



2026 Care Provider Manual

Physician, Care Provider, Facility, and Ancillary
Missouri

Welcome

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

Click the following links 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 manual:** UHCprovider.com/guides – Under Community Plan Care provider manuals for Medicaid Plans by State, click on **Missouri**

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



If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-866-815-5334**.



Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it instead.

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

This manual will be amended as policies change.

Participation Agreement

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

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 “care 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 UnitedHealthcare’s 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

Thank you for your participation in our program and the care you offer our members.

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Chapter 1: Introduction

UnitedHealthcare Community Plan supports the Missouri 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 members 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
- American Indians/Alaskan Natives who receive care from a certified Indian Health Care provider

The health program will offer the following services:

- **TANF** – Temporary Assistance for Needy Families
- **CHIP** – Children's Health Insurance Program

DHSS will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call **Provider Services** at 1-866-815-5334.

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.

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 program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. 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 to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. 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 plans
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to an 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 care 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 program are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health (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

Specialty care managers

Specialty care managers coordinate care for the following members:

- Pregnant members in the Healthy First Steps® program. A care manager coordinates the member's care, including health education and outreach, from the onset of pregnancy through the postpartum checkup.
- Those who have qualifying conditions including elevated lead levels
- Those who require private duty nursing
- Those who require disease management for the following:
 - Major depression
 - Asthma
 - Obesity
 - Diabetes
 - Hypertension
 - Attention Deficit Hyperactivity Disorder (ADHD)

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **1-800-587-5187**, TTY **711**. You may also call **Provider Services** at **1-866-815-5334**

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 support UnitedHealthcare Community Plan's Cultural Competency Program. For Cultural Competency training visit [UHCprovider.com/resourcelibrary](https://uhcprovider.com/resourcelibrary) > Health Equity Resources > **Cultural Competency**.

- **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 care provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

UnitedHealthcare Community Plan offers the following support services:

- **Language interpretation line:**
 - We provide interpreter services Monday–Friday, 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 Community Plan uses InterQual® for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the [digital solutions comparison guide](#). Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions.

Using electronic transactions is fast and efficient and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (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 tools on the UnitedHealthcare Provider Portal:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to **[UHCprovider.com/eligibility](https://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](https://uhcprovider.com/claims)**.
- **Prior authorization and notification** – Submit notification and prior authorization requests. For more information, go to **[UHCprovider.com/priorauth](https://uhcprovider.com/priorauth)**.
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **[UHCprovider.com/pharmacy](https://uhcprovider.com/pharmacy)** for more information.
- **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/mypracticeprofile](https://uhcprovider.com/mypracticeprofile)**.
- **Document library** – Access claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF and can only be pulled at the individual practitioner level. For more information, go to **[UHCprovider.com/documentlibrary](https://uhcprovider.com/documentlibrary)**.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

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, faxes, phone calls and spreadsheets. It also helps:

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

All users will access Direct Connect using the Provider Portal. 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 or dialysis center privileges.

Provider Services

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

They can answer your questions about 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.

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Protection Act (TCPA) Opt Out form**. The provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and the request will be processed within 10 business days and your phone number will be removed from the do not call registry.

For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit UHCprovider.com/contactus.

How to contact us

*We no longer use fax numbers.

Topic	Contact	Information
Behavioral, mental health & substance abuse	Optum® providerexpress.com 1-877-614-0484	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits 1-866-815-5334	Confirm a member's benefits 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	Eligible members may receive up to 20 visits for chiropractic services per rolling year.
Claims	UHCprovider.com/claims 1-866-815-5334 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 disputes	UHCprovider.com/claims Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	Ask about claim issues such as overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.

Topic	Contact	Information
Claim overpayments	Sign in to UHCprovider.com/claims to access the UnitedHealthcare Provider Portal. 1-866-815-5334 Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the Overpayment section for requirements before sending your request.
Electronic data intake 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	UHCprovider.com/eligibility, or access emomed.com. 1-866-815-5334	Confirm member eligibility.
Enterprise voice portal	Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal.	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: UHCprovider.com/mocommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud 1-844-359-7736 or 1-877-401-9430 vendor fraud hotline	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	UHCprovider.com/findprovider > Preferred Lab Network	The Preferred Lab Network webpage provides a full listing of eligible labs.
Medical claim, reconsideration and appeal	UHCprovider.com/claims 1-866-815-5334 Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, 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.
Member services	myuhc.com® 1-866-292-0359, TTY 711 for help accessing member account	Assist members with issues or concerns. Available Monday–Friday, 7 a.m.–7 p.m. CT.

Chapter 1: Introduction

Topic	Contact	Information
Missouri Department of Social Services/HealthNet	Medicaid.gov 1-573-751-3425 dss.mo.gov > mhd > providers	Contact Medicaid directly. View website for more care provider information.
Multilingual/Telecommunication Device for the Deaf (TDD) services	1-866-292-0359 TDD 711	Available Monday–Friday, 8 a.m.–5 p.m. CT, except state-designated holidays.
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 team	Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	Self-service functionality to update or check credentialing information.
NurseLine	1-866-351-6827	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby are	Healthy First Steps® Pregnancy notification form at UHCprovider.com , then Sign In for the UnitedHealthcare Provider Portal. 1-800-599-5985 uhchealthyfirststeps.com	For pregnant members, contact Healthy First Steps by calling or filling out the online pregnancy notification form. Please refer members to the Babyscripts myJourney app to sign up for Babyscripts™ Rewards. Members self-enroll on a smartphone or computer or call 1-800-599-5985 .
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at UHCprovider.com/chat .	Contact if you have issues with your ID. Available Monday–Friday, 7 a.m.–9 p.m. CT, Saturday, 6 a.m.–6 p.m. CT, and Sunday, 9 a.m.–6 p.m. CT.
Pharmacy services	professionals.optumrx.com 1-877-305-8952 (Optum Rx)	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/notification for pharmacy	UHCprovider.com/pharmacy 1-800-392-8030	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript® . Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

Topic	Contact	Information
Prior authorization requests/advanced admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: UHCprovider.com/priorauth Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications".	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 at UHCprovider.com/MOcommunityplan > Prior Authorization and Notification.
Provider services	UHCprovider.com/MOcommunityplan 1-866-815-5334	Available Monday–Friday, 7 a.m.–5 p.m. CT.
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 Provider Services 1-866-815-5334	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	UHCprovider.com/MOcommunityplan > Reimbursement and Policies	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.	Contact if you have issues logging in to the UnitedHealthcare Provider Portal ; you cannot submit a form.
Tobacco free quit line/resources	1-800-784-8669 Interactive training and education	Ask about services for quitting tobacco/smoking. Submit new referrals and submissions to UHCprovider.com/resourcelibrary > news.
Transportation	MTM 1-866-292-0359	To arrange non-emergent transportation, please contact MTM at least 3 business days in advance.

