider information.
3. Click on "Medical Directory."
4. Click on "Medicaid Plans."
5. Click on applicable state.
6. Select applicable plan.
7. Refine the search by selecting "Medication Assisted Treatment."

If you have questions about MAT, please call **Provider Services** at **1-866-633-4449** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Tuberculosis screening and treatment; Direct Observation Therapy

Guidelines for Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

Responsibilities

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

Vision services are covered by March Vision Care. Please see the Reference Guide for information such as compliance, electronic payment information, safety resources and training or call 1-844-516-2724.

Waiver programs

UnitedHealthcare Community Plan of Kentucky does not participate in any of the Kentucky Medicaid Waiver programs. Members may be eligible for long-term care services provided by a nursing facility.

Other federal waiver programs

Members who are ventilator-dependent, have a brain injury, elderly or have a disability (physical, intellectual or developmentally disabled) may qualify for Home and Community Based Services (HCBS). This will allow members to live independently. The state of Kentucky administers the wavier programs. If a member is deemed eligible, we will continue to cover all medically necessary covered services for the member until the member is disenrolled from the Managed Medicaid Program and moved to fee for service.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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

Type of request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 2 business days of receiving the request	Within 2 business days of receiving the request We verbally notify you of approval.	Within 2 business days of the decision
Urgent/expedited pre-service	Within 24 hours of receiving the request	Within 24 hours of the request	As expeditiously as the member's health condition requires, and no later than within 2 business days of receiving the request
Concurrent review	Within 24 hours or next business day following	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 14 calendar days of receiving all pertinent clinical information May extend up to 14 days if the member or care provider requests an extension, and the contractor justifies in writing the need for additional information and how the extension is in the member's best interest.	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

For more information, go to the Kentucky prior authorization page: **UHCprovider.com/kycommunityplan** > Prior Authorization and Notification Resources.

For behavioral health and substance use disorder authorizations, please contact Optum at **1-866-633-4449**.

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities. We perform a record or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 24 hours or 1 business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses InterQual (formally MCG), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

The medical necessity changes to medical guidelines are updated 30 days prior to implementation and may be found in the medical policies and coverage determination guidelines at **UHCprovider.com/policies** > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan** and at **UHCprovider.com/policies** > **Clinical Guidelines**.

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. A written referral is not required when referring a member for medically necessary specialty services.

Please document the referral and medical reason in the patient's medical record. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **1-866-633-4449**.

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

Services not covered by Kentucky Medicaid program

The following services are not included in the Kentucky Medicaid program:

- Any laboratory service performed by a care provider without current certification based on the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual care providers of any laboratory service.
- Cosmetic procedures or services performed solely to improve appearance
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in vitro fertilization, etc.)
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Post mortem services
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature
- Sex transformation services
- Sterilization of a mentally incompetent or institutionalized member
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein
- Services the member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage

Services requiring prior authorization

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

Direct access services – Native Americans

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

Out-of-network services

Prior authorization is not required for emergent or urgent care. Out-of-network physicians, facilities and other health care providers must request prior authorization for all procedures and services, excluding emergent or urgent care.

Seek prior authorization within the following time frames

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

Utilization management guidelines

Call **1-866-633-4449** to discuss the guidelines and utilization management.

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

Utilization management appeals

Utilization management (UM) appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care or other health care services determination. They do not include benefit appeals, which are appeals for noncovered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

See Appeals in **Chapter 12** for more details.

Key contacts

Topic	Links	Phone number
EPSDT	chfs.ky.gov > Agencies > Department for Medicaid Services > Provider Information and Resources > EPSDT – Screenings	1-866-633-4449
Vaccines for Children	chfs.ky.gov	1-502-564-4478

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

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

For complete details about diagnoses codes as well as full and partial screening, examination and immunization requirements, go to the EPSDT schedule.

Developmental disability services and coordination with regional centers

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

Referral – If you determine supportive services would benefit the member, refer the member to the Community Support Branch for the Community Mental Health/ Intellectual Disabilities Center (CCHCN) regional office for approval and assignment of a regional office liaison.

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

First Steps program

The First Steps program is handled by the state of Kentucky. It provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families.

Referring a child: Refer a child to First Step services if the child has a visual, hearing, or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

How to refer: Contact your local Point of Entry (POE) team for evaluation and early intervention services. A list of POE is available at kyfirststeps.org. Or call the main office in Frankfort, KY at 1-502-564-3756 Option 1, or toll free 1-877-417-8377 or 1-877-41STEPS. Provide information requested by POE to complete the referral process.