Topic	Contact	Information
Utilization management	Provider Services 1-866-815-5334	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/protocols. Request a copy of our UM guidelines or information about the program.
Vaccines for children program	health.gov hhs.gov/vaccines 1-573-751-6124	Care providers must participate in the VFC Program administered by the MO Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified MO HealthNet-eligible children. Care providers must enroll as VFC care providers with DHSS to bill for the administration of the vaccine.
Vision services	MARCH Vision Care 1-844-616-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH Vision Care.
Website for MO Community Plan	UHCprovider.com/mocommunityplan	Access your state-specific Community Plan information on this website.
Whole person care person-centered care model (care management/disease management)	MO_CareManagement@uhc.com 1-866-815-5334	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.

Chapter 2: Care provider standards and policies

General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

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

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

Provide official notice

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

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

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 is available to help you and our members with the transition.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers. 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 care Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Visit UHCprovider.com/attestation to view ways to update and verify your care 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 care 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, refer them to an urgent care center.

Participate in quality initiatives

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

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

Provide access to your records

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

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan (Medicaid) and CHIP members as those offered to Commercial members.

Protect confidentiality of member data

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

UnitedHealthcare Community Plan uses member information for treatment, operations and payment.

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

Follow medical record standards

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

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives.

To comply with this requirement, we inform members of state laws on advance directives through member handbooks and other communications.

Your Agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if 1 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 UHCprovider.com/mocommunityplan. Also reference **Chapter 12** of this manual for information on provider claim reconsiderations, appeals, and grievances.

Mutual obligations - UnitedHealthcare and care provider professional conduct

Professional conduct

When we conduct business together, you will work with us to ensure that your employees, agents, and any personnel operating in our facilities or yours comply with the following:

- **Collaborate for member outcomes:** Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism:** At all times, treat other providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.

- **Prohibit threats and harassment:** Create a safe and respectful environment. Any form of threats, harassment, or intimidation is strictly prohibited, including verbal, physical, and written forms.
- **Prohibit violence:** Prohibit acts of violence against other providers, UnitedHealthcare members, and UnitedHealthcare and your employees.
- **Protect confidential employee information:** Not publicly disclose any confidential personal information about UnitedHealth Group's or your employees, including home address, personal telephone numbers, personal and professional email addresses, medical, or employment-related details, to any third party without express written consent from the other party, unless legally required to do so.
- **Inaccurate statements:** Not make any misleading, inaccurate or untrue statements, whether oral or written, that disparage or intentionally harm the reputation or safety of the other party, its affiliates, or its employees. This includes statements made on social media, in public forums, or any other medium of communication.

If the requirements above are not met, we will collaborate and fully cooperate to address the matters.

If you fail to fully cooperate with UnitedHealthcare to address any violation of these requirements, such conduct is a material breach under the Agreement. UnitedHealthcare may:

- Refuse to interact with any individual engaging in such conduct;
- Terminate any professional's participation in UnitedHealthcare's network, without terminating the Agreement between the parties;
- Terminate the Agreement between the parties upon 30 days' prior written notice; and
- Any other remedies available to the parties under the participation Agreement or at law.

Any threat, attempted violence, or acts of violence will be reported to the appropriate authorities including, but not limited to, UnitedHealth Group Corporate Security, appropriate provider security, law enforcement, state and federal regulatory bodies.

Appointment standards (Missouri DHSS access and availability standards)

Comply with the following appointment availability standards:

Primary care/specialist

PCPs and specialists should arrange appointments for:

- Urgent care appointments for physical or behavioral illness injuries that require immediate care, but do not constitute emergencies (e.g., high temperature, persistent vomiting or diarrhea, sudden or severe onset of symptoms not requiring ER services): Within 24 hours
- Routine care with physical or behavioral symptoms (e.g., persistent rash, recurring high grade temperature, non-specific pain, fever): Within 1 week or 5 business days
- Routine care without physical or behavioral symptoms (e.g., well child exams, routine physical exams): Within 30 days
- After-care appointments: Within 7 calendar days after hospital discharge
- After-hours phone messaging: 24 hours, 7 days a week
 - Offices must have a phone message or answering service available that instructs members how to contact a physician for urgent or emergency conditions

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within 7 calendar days of request
- Third trimester: Within 3 calendar days of request
- High-risk: within 3 calendar days of identification of high risk

Appointment availability survey

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

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.

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 provider directory information, submit applicable changes to:

- **Delegated care providers** – submit changes to your designated 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.

- Waiting times for scheduled appointments—defined as time spent in the lobby and examination room before being seen by a care provider—do not exceed 1 hour from the scheduled appointment time

Care provider attestation

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

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

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice
- Get prior authorization:
 1. To access the prior authorization app, go to UHCprovider.com, then click Sign In.
 2. Select the prior authorization and notification app.
 3. View notification requirements.
- Identify and bill other insurance carriers when appropriate.

If you have questions, see chat options and contact information at **UnitedHealthcare Provider Portal**, Monday–Friday, 7 a.m.–9 p.m. CT.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- **Urgent:** 24 hours
- **Non-urgent:** 10 business days

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

Specialties include internal medicine, pediatrics or obstetrics/gynecology

PCPs are an important partner in the delivery of care, and MO Department of Social Services (DSS) members may seek services from any participating care provider. The MO DSS 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 (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

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

NPs may enroll with the state as solo providers, but PAs cannot. PAs must be part of a group practice.

Members may change their assigned PCP by contacting Member Services. Customer service is available Monday–Friday, 7 a.m.–7 p.m. ET.

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

Women have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs 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, and radiology) 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 by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP’s nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services.

Recorded messages are not acceptable.

Consult with other appropriate 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

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

Specialties include internal medicine, pediatrics or obstetrics/gynecology

Specialists may serve as PCPs for members with chronic and disabling conditions that require ongoing care if they agree, in writing, to accept the member as a primary care patient and provide care.

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, UnitedHealthcare Community Plan clinical, or pharmacy department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.