Next steps: The POE team will evaluate to determine eligibility, then a service coordinator will be assigned to help the child's parents through the process. The assigned coordinator from First Steps, who is employed by the state, will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the Individualized Family Service Plan (IFSP). UnitedHealthcare Community Plan provides member case management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

- Complete history including physical and mental health development and assessment for substance abuse
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment and screening (Use the Childhood Lead Poisoning Verbal Risk Assessment Questionnaire.)
- Personal-social and language skills
- Nutrition assessment and BMI
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

Without all these components, you cannot bill for a full screen. You may only bill for a partial screen.

Interperiodic screens

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

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

Lead screening/treatment

The American Academy of Pediatrics recommends using the lead risk assessment starting at 6 months. For more information go to chfs.ky.gov.

Call **Provider Services** at **1-866-633-4449** if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Vaccines for Children

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

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

Contact VFC if you have questions.
Phone: 1-502-564-4478

Any child through 18 years of age who meets at least 1 of the following criteria is eligible for the VFC Program:

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured – these children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.

You are required to administer VFC immunizations to qualified Kentucky Medicaid eligible children who enroll in the VFC program. To enroll a child in the program, you may contact their Cabinet for Health and Family Services immunization program field staff representative for their area. A contact list of field staff representatives may be found at chfs.ky.gov.

Covered special services

UnitedHealthcare Community Plan covers the following medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures to all members younger than 21:

- Inpatient hospital services
- Outpatient services, rural health clinics and federally qualified health center services
- Other laboratory and X-ray services
- Early and periodic screening, diagnosis, and treatment services and family planning services and supplies
- Physicians services, medical and surgical services furnished by a dentist
- Medical care by other licensed practitioners
- Home health care services
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy and related services
- Prescribed drugs including mental/behavioral health drugs, dentures, and prosthetic devices; and eyeglasses
- Other diagnostic, screening, preventive and rehabilitative services
- Nurse-midwife services
- Hospice care
- Case management services
- Respiratory care services
- Services provided by a certified pediatric NP or certified family NP (to the extent permitted under state law)
- Other medical and remedial care specified by the secretary
- Other medical or remedial care recognized by the secretary but which are not covered in the plan including services of Christian science nurses, care and services provided in Christian science sanitariums and personal care services in a recipient's home

EPSDT diagnosis and treatment services, plus special services not covered by the Kentucky Medicaid Program will be covered by UnitedHealthcare Community Plan. These are all subject to the prior authorization process and based on medical necessity.

UnitedHealthcare Community Plan is responsible for identifying care providers who can deliver the EPSDT special services needed by members younger than 21 and for enrolling these care providers into the UnitedHealthcare Community Plan network, consistent with state contract requirements. Training is provided regarding physical assessment procedures for NPs, RNs and PAs who provide EPSDT screening services.

EPSDT diagnosis and treatment service and EPSDT special services may be covered, subject to the prior authorization and based on medical necessity.

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-866-633-4449**
Healthy First Steps Rewards	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value-added services	**UHCCommunityPlan.com/ky** > View plan details	**1-866-633-4449**

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **1-866-633-4449** unless otherwise noted.

We met and continue to meet with and listen to local providers and community-based organizations in Kentucky. We understand there are opportunities to enhance Medicaid covered services with value-added services. Based upon extensive local market engagement and analysis of the population and the Commonwealth's priorities, we thoughtfully designed the following value-added services to address health disparities and improve overall health outcomes.

Access to care

Substance use disorder helpline

Unfortunately, stigma stops many afflicted with substance use disorder (SUD) from seeking treatment. The SUD Helpline is an anonymous confidential helpline where people can call and speak with a licensed substance use expert for information on SUD treatment. Members can get a treatment referral if they choose to explore their specific benefits. To reach the SUD helpline, call **1-855-780-5955.**

Seeking safety

Members who have a history of trauma or addiction have access to Seeking Safety, which focuses on teaching coping skills to help individuals feel safe in their relationships, thinking and actions. Seeking Safety is the most popular and scientifically studied counseling model for trauma and addiction, with an emphasis on adapting to each person's needs. For more information, go to **providerexpress.com.**

Alternative chronic pain management

Acupuncture — evidence-based alternative for pain management

A key component of traditional Chinese medicine, acupuncture is a technique for balancing the flow of energy and stimulating nerves, which can boost the body's natural system. Acupuncture is believed to relieve discomfort associated with a variety of conditions, such as chronic pain management, low back pain and migraines. This service has also been known to help those with OUD. Payment for more than 30 acupuncture visits per benefit year requires prior authorization.

Mindfulness

Through **myuhc.com,** members have access to online meditations for the use of mindfulness in the alleviation of chronic pain. Mindfulness is a type of meditation focused on being intensely aware of what an individual is sensing and feeling in the moment, without interpretation or judgment. Practicing mindfulness involves breathing methods, guided imagery and other practices to relax the body and mind and help reduce stress. Studied in many clinical trials, the overall evidence supports the effectiveness of mindfulness for variety of conditions, including stress, anxiety and alleviation of chronic pain.

Doctor Chat—virtual visits

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

Health-related benefits

Quit Now Kentucky

Get help quitting smoking at no cost.

1-800-QUIT-NOW, TTY **711**

quitnowkentucky.org

Online education

Suicide Prevention/Question, Persuade and Refer training

This is a 1-hour online course that helps identify if someone is contemplating suicide through 3 simple steps: Question, Persuade and Refer, (QPR) to encourage the person to seek help. Listed in SAMHSA National Registry of evidence-based practices, QPR helps community members reduce the fear or stigma that might get in the way of assisting a coworker, friend or family member considering suicide.

dailystrength.org

Support groups have long since filled the gap between medical treatment and the need for emotional support. An individual's relationship with their clinician may not prove adequate emotional support and a person's family and friends may not understand the impact of a disease or treatment. DailyStrength is an online support resource that provides over 500 support communities for people facing similar life challenges, medical conditions and mental health issues.

Transition supports

Community care package – home-delivered meals to support transitions of care

For those eligible members who are diabetic or prediabetic after hospital discharge from an acute inpatient hospital stay into a community setting and need nutritious prepared meals delivered, this offers a customized solution. Members who have also recently given birth may be eligible to receive this service. Members will have the convenience of choosing their meals and having them delivered, regardless of their geographic location in Kentucky to aid with recuperation at home and managing their condition. Members will have access to 14 prepared home-delivered meals.

On My Way

On My Way ™ (OMW) is an online program helps young adults who are either transitioning from foster care or from their parents'/ guardians' home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

Healthy First Steps Rewards

Healthy First Steps™ (HFS) Rewards is a specialized case management program help all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks.

The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine. These incentives are designed to help expectant enrollees and their babies stay healthy during and after pregnancy.

Rewards for moms and babies

- Earn rewards for going to prenatal and postpartum visits.
- The program connects with other expectant moms for support during pregnancy and beyond.

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

How it works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them. Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How you can help

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

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral Health/Provider Express	**providerexpress.com**	**1-877-614-0484**
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-866-633-4449**

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

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

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

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

To request an ID number, go to the Department of Social Services website at chfs.ky.gov > go to the section titled "Apply to be a Medicaid Provider."

Behavioral health service providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member or legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

Overview

For an interactive overview of our Medicaid plan including behavioral health services, view the **Introduction to UnitedHealthcare Community Plan of Kentucky** course.

How to join our network

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

Covered services

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

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

For member resources, go to **providerexpress.com** click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include:

- Community-based services including:
  - Assertive community treatment
  - Comprehensive community support services
  - Outpatient day treatment
  - Peer support services
  - Psycho-education
  - Targeted case management
  - Therapeutic behavioral health services
- Crisis services including:
  - Residential crisis intervention
  - Mobile crisis intervention services
- Inpatient and residential services including:
  - Behavioral health long-term residential treatment
  - Inpatient behavioral health and substance use disorder treatment
  - Intensive outpatient treatment for behavioral health and substance use disorder
  - Partial hospitalization for behavioral health and substance use disorder
  - PRTF (level I & II)
  - Substance use disorder residential treatment
- Outpatient services including:
  - Applied behavioral health analysis (ABA)
  - Diagnostic evaluation and assessment
  - Electroconvulsive therapy
  - Medication-assisted treatment for substance use disorder
  - Medication management
  - Psychological testing
  - Psychotherapy and counseling; individual, group and family
  - Screening, brief intervention and referral to treatment (SBIRT)
  - Transcranial magnetic stimulation

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility application on the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign in.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral.

Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. View the **Kentucky Medicaid prior authorization code list for behavioral health services**.

Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth** or calling **1-866-633-4449.**

Collaboration with other care providers

Coordination of care

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

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

Please talk to your patients about the benefits of sharing essential clinical information. Behavioral health service providers must refer members to their PCP for any physical health problems they are not licensed to provide.

For more information on coordination of care, visit **providerexpress.com**.

Portal access

Website: **UHCprovider.com**

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

View the prior authorization list, find forms and access the care provider manual. Or call the **Provider Services** at **1-866-633-4449** to verify eligibility and benefit information, available 8 a.m.–5 p.m. CT, Monday–Friday.

Behavioral health care providers

Website: **providerexpress.com** or **1-877-614-0484**
Update your practice information, review guidelines and policies, verify eligibility, review electronic claim submission, view claim status and submit notifications/prior authorizations.