- Inform UnitedHealthcare Community Plan when your patient panel has reached 85% capacity and when you want it open or closed
- 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 MO DHSS Access and Availability standards for scheduling appointments
- Maintain continuity of each member's health care
- Make referrals for specialty care and other medically necessary services to both in-network and out-of-network providers
- Work with health plan care managers to develop plans of care for members receiving care management services
- When needed, maintain formal relationships with other PCPs to arrange for their members to receive care from other PCPs after hours, during certain days, for certain services or for other reasons to extend their practice
- Conduct a behavioral health screen to determine whether the member needs behavioral health services
- Maintain and share comprehensive, current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens
- Participate in the health plan's care management team, as applicable and medically necessary
- Attend institutions with teaching programs when needed. These programs involve PCP teams made up of residents and a supervising faculty physician.

PCPs are ultimately responsible for the activities listed in this section for the members assigned to them. To assist PCPs, the health plan provide resources PCPs may not have access to.

Rural health clinic, federally qualified health center or primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic (RHC) or federally qualified health center (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 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

Primary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services at 1-866-815-5334**.
2. Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
4. Refer patients to UnitedHealthcare Community.
5. Identify and bill other insurance carriers when appropriate.
6. Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialist responsibilities

- 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 MO DHSS Access and Availability standards for scheduling appointments. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 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 care providers include:

- Freestanding radiology and clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment

- Infusion care
- Therapy
- Ambulatory surgery centers
- Freestanding sleep centers
- Other noncare providers

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

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

Ancillary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call Provider Services at **1-866-815-5334**.
2. Check the member's ID card at the time of service. Verify member with photo identification.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
4. 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 care 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 care 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 care provider, they become a "delegated entity" or "delegate." UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other care providers, but those agreements must follow UnitedHealthcare's product-specific regulations. To obtain and maintain delegation, care 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 care providers.

What does it mean for you if you are not a capitated/delegated care 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. Payment 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

Benefits

Click UHCprovider.com/mocommunityplan or UHCprovider.com/eligibility or call **Provider Services** at **1-866-815-5334** for more information.

For a list of covered services, go to the Missouri DSS website: dss.mo.gov.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the UnitedHealthcare 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 initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

MO DSS 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. MO DSS 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/MO** > 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, have the payer assignment of newborns checked daily.



Get eligibility information by calling the MO HealthNet at 1-573-751-3425. You may also go to dss.mo.gov or Emomed.com.

Unborn enrollment changes

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



Members may call MO HealthNet at 1-573-751-3425 or go to the following link: dss.mo.gov.

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 MO DSS, MO's Medicaid program. The MO DSS determines program eligibility. An individual who becomes eligible for the MO DSS program either chooses or is assigned to 1 of the MO DSS-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, 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**. 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 Missouri DSS Medicaid number is also on the member ID card.

Sample health member ID cards



Health Plan (80840) 911-86050-02

Member ID: 001600012

Group Number: MOHNET

Member:

REISSUE M ENGLISH

Payer ID: 86050

DCN #:

99999912

PCP Name:

DOUGLAS GETWELL

PCP Phone: (717) 851-6816

S1803 MT ROSE AVE STE B3

YORK, MO 174033051

0501

UnitedHealthcare Community Plan of Missouri
Administered by UnitedHealthcare of the Midwest, Inc.



Health Plan (80840) 911-86050-02

Member ID: 001600014

Group Number: MOHNET

Member:

REISSUE M SPANISH

Payer ID: 86050

DCN #:

99999914

PCP Name:

DOUGLAS GETWELL

PCP Phone: (717) 851-6816

S1803 MT ROSE AVE STE B3

YORK, MO 174033051

0501

UnitedHealthcare Community Plan of Missouri
Administered by UnitedHealthcare of the Midwest, Inc.

In case of emergency call 911 or go to nearest emergency room.

Printed: 10/13/20

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.MyUHC.com/CommunityPlan or call.

For Members:

Behavioral Health:

Dental/Vision:

NurseLine:

866-292-0359

866-292-0359

866-292-0359

866-351-6827

TTY 711

TTY 711

TTY 711

TTY 711

For Providers:

Dental Providers:

Medical and BH Claims:

UHCprovider.com

855-934-9818

PO Box 5240, Kingston, NY, 12402-5240

866-815-5334

Transportation:

Pharmacy:

866-292-0359

800-392-2161 or 573-751-6527

UHC19037 Approved 09/26/18

In case of emergency call 911 or go to nearest emergency room.

Printed: 10/13/20

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.MyUHC.com/CommunityPlan or call.

For Members:

Behavioral Health:

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866-815-5334

Transportation:

Pharmacy:

866-292-0359

800-392-2161 or 573-751-6527

UHC19037 Approved 09/26/18

Primary care provider - initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, call the Member Services number on the back of the member's card, or mail with the specific event(s) documentation. Provide the specific details of the events that occurred. Documentation includes the dates of failed appointments or a detailed account of reasons for termination request, member name, date of birth, MO HealthNet number, current address, current phone number and the care provider's name mo_clinops@uhc.com.
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:

- Provider Portal: Access the Provider Portal through UHCprovider.com/eligibility
- Provider Services available Monday-Friday, 7 a.m.-5 p.m. CT
- Missouri Emomed.com

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (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 UnitedHealthcare Care provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at UHCprovider.com/guides. For state-specific information, go to UHCprovider.com > Resources > **Health Plans**.

For Missouri D-SNP information, go to UHCprovider.com/MO > Medicare > **Dual Complete Special Needs Plans**.

Chapter 4: Medical management

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

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.



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

Emergency ambulance transportation

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

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

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

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

Non-emergent ambulance transportation

UnitedHealthcare Community Plan members may get non-emergent stretcher/ambulance transportation services for covered services.

Members may get transportation when they are bed-confined before, during and after transport.



For non-urgent appointments, members must call for transportation at least 3 days before their appointment. To make a request, call **1-866-292-0359**.

Schedule non-emergent ambulance or stretcher rides up to 30 days in advance.



Members must call Monday-Friday, between 8 a.m.-5 p.m. CT, to schedule transportation. If they have questions about their order, they may call **1-866-292-0359**.

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) 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.

Non-emergent medical transportation must be requested at least 3 days in advance. Members can call **1-866-292-0359**.

Schedule non-emergent medical transportation up to 30 days in advance.

Non-emergent medical transportation requests are accepted Monday-Friday, 8 a.m.-5 p.m. CT.

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
- 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, Monday–Friday, 7 a.m.–7 p.m. local time

Make sure the medical record is available.

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

Chiropractic services

Chiropractic services must be provided by a licensed chiropractor. Services are limited to:

- Examinations
- Diagnoses
- Adjustments
- Manipulations and treatment of malpositioned articulations and structures of the body

Eligible members may receive up to 20 chiropractic visits per rolling year.

Dental services

Covered

A Dental Provider Manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.

The following services are covered for children younger than 20 years, pregnant members, the blind and nursing facility residents:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

Noncovered

A limited dental benefit is offered for adults.

Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services.

Standard ADA coding guidelines apply to all claims. To find a dental provider, go to [UHCprovider.com/Dental Directory](https://UHCprovider.com/DentalDirectory).

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions 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/policies > 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 non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

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

We pay out-of-network care providers for emergency services at the current program rates at the time of service.

We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

For an emergency, the 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.

After the member has received emergency care, the hospital must seek approval within 30 minutes for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or does not receive a decision within 1 hour or they need to speak with a peer (medical director), call **1-800-955-7615**.

The treating care provider may continue with care until

the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.



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

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/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services**.

UnitedHealthcare Community Plan makes

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



For policies and protocols, go to UHCprovider.com/policies > **For Community Plans**.

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

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health.

UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear
- 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.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
 - GIFT (Gamete intrafallopian transfer)
 - ZIFT (zygote intrafallopian transfer)
 - Embryo transport
- Infertility services, if given to achieve pregnancy

Note: Diagnosis of infertility is covered. Treatment is not.

- Morning-after pill. Contact the Missouri DSS to verify state coverage.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DSS Regulations for more information on sterilization.

Care coordination/health education

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with 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

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

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

Facility admission notification requirements

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

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

Health home program

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of the state's highest-need individuals. Health Home helps improve coordination of care, quality, and increase individual participation in their own care. The program reduces Medicaid inpatient hospital admissions, avoidable ER visits, inpatient psychiatric admissions, and the need for nursing home admissions. We work with area hospitals in providing transitional care services to members enrolled in Health Home.

Hospitals and care providers may refer individuals to

us for potential Health Home enrollment. Health Home eligibility is determined by Medicaid. The program provides services beyond those typically offered by care providers, including:

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



For more information about Health home program, call 1-866-815-5334.

Hearing services

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

Hospice

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

Home hospice

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

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. DSS covers residential inpatient hospice services.

DSS will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory



The Preferred Lab Network webpage provides a full listing of eligible labs.

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in 1 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 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.



Call Healthy First Steps at **1-800-599-5985**.

Healthy First Steps strives to:

- Increase early identification of expectant members 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 members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Missouri Tobacco QuitServices program
- Help identify and build the member'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

UnitedHealthcare Community Plan only allows per-visit billing for each obstetrical service. The per-visit information helps us track and evaluate prenatal and postpartum care for our members. To learn more about billing for obstetrical service as well as for global days and their values, read our Obstetrical Services policy on UHCprovider.com/policies > For Community Plans > Reimbursement Policies, type in Obstetrical Services policy.

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 **1-866-815-5334** or go to **UHCprovider.com/priorauth**. For prior authorization requirements, **UHCprovider.com/MOcommunityplan** > 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 they have an established relationship with a non-participating 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 C-section require clinical information and medical necessity review.



Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online prior authorization and notification tool at **UHCprovider.com/priorauth**, or by calling **1-866-815-5334**.

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, care provider ID
- Facility name (care provider ID)
- Vaginal or Caesarean delivery

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

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

Non-routine 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 a NP, PA 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 Babyscripts™ Rewards in Chapter 6.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the 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

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members.

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

Bright Futures assessment

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

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

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

Settings for Bright Futures implementation include:

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

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

Home care and all prior authorization services

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

Hysterectomies

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

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

Based on the physician manual for hysterectomies, do not use the Sterilization Consent Form in lieu of the Acknowledgment of Receipt of Hysterectomy Information Form MO 886-3280 (7-08). Do not attach the form or certificate of medical necessity to the claim.



Find the form on the Missouri MO HealthNet Manuals website, manuals.momed.com.

See “Sterilization consent form” section on next page for more information. Exception: MO DHSS 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. Payment 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 member’s life. In this case, follow the Missouri 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 care provider network.

Sterilization and hysterectomy procedures

Payment 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, anesthesiologist or hospital.

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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



You may also find the form on the Missouri Department of Social Services website dss.mo.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 NRS guideline for Inhaled Nitric Oxide (iNO) therapy at [UHCprovider.com/policies](https://uhcprovider.com/policies) > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Clinical Guidelines.

Pharmacy

Pharmacy preferred drug list

UnitedHealthcare Community Plan determines and maintains its preferred drug list (PDL) of covered medications.

This list applies to all UnitedHealthcare Community Plan of Missouri members. Specialty drugs on the PDL are identified by a “SP” in the “Requirements and Limits” section of each page.

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 non-preferred medication, call the pharmacy prior authorization at **1-800-310-6826** or 1-573-751-6527 or use the online prior authorization and notification tool on the [UnitedHealthcare Provider Portal](#).

We provide you PDL updates before the changes go into effect. Change summaries are posted on [UHCprovider.com](https://uhcprovider.com). Find the PDL and Pharmacy Prior Notification Request form at [UHCprovider.com/priorauth](https://uhcprovider.com/priorauth).

Pharmacy prior authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start before prior authorization is secured and the prescriber cannot be reached. The rules apply to non-preferred PDL drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call pharmacy prior authorization at **1-800-392-2161** or 1-573-751-6527. We 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, or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement

- May not be available at retail pharmacies
- May be oral, injectable, or inhaled



Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to UHCprovider.com/priorauth.

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 cardiology

Advanced imaging 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 at:

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



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

Screening, brief interventions, and referral to treatment services

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

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

What is included in screening, brief interventions, and referral to treatment services?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. 3 of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependences to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.**

SBIRT services will be covered when all of the following are met:

- The billing and servicing care providers are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is Z71.41
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per provider, per year

The SBIRT assessment, intervention, or treatment takes places in 1 of the following places of service:

- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC
- Community mental health center
- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter



For more information about E/M services and outreach, see the Department of Health and Human Services Evaluation and Services online guide at cms.gov.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and FDA-approved medications, including buprenorphine, methadone, and naltrexone, to treat opioid use disorder (OUD). To prescribe buprenorphine, you must be registered with the Drug Enforcement Administration (DEA) and authorized in accordance with state requirements. You may provide MAT services without offering in-house counseling; however, you are responsible for referring patients to qualified behavioral health care providers for counseling services when needed. To locate participating MAT care providers, including medical care providers, use the UnitedHealthcare provider directory at UHCprovider.com/findprovider. You can search the directory using applicable treatment or specialty terms, such as medication assisted treatment, to identify care providers for the applicable plan and state.



If you have questions about MAT, please call Provider Services at **1-866-815-5334**, enter your Tax Identification Number (TIN) then say “Representative,” and “Representative” a second time, then “Something Else” to speak to a representative.