Claims

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

Monitoring Audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention**
  Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices and education
- **Treatment**
  Access and reduce barriers to evidence-based and integrated treatment
- **Recovery**
  Support case management and referral to person-centered recovery resources
- **Harm reduction**
  Access to Naloxone and facilitating safe use, storage and disposal of opioids
- **Strategic community relationships and approaches**
  Tailor solutions to local needs
- **Enhanced solutions for pregnant mom and child**
  Prevent neonatal abstinence syndrome and supporting moms in recovery
- **Enhanced data infrastructure and analytics**
  Identify needs early and measure progress

Prescribing opioids

MedImpact on behalf of UnitedHealthcare Community Plan of Kentucky will align with the state opioid preferred drug list (PDL) and coverage rules.

Lock-In programs

The UnitedHealthcare Community Plan of Kentucky lock-in program identifies members who meet criteria for prescription medication and emergency department (ED) misuse. Members who meet the criteria for ED misuse will receive education and care management.Members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances) will be placed into the lock-in program where they can only receive prescriptions from a single pharmacy for at least 1 year.

Expanding medication — assisted treatment access and capacity

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

To find a behavioral health MAT care provider in Kentucky:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Behavioral Health Directory."
3. Click on "Medicaid plans."
4. Select "(state)."
5. Click on the applicable plan name.
6. In the search field, type "Medication Assisted Treatment" and click "Search."

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

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/ky**	Check the number on the back of the member's ID card.
Member handbook	**UHCCommunityPlan.com/ky** > Medicaid > **View Details** > Member handbook	Check the number on the back of the member's ID card.

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

Privacy Regulations

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

Access to protected health information

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

Amendment of protected health information

Our members have the right to ask that information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, certain information must be provided to the member explaining the reason for the denial and actions the member may take.

Accounting of disclosures

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

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

Right to request restrictions

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

Right to request confidential communications

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

Member rights and responsibilities

The following information is in the member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com/ky** > Medicaid > **View Details** > Member handbook

Native American access to care

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

Members rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their health care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy

- Get any approvals needed before receiving treatment
- Use the emergency room only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

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

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

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a timely, legible, current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records. • Release only to entities as designated consistent with federal requirements • Kept in a secure area accessible only to authorized personnel

Topic	Contact
Procedural elements	**Medical records are readable (by at least a peer of the writer).** • Date of entry and date of encounter • Care provider identification by name • Identification of current problems • Sign and date all entries with date of entry and date of encounter • Patient name/identification number is on each page of the record • Document language spoken and cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, age, gender, address(es), phone number(s), employer, contact information, marital status, emergency contact name and phone numbers (if no phone contact name and number), consent forms, race and ethnicity, guardianship information and an indication whether the member's first language is something other than English • An advance directive is a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions and current problems • Include a list of prescribed and over-the-counter medications. Review it annually. • Document the presence or absence of allergies or adverse reactions noted in a prominent location • All written denials of service and the reason for the denial • Past medical history; including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e., documentation of chickenpox). • Consultation, laboratory and radiology reports filed in the medical record contain the ordering care provider's initials or other documentation indicating review • Documentation of immunization pursuant to 902 KAR 2:060 • Identification and history of nicotine, alcohol use or substance abuse • Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020 • Follow-up visits provided secondary to reports of emergency room care • Hospital discharge summaries, home health care reports, and practitioner care are documented

Topic	Contact
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • Medical and surgical history • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults pursuant to 902 KAR 2:060 • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact
Problem evaluation and management	Documentation for each visit includes: • Date of entry and date of encounter • 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). This includes EPSDT reports received from other providers, such as appointment and rescheduled dates for EPSDT screening. It also includes parental or guardian refusal of EPSDT screenings or special services, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers. • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – Time-frame for follow-up visit as appropriate – Appropriate use of referrals/consults, studies, tests • There is evidence of care provider follow-up of abnormal results • X-rays, labs, consultation reports, behavioral health reports, ancillary care provider's reports, facility records and outpatient records are included in the medical record with evidence of care provider review by signature or initials • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status • Plan of treatment including: – Medication history, medications prescribed, including the strength, amount, directions for use and refills – Therapies and other prescribed regimen – Follow-up plans including consultation, referrals and directions, including time to return

Member copies

A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

Member hospitalization records

Member hospitalization records should include, at a minimum:

- Identification of the patient
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission
- The plan of care (as required under 42 C.F.R. 456.172 for mental hospitals or 42 C.F.R. 456.133 for hospitals)
- Reasons and plan for continued stay, if applicable
- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- For non-mental health hospitals only: date of operating room reservation and justification of emergency admission, if applicable
- Other supporting material appropriate to include

Medical record review

At least every 3 years and on an ad hoc basis, we conduct a review of our members' medical records to assess compliance with the Medical Documentation Standards.

Kentucky Health Information Exchange

UnitedHealthcare encourages its network providers to sign a participation agreement with Kentucky Health Information Exchange (KHIE). This allows for network providers and KHIE to connect and share their patient electronic health records (EHRs). The goal is to help improve care coordination resulting in higher quality care and better outcomes. The data set required for submission is a Summary of Care Record.

Hospitals that use the contractor should be encouraged to also submit admission, discharge, and transfer messages to KHIE.

If the provider does not have an EHR, they must sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services. This allows clinical information to be securely shared with other providers in their community of care.

You can get started with KHIE by going to khie.ky.gov > Get Started to contact a KHIE outreach coordinator who will tell you about the services and work with you to develop a service path regarding the services you're interested in. The outreach coordinator will assist you with signing the KHIE Participation Agreement.

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: **UHCprovider.com** > Resources > Resource Library > **Join Our Network and Credentialing** Chiropractic: **myoptumhealthphysicalhealth.com**	**1-866-633-4449**
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

- Providing requested timely medical records
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Participating in practitioner appointment access and availability surveys

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Care provider satisfaction

Every year, we conduct care provider satisfaction assessments as part of our QI efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Town hall meetings
- Feedback from our Provider Advisory Committee attendees

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages an independent market research firm to analyze and report findings.

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to the National Committee for Quality Assurance standards (NCQA), KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current DEA certificate
- Current professional liability insurance

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

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

Criteria includes:

- Required medical or professional education and training
- Verification of post-graduate education or training and/or board certification
- Current license or certification
- DEA certificate and number, if applicable
- Medicare/Medicaid Program Participation Eligibility
- Work history
- Professional liability insurance
- Malpractice history
- Sanction and limitation on licensure
- Hospital staff privileges, if applicable
- Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs younger than 21 years old

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
- Have no Medicare/Medicaid sanctions

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

The National Credentialing Center (NCC) completes these reviews. Organizational providers will need to complete the UnitedHealthcare Facility **Application** and submit supporting documentation.

Go to **UHCprovider.com/join** to submit a participation request. Please ensure your Council for Affordable Quality Healthcare (CAQH) is updated and attested prior to submitting your request for participation.

For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

Credentialing process

Credentialing files are presented to the peer review committee when additional review is required. Credentialing files meeting all credentialing criteria and don't require further review are electronically approved by the medical director.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Confidentiality

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

Care provider participation

Meet the credentialing and recredentialing standards and be eligible to enroll with the Kentucky Medicaid program. As a condition of network participation, you must be enrolled with the Kentucky Medicaid program.

Resolving disputes

Contract concerns

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

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

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

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

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier (NPI)

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

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

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

Reporting and auditing

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud, waste and abuse line** or go to **uhc.com/fraud**.

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

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

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Kentucky to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the Kentucky Department of Health and Human Services.

Record retention, reviews and audits

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

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

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

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

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and service (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow up to ensure that members receive care in a safe, clean and accessible environment.

For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

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

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

Criteria for site visits

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

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety.	Access to facility in poor repair to pose a potential risk to patients. Needles and other sharps exposed and accessible to patients. Drug stocks accessible to patients. Other issues determined to pose a risk to patient safety.	1 complaint.
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space.	Office facilities are dirty; smelly or otherwise in need of cleaning. Office exams rooms do not provide adequate privacy.	2 complaints in 6 months.
Other.	All other complaints concerning the office facilities.	3 complaints in 6 months.

Chapter 11: Billing and submission

Key contacts

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

Our claims process

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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

Claims process from submission to payment

1. You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact National Plan and Provider Enumeration System NPPES. Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-866-633-4449**.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

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

Acceptable claim forms

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

Refer to your billing manual for your registered provider type.

Clean claims and submission requirements

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

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

We may require additional information for some services, situations or state requirements.

Submit any services completed by N.P.s or P.A.s who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims according to their agreement.

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool.

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms

For more information, see **EDI Claims**.

Electronic data interchange companion documents

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

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

The companion document provides general information and specific details pertinent to each transaction.

These documents should be shared with your software vendor for any programming and field requirements. The companion documents are located on **UHCprovider.com/edi** > **EDI transaction and code sets**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our EDI at **UHCprovider.com** > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options.**

e-Business support

Call **Provider Services** at **1-866-633-4449** for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

To find more information about EDI online, go to **UHCprovider.com/edi**.

Electronic payment solution: Optum Pay

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

Why choose Automated Clearing House/ direct deposit?

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

What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com**.

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

Completing the UB-04 form

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

- Include ICD-10-CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

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

Capitated services

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

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

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

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

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

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

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefits

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

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

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

Hospital and clinic method of billing professional services

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

Global days

Global days include the billable period involving pre-operative visits, the procedure itself and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC) or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com/policies** > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical Laboratory Improvements Amendments

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

CLIA reimbursement policy information can be found **here**.