Tuberculosis screening and treatment

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

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 at marchvisioncare.com for information such as compliance, electronic payment information, safety resources and training or call 1-844-516-2724.

Waiver programs

Human immunodeficiency virus/acquired immune deficiency syndrome waiver program

The human immunodeficiency virus / acquired immune deficiency (HIV/AIDS) in-home waiver services program is available to members who would otherwise require long-term institutional services.

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

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

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

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS services. These members are referred to the Long Term Care Division/ HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid Program.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering 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



For behavioral health and substance use disorder authorizations, please call **1-866-815-5334**.



If you have questions, go to your state's prior auth page: **UHCprovider.com/MOcommunityplan** > Prior Authorization and Notification Resources.

Care Management

We provide care management services to members with complex medical conditions or serious psychosocial issues. The Medical Care Management department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for care management by calling care management at **1-877-856-6351**.

Type of request	Decision TAT/ practitioner notification of approval	Written practitioner/ member notification of denial
Routine service.	Within 36 hours of the decision.	Within 36 hours of the decision.
Urgent.	Within 24 hours of request receipt.	Within 24 hours of the request.
Initial reviews of inpatient admissions.	Within 36 hours.	Within 36 hours.
Concurrent reviews of inpatient admissions.	Within 36 hours.	Notified within 36 hours of determination and member notification.
Retrospective review inpatient admissions.	Within 30 business days.	Within 14 days of determination and member notification within 1 business day.

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 Care Guidelines, 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 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 or medical director.

UnitedHealthcare Community Plan uses InterQual Care Guidelines (we previously used 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.

Lock-In Program

The Lock-In Program is a method used to protect against members overusing health care services. We analyze utilization patterns for patterns of fraud, misuse, abuse and wasteful or inappropriate care. A member may also be referred to the Lock-In Program by their care provider, a facility or other source. The Lock-In Program implemented by the health plan does not include a lock-in for pharmacy. The health plan coordinates with the state to verify appropriate identification for the pharmacy Lock-In Program.

You have the right to accept or decline being the member's single PCP (Lock-In PCP). You can refuse to continue providing care to the member if you have documented reasons for ending your relationship. In these instances, you must call Provider Services to discontinue the lock-in relationship and begin the process of assigning another lock-in provider to the member.

We may approve requests for other care providers when members show they need more than 1 physician to handle specialized treatment. We must receive these requests within 20 days of the original written Lock-In Program enrollment notification. If the other care provider does not agree to or cannot confirm the Agreement by the start date, the Lock-In PCP must make a referral.

The PCP provides and directs the member's care. They must also make any necessary referrals to other care providers, services, or facilities as medically indicated.

A medical referral form for restricted participants must be sent to the referred care provider or facility before or at the time of service being rendered. This form must be mailed in with each claim from the referred-to care provider. This form is on the Missouri provider portal at UHCprovider.com/mocommunityplan in the care provider forms section. You may also call **Provider Services** at **1-866-815-5334**.

Lock-In periods last 24 months. Case reviews are conducted by the health plan no sooner than 12 months and before the end of the Lock-In period. The health plan conducts case reviews to assess member utilization patterns. If a pattern of member misuse continues, the lock-in period renews for 24 more months.

Members selected for the Lock-In Program or whose lock-in period was extended have all appeal and fair hearing rights granted by state and federal regulations.

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at UHCprovider.com/policies > **For Community Plans**.

Referral guidelines

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

We require prior authorization of all out-of-network referrals. The nurse reviews the request for medical necessity 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.

Care provider payment

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

- Determine if the member is eligible on the date of service by using the **UnitedHealthcare Provider Portal**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Missouri 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 MO DSS. 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 care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-866-815-5334**.
- 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 UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
 - Prescription drugs
 - Long-term care services in a nursing home
 - Nursing facility services
 - Intermediate care facilities for members with mental handicap
 - Home- and community-based waiver services
 - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
 - Residential inpatient hospice services
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses

- Ambulances, unless medically necessary
- Infertility services

Services requiring prior authorization



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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

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

Utilization management guidelines



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

Utilization management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service basis.

The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Utilization management appeals

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



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

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

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 21, including pregnant members. EPSDT screening includes the following:

- Immunizations
- Hearing
- Vision
- Speech screening and nutritional assessments
- Dental screening
- 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 at Healthy Child Forms, go to: [dss.mo.gov > mhd > providers](https://dss.mo.gov/mhd/providers). Find details on how to fill out the Healthy Child form at: [manuals.momed.com > forms > HCY Screening > Guide > Instructions](https://manuals.momed.com/forms/HCY_Screening).

Childhood lead poisoning prevention services

Childhood lead poisoning prevention services may include screening, diagnosis, treatment and follow-up. All children enrolled in MO HealthNet Medicaid, regardless of whether coverage is funded through title XIX or XXI, are required to receive blood lead screening tests at ages 12 months and 24 months. For more information, see the CMS documents Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels among Young Children.

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 Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

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

Continuity of care – The regional center 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.

Full screening

Perform a full screen. Include:

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

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

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

If you find a child has a lead blood level over 10 ug/dL, notify the state by fax at 1-573-526-6946. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Safe/care examinations

Medicaid covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) Examinations. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through MO Medicaid on a fee-for-service basis. Information on SAFE-CARE examinations is located at dss.mo.gov > providers. Call MO Medicaid for more information.

Targeted case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational, and other services provided by a regional center or local governmental health program as appropriate.

Identification – The 5 target populations include:

1. Children younger than 21 at risk for medical compromise.
2. Medically fragile individuals.
3. Individuals in frail health, older than 18 and at risk of institutionalization.
4. Members in jeopardy of negative health or psychosocial outcomes.
5. Members infected with a communicable disease, including tuberculosis, HIV/AIDS, or who have been exposed to communicable diseases, until the risk of exposure has passed.

Referral – Members who are eligible for TCM services are referred to a regional center or local governmental health program.

Continuity of Care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the contract.

Vaccines for children program

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.

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 FQHC or RHC. They cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Chapter 6: Value-added services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **1-866-815-5334** unless otherwise noted.

Chronic condition management

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

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

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

Referral – PCPs may make referrals to support practice-based interventions by contacting the health services team at **1-866-815-5334**.

Early intervention program

Early Intervention promotes the development of infants and toddlers with developmental challenges and delays. It also covers certain disabling conditions. The program provides services to eligible children from birth to 3 years old and their families.

Electronic breast pumps

If your patient who is a UnitedHealthcare Community Plan member needs a breast pump, you can order it [online](#) or by calling AeroFlow Breastpumps at 1-844-867-9890. Members also have the option to order their own breast pump.