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

High-cost drugs

In compliance with Kentucky Department of Medicaid policy, UnitedHealthcare requires providers to submit additional documentation with claims for certain high-cost drugs. Required documentation includes, but is not limited to:

- The actual acquisition cost of the drug with the invoice amount from the manufacturer or buyer of the drug
- The applicable NDC or J-code identifying the drug
- The quantity of the drug

Failure to include this information may result in a rejected claim and may require resubmission of the claim for payment.

UnitedHealthcare periodically receives updates to the list of drugs that meet the "high-cost" classification from the Kentucky Department of Medicaid.

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

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

Provider Services

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

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

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

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the UnitedHealthcare Provider Portal by signing in at **UHCprovider.com** with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

The UnitedHealthcare Provider Portal lets you move quickly between applications. This helps you:

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

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

Find UnitedHealthcare Provider Portal training at **UHCprovider.com/training**.

UnitedHealthcare Provider Portal training course is available using the **UnitedHealthcare CommunityCare Provider Portal user guide**.

Resolving claim issues

To resolve claim issues, contact **Provider Services** at **1-866-633-4449**, use the UnitedHealthcare Provider Portal, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

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

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

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim.

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

Timely filing

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

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

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

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

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

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing. Timely filing in Kentucky is 12 months from the date of service.

Balance billing

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

Do not balance bill members if:

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

If you don't know who your provider advocate is, utilize our live chat available at **UHCprovider.com/chat**.

Third-party resources

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

Chapter 12: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form, digital or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5270	**UHCprovider.com/claims**	**1-866-633-4449**	For online submissions, use the **UnitedHealthcare Provider Portal**.	24 months from the Provider Remittance Advice (PRA).	24 months from the PRA.
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider			**1-866-633-4449**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**. Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.**	Claim reconsiderations (adjustment requests) are accepted within 24 months from the PRA.	45 business days.
Care provider claim formal appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider		**UHCprovider.com/claims**	**1-866-633-4449**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**. Most care providers in your state must submit appeal requests electronically. For further information on appeals, see the **Reconsiderations and Appeals interactive guide.**	60 calendar days from the provider remittance advice.	Resolve within 30 calendar days. *May be extended by 14 calendar days.
Care provider grievance	A complaint expressing dissatisfaction with operations, activities or behavior of a health plan or member.	Care provider	**UnitedHealthcare Community Plan Grievances and Appeals Unit** P.O. Box 31364 Salt Lake City, UT 84131-0364	**UHCprovider.com/claims**	**1-866-633-4449**	Use the Prior Authorization application on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then Sign In or go to and click on Prior Authorization and Notification.	60 calendar days from the provider remittance advice. Providers are to use a Standard Department Provider Grievance Form, when submitting a grievance.	Resolve within 30 calendar days. *May be extended by 14 calendar days.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form, digital or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	• Member • Care provider, or other authorized representative (such as friend or family member), with written member consent	UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**UHCprovider.com/claims** ***AOR Consent Form** on this site for members to provide written consent to authorized representatives.	Member Services: **1-866-293-1796**		60 calendar days from receipt of the adverse benefit determination notice.	Expedited appeals - 72 hours* Standard appeals - 30 calendar days* *May be extended by 14 calendar days.
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider, or other authorized representative (such as friend or family member), with written member consent	UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**UHCprovider.com/claims** ***AOR Consent Form** on this site for members to provide written consent to authorized representatives.	Member Services: **1-866-293-1796**		No time limit.	30 calendar days.

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

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

Denial

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

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

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

Other top reasons for denial include:

- **Duplicate claim**
  The denial occurs when a provider submits a claim twice for the same member, same date of service and same service code(s).
- **Claim lacks information**
  Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired**
  Care providers must verify member eligibility prior to rendering services. One of the most common claim denials involving verification is when a patient's health insurance coverage expires and the patient and practice are unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can change. Providers must check eligibility on the date of service to ensure member is still eligible for Medicaid services.
- **Provider validation edits**
  All providers billed on a claim must be registered with Kentucky Medicaid for the date of service. Please refer to the billing manual for your provider type for provider billing requirements.
- **Claim not covered by UnitedHealthcare Community Plan**
  The claim denied because the services are not covered by Kentucky Medicaid. You can easily avoid this problem by using real-time verification.
- **Timely filing limit denial**
  New claims must be submitted with 12 months from the date of service.

Claim correction

What is it?

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

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Refer to the **grid** at the beginning of this chapter for contact and submission information.

Additional information

When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

For 837 professional claims, use Medicaid resubmission code 7 (for correction/replacement of prior claim) or 8 (to void a claim).

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal – the claim needs to be corrected through resubmission.

Common reasons for rejected claims:

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

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

How to use:

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

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

Claim reconsideration

What is it?