UnitedHealthcare Community Plan of Missouri covers breast pumps at no cost for members. You or the member can request 1 up to 60 days prior to the member's due date or up to 6 weeks after birth. Questions? Call **Provider Services** at **1-866-815-5334**.

Babyscripts

Pregnant members can sign up for Babyscripts™ by visiting the Apple App Store® or Google Play™ store on their smartphone and downloading the Babyscripts™ Journey app.

Babyscripts™ engages members in a variety of methods (app notifications, email and text messages) and provides daily education on important topics that are specific to pregnancy stages.

Members will also receive appointment reminders for recommended doctor visits and can earn gift cards for completing important prenatal and postpartum visits. To sign up, members can visit the Apple App Store® or Google Play™ store on a smartphone.

Download the **Babyscripts myJourney app** or call **1-800-599-5985**. It's that simple.

How can you help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Provide program information.
3. Encourage the member to enroll in Babyscripts™.

Hypoallergenic bedding

Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can help to lower asthma-related hospitalizations and ER visits. Hypoallergenic bedding is limited to individuals with asthma in case management. It is limited to \$150 annually per member. The program requires prior authorization and documentation stating they have severe asthma. The member's service coordinator will decide eligibility.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-866-351-6827** to reach a nurse.

Substance use disorder recovery coaching

Our substance use disorder (SUD) recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

Women, infants and children supplemental nutrition program

State funded program

The state also has programs, such as Women, Infants, and Children Supplemental Nutrition programs (WIC) to help with nutritional needs for low income families.

For more information about WIC, call 1-573-751-6204 or 1-800-392-8209. Or go to health.gov/living/families/wic.

Diabetes tailored meals

Member in the plan who is enrolled in diabetes disease management (DM) are eligible for diabetes tailored meals for members with diabetes. This program utilizes the UnitedHealthcare's MHD approved ABH vendor from Mom's Meals, for chronic DM which shows outcomes of improved overall health. This is a 12-week program with 4 weeks of nutritional education followed by 8 weeks of diabetic tailored meals. Members will be enrolled in case management (CM) for ongoing disease focused care.

Maternal comfort supplies

Expectant / pregnant members are eligible for maternal comfort supplies. Eligible members can select from support items such as belly band and compressions socks.

Pack n' play / car seat

Expectant / pregnant members can request one baby item up to 60 days before their estimated due date through up to 6 weeks after delivery.

Calm Health

A digital self-help app that offers mindfulness meditations for stress, anxiety, depression and more. Members can download the Calm Health app to get on-demand support at any time.

UHC Walmart + Membership

For adults 18 years and over who are eligible for case management (CM) based on screening. The benefit will provide eligible members living within 12 miles of a Walmart with a Walmart + membership. Walmart + provides free delivery from store as soon as same day, free shipping with no minimum order, Walmart reward program, video streaming on Paramount+ and fuel savings at Exxon, Mobile, and Walmart gas stations.

Chapter 7: Mental health and substance use

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

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

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

You must have 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 mmac.mo.gov > go to the section titled "Apply to be a Medicaid Provider."



How to Join Our Network: Credentialing information is available at providerexpress.com > **Our Network**.

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 1 place. [Liveandworkwell.com](https://liveandworkwell.com), accessed through a link on myuhc.com, includes mental health and well-being information, articles on health conditions, addictions and coping and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.



For member resources, go to providerexpress.com 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:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment
 - Partial hospitalization
 - Social detoxification
 - Day treatment
 - Intensive outpatient
 - Medication management
 - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
 - SUD treatment
 - Psychological evaluation and testing
 - Initial diagnostic interviews
 - Hospital observation room services (up to 23 hours and 59 minutes in duration)
 - Child-parent psychotherapy
 - Multi-systemic therapy
 - Functional family therapy
 - Electroconvulsive therapy
 - Telehealth
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online using the Eligibility and Benefits tool on the [UnitedHealthcare Provider Portal](#) > 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. Help ensure prior authorizations are in place before rendering non-emergent services. Request prior authorization using the prior authorization and notification tool on the [UnitedHealthcare Provider Portal](#) or by calling 1-800-366-7304.

Collaboration with other care providers

Coordination of care

When a member is receiving services from more than 1 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.

Portal access

You can use the UnitedHealthcare Provider Portal for all of your online services, including claims, eligibility, prior authorization, referrals and much more.

The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

Claims

Submit claims using the CMS 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate.

Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in [Chapter 11](#).

Monitoring audits

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

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention:**
 - Prevent Opioid-Use Disorders (OUD) before they occur through pharmacy management, care 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 member and child**
 - Prevent neonatal abstinence syndrome and supporting members in recovery
- **Enhanced data infrastructure and analytics**
 - Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our UnitedHealthcare Provider Portal to help ensure you have the information you need, when you need it.

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



Access these resources at **UHCprovider.com/resourcelibrary** to find a list of tools and education.

Prescribing opioids

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

Pharmacy lock-in

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

When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Expanding medication assisted treatment access and capacity

Evidence-based medication-assisted treatment (MAT) is critical to the treatment of opioid use disorder (OUD). MAT uses a chronic-condition approach that includes medication, counseling, cognitive behavioral therapies, and recovery support. We work to expand MAT access and maintain a robust network of participating care providers to support member needs. To locate participating behavioral health MAT care providers in your state, use the UnitedHealthcare provider directory at **UHCprovider.com/findprovider**. You can search the directory using applicable treatment or specialty terms, such as medication assisted treatment, to identify care providers for the appropriate plan and service area.



To find medical MAT care providers, see the MAT section/**Chapter 4**.

If you have questions about MAT, call **Provider Services at 1-866-815-5334**. Enter your TIN, then enter “0” to speak to a representative.

Chapter 8: Member rights and responsibilities

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

Privacy regulations

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

Access to protected health information

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

Amendment of protected health information

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

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

- For treatment, payment and health care operations purposes
- To 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: UHCprovider.com/mocommunityplan. Members should check the procedure section of the member rights policy to review their rights.

Native American access to care

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

Member 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 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 that 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 ER 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 for Quality Assurance (NCQA) are to:

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

Chapter 9: Medical records

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 United Healthcare 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 you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel
*Critical element	

Topic	Contact
Medical record contents	• Identification of the member including name, birth date, address and telephone number • The date(s) the member was seen • The current status of the member, including the reason for the visit • Observation of pertinent physical findings • Assessment and clinical impression of diagnosis • Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered; and • Any informed consent for office procedures – Medical records remaining under the care, custody, and control of the physician shall be maintained by the physician, or the physician’s designee, for a minimum of 7 years from the date of when the last professional service was provided – Any correction, addition, or change in any medical record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change – A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician – The member’s medical record is the property of the provider who generates the record. Upon the written request of a member, guardian, or legally authorized representative of a member, the health plan shall furnish a copy of the medical records of the member’s health history and treatment rendered. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each member is entitled to 1 free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

***Critical element**

Topic	Contact
Procedural elements	Medical records are readable* • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member’s first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • Medical and surgical history* • A family history that includes relevant medical history of parents or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

*Critical element

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

*Critical element

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).

Medical record review

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

- Problem list with:
 - Biographical data with family history
 - Past and present medical and surgical intervention
 - Significant medical conditions with date of onset and resolution
 - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (13 years and older)
- Copy of advance directive, or other document as allowed by state law, or notate member does not want on

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

Member hospitalization records should include, as appropriate:

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

Chapter 10: Quality management program and compliance information

What is the quality improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

- Providing requested timely medical records
- Cooperation with quality-of-care investigations. For example, responding to questions or completing quality-improvement action plans
- Participation in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review

- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, or secure email.
- 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, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

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

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

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

Clinical Practice Guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making. For more information, go to uhcprovider.com/cpg.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable MO statutes and the NCQA. The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat 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; and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities 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. Find applications on the Council for Affordable Quality Healthcare caqh.org website.

United Healthcare Community Plan complies with applicable federal requirements with respect to home health agencies, as amended.

Go to UHCprovider.com/join to submit a participation request.

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

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

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

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes.

We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the caqh.org 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 you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application; please connect with a live advocate via chat. It is available 7 a.m.–7 p.m. CT at UHCprovider.com/chat.

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.

If you don't meet our recredentialing requirements, we will end your participation with our network. We will send you a written termination notice in compliance with applicable laws, regulations and other requirements.

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 care 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 care 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 care 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 care provider manual.

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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
- Help ensure compliance with the security regulations by the covered entity's staff

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

Find additional information on HIPAA regulations on 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 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 report questionable incidents involving members or care providers, call our fraud, waste and abuse line, go to uhc.com/fraud, or refer to the fraud, waste, and abuse section of this care provider manual for additional details.

Please refer to the fraud, waste and abuse section of this manual for additional details about the UnitedHealthcare Community Plan fraud, waste, and abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts.

When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable care 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 MO 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 MO 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 MO program Agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

You must cooperate with the state or any of its authorized representatives, the MO Department of Health and Human Services, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your care 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 care Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable care 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 assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all 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

Our claims process



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

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**. Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the 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 payment 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.

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

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

Clean claims and submission requirements

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

- A health service provided by an eligible health care provider to a covered 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 NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at UHCprovider.com/guides.

You can also visit UHCprovider.com/policies. Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol

Electronic claims submission and billing

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

- All claims are set up as “commercial” through the clearinghouse
- Our payer ID is 86050
- 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** section.

Electronic data interchange companion documents

UnitedHealthcare Community Plan's electronic data interchange (EDI) 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. For more information see UHCprovider.com/edi > **EDI transaction and code set link**.

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, go to UHCprovider.com/edi > **EDI Clearinghouse Options**.

e-Business Support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For further information about EDI online, go to UHCprovider.com/resourcelibrary to find **Electronic Data Interchange** menu.

Electronic payment solution: OptumPay

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

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/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/EDI**.

Visit the [National Uniform Claim Committee](https://www.nucm.org/) 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 CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

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. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary care 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, they received ER treatment, observation, or other outpatient hospital services.

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

Form reminders

- Note the attending provider name and identifiers for the 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 care provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

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

- **Subrogation:** We may recover benefits paid for a 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 care provider's name is placed in box 31, and the servicing care 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.

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.

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

Billing guidelines for 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.

Medical necessity

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

Place of service codes

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

Asking about a claim

You can ask about claims through Provider Services and the **UnitedHealthcare Provider Portal**.

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.

UnitedHealthcare Community Plan Provider Portal

Go to UHCprovider.com and sign in to view your claims transactions

Resolving claim issues

View the **appeals and grievances grid** for submission information.

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

For paper claims

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

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

Timely filing

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

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

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

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

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

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

Balance billing

Do not balance bill members if:

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

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

If you don't know who your provider advocate is, connect with a live advocate via chat on [UHCprovider.com/chat](https://www.uhcprovider.com/chat), available 7 a.m.–7 p.m. CT.

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 provider 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. We no longer use fax numbers.

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?	Digital submission and address	Online form for 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 resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care provider	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240	UHCprovider.com/claims	1-866-815-5334 , TTY 711	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations .	365 days from claim denial/paid date.	365 days from claim denial/paid date.
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			1-866-815-5334 , TTY 711	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . For further information on reconsiderations see the Reconsideration and Appeals Interactive Guide .	365 days from claim denial/paid date.	365 days from claim denial/paid date.
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			1-866-815-5334 , TTY 711	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . For further information on appeals see the Reconsideration and Appeals Interactive Guide .	90 calendar days from reconsideration decision date.	Acknowledge receipt: 10 calendar days. Resolution: 30 calendar days.

Chapter 12: Claim reconsiderations, appeals, and grievances

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider grievance/complaint	A complaint expressing dissatisfaction or dispute with policy, procedure, operations or any aspect of health plan functions.	Care provider	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364		1-866-815-5334 , TTY 711	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations .	90 days from incidence date.	Acknowledge receipt: 10 business days. Resolution: 90 calendar days.
Member appeal	A request to change an adverse benefit determination that we made.	*Member *Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent.	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims *AOR Consent Form on this site for member appeals.	1-866-292-0359 , TTY 711		60 calendar days.	Urgent appeals – 72 hours. Standard appeals – 30 days.
Member grievance	A member's expression of dissatisfaction regarding the plan or care provider, including quality of care concerns.	*Member *Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent.	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364		1-866-292-0359 , TTY 711		N/A	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 provider agreements 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**

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

- **Claim lacks information**

Basic information is missing, such as a person's date of birth; or information is incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

- **Eligibility expired**

Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

- **Claim not covered by UnitedHealthcare Community Plan**

Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

- **Time limit expired**

This is when you don't send the claim in time.

Claim correction

What is it?

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

When to use:

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

How to use:

View the [appeals and grievances grid](#) for 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.

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.

View the [appeals and grievances grid](#) for submission information.

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it cannot be paid.

To submit the corrected claim information, see claim correction and reconsideration section of this chapter for more information.

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

Reconsiderations can be done repeatedly but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records

For medical necessity denials:

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

How to use:

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

View the [appeals and grievances grid](#) for submission information.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call Provider Services if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements

- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- 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 (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

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

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:

View the [appeals and grievances grid](#) for submission information.