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

When to use:

Reconsiderations can be done repeatedly but should include new information each time. We advise you use the reconsideration process before a formal appeal. Submit a claim reconsideration when you think a claim has not been properly processed.

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

For medical necessity denials – In your request, please include any additional clinical information that may not have been reviewed with your original claim

Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

Refer to the **grid** at the beginning of this chapter for contact and submission information.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-866-633-4449** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless you submit a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity

- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation

What is it?

Proof of timely filing is necessary when the provider needs to extend the timely filing limit of a claim. Timely filing examples include the following:

- Claim was filed timely by provider but is not on file in the claim system at UnitedHealthcare Community Plan
- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

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

How to use:

Submit a reconsideration request electronically or by mail with the following information:

Electronic claims – Include the EDI acceptance report stating we received your claim

Mail reconsiderations – Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:

- Correct member name
- Correct date of service
- Claim submission date

Additional information – Timely reconsideration requests are accepted within 24 months from the PRA.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

Our contract with the Kentucky Department for Medicaid Services requires all network care providers report and return to us, any identified overpayment within 60 days of identification. You must include in writing the reason for the overpayment.

The following information outlines that process.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment and reason for the overpayment within 60 days. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-866-633-4449**.

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

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

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

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
P.O. Box 101760
Atlanta, GA 30392-1760

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal.

Online – Go to **UHCprovider.com** > Sign in. Then, use the claims link tool to fill out the reconsideration form and submit your request. Please include a copy of this letter, the updated PRA and any supporting documents.

Mail – Send a completed reconsideration form, the updated PRA and a copy of this letter along with any supporting documents to:

UnitedHealthcare Provider Appeals
Attn: Overpayment Disputes
PO Box 740804
Atlanta, GA 30374-0804

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

In accordance with 907 KAR 1:671, in addition to the dispute rights communicated in this section, providers have the right to an administrative hearing. To file a request for an administrative hearing, providers may submit a written request within 30 days of the UnitedHealthcare internal appeal determination to:

Office of the Commissioner
Department for Medicaid Services Cabinet for Health and Family Services
275 East Main Street, 6th Floor
Frankfort, KY 40621-0002

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim.
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.29	Contract states $50.00, claim paid $77.29.
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1.
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance.
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated.

Appeals

What is it?

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

When to file:

If you do not agree with the outcome of the claim reconsideration decision, use the claim appeal process. We recommend using the reconsideration process first before doing a formal appeal.

If you have exhausted your DRG appeal with MedReview, your next step is to file an internal appeal with UnitedHealthcare.

How to use:

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

Refer to the **grid** at the beginning of this chapter for contact and submission information.

If you are unhappy with the appeal decision, you may request an external independent third-party review (EITPR) of UnitedHealthcare Community Plan's appeal decision. Please see **EITPR section**.

Questions about your appeal or need a status update?

Call **Provider Services** at **1-866-633-4449**. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

In-person meeting

UnitedHealthcare will provide the opportunity for an in-person meeting with a UnitedHealthcare representative, to all Medicaid providers, on any clean claim that remains unpaid for 45 days or more after the date received by UnitedHealthcare and that individually, or in aggregate, exceeds $2,500.

Care provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone** – Call **Provider Services** toll free at **1-866-633-4449**
- **Mail** – Send care provider name, contact information and your grievance to:

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

- **UnitedHealthcare Provider Portal:** Use the Prior Authorization and Notification application on the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** then Sign In and click on Prior Authorization and Notification.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Member benefit appeals

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You, with a member's written consent, or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Doesn't act within the time frame CMS or the state requires

When to use:

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

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

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

Toll-free – **1-800-587-5187** TTY **711**

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

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

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal 72 hours from when we receive it.

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

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

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

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

Member grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

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

Where to send:

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

Mailing address:

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

Toll-free – **1-800-587-5187** TTY **711**

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

State fair hearings

What is it?

A state fair hearing lets members share why they think Kentucky Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

Office of the Ombudsman and Administrative Review
Attn: Medicaid Appeals and Reconsiderations
275 East Main Street, 2E-O
Frankfort, KY 40621

Phone – 1-502-564-5497

Fax – 1-502-564-9523

Email – providermcoinquiry@ky.gov

External independent third-party review

If you are unhappy with the appeal decision, you may request an EITPR of UnitedHealthcare Community Plan's appeal decision.

This external review provides for the decision to be heard by an outside third-party reviewer chosen by the state of Kentucky.

You may request an EITPR if UnitedHealthcare Community Plan issues an adverse decision regarding:

- Authorization of a new health care service to a member
- A claim reimbursement for health care services to a member

You may not request an EITPR for a reconsideration decision.

External independent review submission

You can send your request electronically, online or by mail.