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

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

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

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

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

Where to send:

Mail refunds with an overpayment return check or the overpayment refund/notification form to:

UnitedHealthcare Community Plan

ATTN: Recovery Services

P.O. Box 740804

Atlanta, GA 30374-0800

Instructions and forms are on [UHCprovider.com/claims](https://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. See **Chapter 10**, Resolving disputes section.

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

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/26	14A0000000001	01/31/26	\$115.03	\$115.03	Double payment of claim.
2222222	02/02/26	14A0000000002	03/15/26	\$77.29	\$27.29	Contract states \$50.00, claim paid \$77.29.
3333333	03/03/26	14A0000000003	04/01/26	\$131.41	\$98.56	You paid 4 units, we billed only 1.
44444444	04/04/26	14A0000000004	05/02/26	\$412.26	\$412.26	Member has other insurance.
55555555	05/05/26	14A0000000005	06/15/26	\$332.63	\$332.63	Member terminated.

Appeals (step 2 of dispute)

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 use:

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

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information.

View the [appeals and grievances grid](#) for submission information.

For disputes regarding payment for covered services between health plan and provider, the member will not be charged for any of the disputed cost except as allowed with a private pay agreement.

Questions about your appeal or need a status update?

Call Provider Services for questions about your appeal, or if you need a status update or assistance in the provider appeal filing process.

State appeals and administrative hearings

State care provider appeal request: A written request asking for a state review of a care provider appeal resolution.

State care provider appeal decision: The written determination concerning a state care provider appeal request.

If UnitedHealthcare Community Plan's appeal resolution is not wholly in your favor, you may request a state provider appeal no later than 90 calendar days from UnitedHealthcare Community Plan's appeal resolution date. The health plan will cooperate with MO HealthNet until a state provider appeal decision is issued.

Send the MO HealthNet Provider Appeal copy of UnitedHealthcare Community Plan's final decision, and any other supporting documentation by email, fax or mail to:

Email: MHD.PROVIDERAPPEAL@dss.mo.gov

Fax: 1-573-526-3946

Mail: MO HealthNet Division
Attn: Provider Appeals
PO Box 6500
Jefferson City, MO 65109

If you have questions about your state appeal, call Provider Appeals at 1-573-751-3425.

MO HealthNet will acknowledge receipt of your state appeal request within 10 calendar days. The state's appeal decision will be within 90 days of receiving all requested information from you.

If the state's appeal decision is in Agreement with UnitedHealthcare Community Plan's appeal decision, you have the right to appeal MO HealthNet's decision to the Administrative Hearing Commission.

You must file an appeal with the Administrative Hearing Commission within the following time frames:

- 30 calendar days from the state's decision. The claim must be at least \$500.
- 90 calendar days from the state's decision for cumulative claims. The claims must total at least \$500.

Care provider grievance/complaint

What is it?

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

When to file:

You may file a grievance/complaint 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:

View the [appeals and grievances grid](#) for submission information.

You may only file a grievance on a member's behalf with the written consent of the member.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Member appeals

What is it?

A review by UnitedHealthcare Community Plan of an adverse benefit determination.

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

- Reduces, suspends or ends a previously authorized service
- Refuses, in whole or in part, a clean claim 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

Other kind of appeals include:

- **Administrative appeal:** an appeal of an adverse benefit determination based on the member's Medicaid benefit plan (e.g., the service is excluded under the plan)
- **Clinical appeal:** an appeal of a utilization review adverse benefit determination in which the adverse benefit determination is based on medical necessity or because the service requested is experimental, investigational or unproven
- **Pre-service appeal:** a request to change a plan denial of care or a service before the member gets the care or service (e.g., appeals of pre-authorization requests)
- **Post-service appeal:** a request to change a claim denial or reduce payment for services the member already received

A member and an authorized representative (with the written consent of the member) who is not a care provider may request a continuation of benefits while the appeal is pending if that request occurs on or before the later of the following timely filing requirements:

- Within 10 calendar days of UnitedHealthcare Community Plan sending the notice of adverse benefit determination

- On the intended effective date of UnitedHealthcare Community Plan's proposed adverse benefit determination

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 on the notice of adverse benefit determination.

View the [appeals and grievances grid](#) for submission information.

How to use:

Whenever we 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 in 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 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 providerforms.uhc.com.

Member grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan 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.

View the [appeals and grievances grid](#) for submission information.

We will send an answer no longer than 30 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 MO Medicaid services should not have been denied, reduced or terminated.

When a member's appeal with UnitedHealthcare Community Plan is not decided in their favor, they may request a state fair hearing. They may also request one if UnitedHealthcare Community Plan fails to adhere to the notice and timing requirements for filing a grievance or appeal, and the member has exhausted the health plan's internal level of appeal.

If they have been getting medical care, and UnitedHealthcare Community health plan reduces, suspends or terminates the service, members can appeal. For medical care not to stop while they appeal the decision, they must appeal within 10 days from the date the Notice of Adverse Benefit Determination was mailed. They must tell us not to stop the service while they appeal.

If, at the member's request, UnitedHealthcare Community Plan continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until 1 of following occurs:

- The member withdraws the appeal or request for state fair hearing

- The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after UnitedHealthcare Community Plan sends the notice of an adverse resolution to the member's appeal
- A state fair hearing office issues a hearing decision adverse to the member

If the adverse benefit determination is upheld, a member may be required to pay for the cost of the services furnished pending the outcome of the appeal or state fair hearing.

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:

MO HealthNet Division Stakeholders Services
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the member appeal or 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 or regulation.

Fraud, waste, and abuse

Call the 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 law, 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 UHCprovider.com/mocommunityplan > 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 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

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 Monday–Friday, 7 a.m.–7 p.m. CT, 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.
- **UHCprovider.com/MOcommunityplan:** The UnitedHealthcare Community Plan of Missouri page has state-specific resources, guidance and rules.
- **Policies and protocols:** **UHCprovider.com/policies > For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols.
- **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)

- **Missouri health plans:** **UHCprovider.com/MO** is the fastest way to review all of the health plans UnitedHealthcare offers in Missouri. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (Commercial and Medicare Advantage) offered in that market.
- **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 care provider 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 training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in 1 of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to “Profile & Settings,” then “Account Information” to manage your email.

Care provider office visits

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

Care provider manual

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

State websites and forms

Find the following forms on the state’s website at dss.mo.gov:

- Sterilization consent form
- Informed consent for hysterectomies form
- Provider Service Agreement (MC 19 form)