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

Email the request form to- eir_ky@uhc.com

When submitting your request for an EITPR, please use the new **EITPR form** available on the Provider Portal under the Provider Forms and References tab, specifically in the KY Department of Medicaid Services forms section. Ensure you complete all required fields, addressing:

- Each specific issue and dispute you have with our decision.
- The reasons you believe our decision is incorrect.
- The name, mailing address, email address, and phone number of the designated contact person.

You may attach additional documentation to this form and submit it electronically or by mail. Please note that we will not accept EITPR requests that are not submitted using this form.

You may call **Provider Services** at **1-866-633-4449** if you need additional assistance.

The external reviewer will only review the records and documentation you submit during the appeal process, along with medical necessity criteria applied in the appeal decision. If additional documentation needs review, you must use the Provider Administrative Hearing process. The EITPR is an optional process available to care providers only.

External independent review request requirements

You must complete the appeal process prior to requesting an external review. For denials of authorization of a new health care service, you may submit an authorization from the affected member.

We must receive EITPR requests within 60 calendar days from the date of the notice of appeal resolution.

EITPR requests must involve a denial of authorization for a new health care service or a denial of a claim for reimbursement. Authorization decisions that terminate, suspend or reduce previously authorized services, and qualify for continued services, are not eligible for EITPR. We will deny your request for external review if the member no longer wants the denied health care service.

If a member is currently involved in a state fair hearing regarding this same dispute, the EITPR will not be granted until the member's hearing has been fully adjudicated.

We will deny the request if you do not meet the requirements previously listed. UnitedHealthcare Community Plan will acknowledge receipt of your request, in writing, within 5 business days of receipt. The external, independent third-party reviewer must complete their review within 30 calendar days of receiving documentation. The reviewer may extend the time to issue a decision by 14 calendar days if UnitedHealthcare Community Plan and you agree. We will notify you within 10 business days of receipt of the external reviewer's decision.

Administrative appeal

A provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance by applicable state laws and regulations.

You must file a request for an administrative hearing within 30 calendar days.

If the provider does not prevail in the administrative hearing, the provider is responsible for applicable costs paid to DMS within 30 days.

If the Provider prevails in the external appeal, we will comply with the Final Order within 60 days unless the Final Order designates a different timeframe.

Filing a request for an administrative hearing

In accordance with 907 KAR 1:671, in addition to the dispute rights communicated in this section, you have the right to an administrative hearing. To file a request for an administrative hearing, submit a written request within 30 days of our internal appeal determination to:

Office of the Commissioner
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6th Floor
Frankfort, KY 40621-0002

Processes related to reversal of our initial decision

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

1. As quickly as the member's health condition requires or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

In accordance with 907 KAR 1:671, in addition to the dispute rights communicated in this section, providers have the right to an administrative hearing.

To file a request for an administrative hearing, providers may submit a written request within 30 days of the UnitedHealthcare internal appeal determination to:

Office of the Commissioner Department
for Medicaid Services Cabinet for
Health and Family Services
275 East Main Street, 6th Floor
Frankfort, KY 40621-0002

Fraud, waste and abuse

Call the toll-free **Fraud, waste and abuse hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

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

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

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

Find out how we follow federal and state regulations around false claims at **UnitedHealthcare Community Plan of Kentucky** > Integrity of Claims, Reports, and Representations to the Government.

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com** > Resources > **Resource Library**	**1-866-633-4449**
News and bulletins	**UHCprovider.com/news**	
Provider manuals	**UHCprovider.com/guides**	

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- Chat support available
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UnitedHealthcare Community Plan of Kentucky page**
  UHCprovider.com/kycommunityplan has resources, guidance and rules specific to Kentucky. Be sure to check back frequently for updates.
- **Policies and protocols**
  This **library** includes UnitedHealthcare Community Plan policies and protocols.
- **Health plans by state**
  UHCprovider.com/ky is the fastest way to review all of the health plans UnitedHealthcare offers in Kentucky. To review information for another state, simply use the drop-down menu at **UHCprovider.com/guides** > **Community Plan Provider Manuals for Medicaid Plans by State** to select a state, then select the type of plan (commercial, Medicare Advantage, etc.), then review the specific plans offered in that market.
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**: This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in **Chapter 1** of this manual or by visiting **UHCprovider.com/portal**.
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.

- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the **UnitedHealthcare Provider Portal,** plan and product overviews, clinical tools and state-specific training. View the **Introduction to UnitedHealthcare Community Plan of Kentucky** course for an overview of our Medicaid plan

More training resources are available at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal.

   Already have an ID? To review or update your email, simply sign in to the portal. Go to Profile & Settings, then Account Information, to manage your email.
2. **Subscribe** to Network News email briefs to receive regular email updates.
3. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Care provider office visits

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

State websites and forms

Find forms on the state's website at Medicaid Assistance Program Forms.