



2026 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

New York

Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual. This up-to-date reference PDF allows you and your staff to find important information, such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites in the **How to Contact Us** section.

Click to access different care provider manuals

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

View the [Medicaid glossary](#) for definitions of terms commonly used throughout the care providers manual.



If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-866-362-3368**.



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

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 provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- “Community Plan” refers to the UnitedHealthcare Medicaid plan
- “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us
- “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to “ID card” includes 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 New York state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children, from birth through 18 years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- 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

We offer the following Medicaid plans:

- UnitedHealthcare Community Plan
- UnitedHealthcare Wellness4Me (HARP)

CHIP Plans

- Child Health Plus

Marketplace Plan

- Essential Plan

Dual Eligible Plans (Medicare-Medicaid)

- UnitedHealthcare Dual Complete NY-S002 (HMO POS D-SNP)
- UnitedHealthcare Dual Complete NY-Q001 (HMO POS D-SNP)
- UnitedHealthcare Dual Complete NY-S001 (PPO D-SNP)
- UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)

UnitedHealthcare Dual Complete® NY-Y001 (HMO D-SNP) is part of the Medicaid Advantage Plus (MAP) plan, which UnitedHealthcare will participate in 2023.

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call **Provider Services** at 1-866-362-3368.

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 the care provider 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 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 community health worker (CHW) 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 providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call our Case Management hotline at **1-800-493-4647**. Members may also call this line directly.

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
- 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

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 more information, go to UHCprovider.com/resourcelibrary > Health Equity Resources > **Cultural Competency**.

Coverage of medical language interpreter services

UnitedHealthcare Community Plan reimburses integrated outpatient departments (Articles 28, 31, 32, and 16), hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf or hard of hearing. This payment is made based on rates established in care Provider Agreements or the following rates:

HCPCS procedure code T1013	Office-based practitioners	Article 28, 31, 32 and 16 facilities that bill with ambulatory patient groups (APG)
1 Unit: Includes a minimum of 8 and up to 22 minutes of medical language interpreter services.	\$11.00	\$11.00
2 Units: Includes 23 or more minutes of medical language interpreter services.	\$22.00	\$22.00

Patients with LEP are defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff.

You must document in the medical record your need for a medical language interpreter. The interpreter should be employed by or contracts with you and should attend the medical visit. These services may be provided either face-to-face or by telephone.

The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013-sign language and oral interpretation services and is billable during a medical visit. Medical language interpreter services are included in the prospective payment system rate for those FQHCs that do not participate in APG reimbursement.

UnitedHealthcare Community Plan provides the following:

- **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**.
- **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**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

For a complete list of UnitedHealthcare policies and clinical guidelines, see [UHCprovider.com/nycommunityplan](https://uhcprovider.com/nycommunityplan) > **Current policies and clinical guidelines**.

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](https://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)
 - Electronic remittance advice (ERA/835)

Visit [UHCprovider.com/edi](https://uhcprovider.com/edi) for more information. Learn how to optimize your use of EDI at [UHCprovider.com/optimizeedi](https://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](https://uhcprovider.com/poca).

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow [these steps](#) to register

Here are the most frequently used portal tools:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to [UHCprovider.com/eligibility](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** – Contact NYRx@health.ny.gov or 1-800-541-2831 for Medicaid pharmacy policy-related questions
- **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, which 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 timeframes
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

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

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

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network care 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 it 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 1-866-362-3368	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits	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.
Care model (care management)	1-800-493-4647 UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP): 1-866-214-1746	Refer high-risk members (e.g., special health care needs, disabilities, cancer, diabetes, HIV/AIDS) and members who need private-duty nursing.
Chiropractor care	myoptumhealthphysicalhealth.com 1-800-873-4575	Benefit coverage varies by age and plan. Contact Provider Services for more information.
Claims	UHCprovider.com/claims 1-866-362-3368 Mailing address: UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): UnitedHealthcare Community Plan 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	Sign in to UHCprovider.com/claims to access the UnitedHealthcare Provider Portal. 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.

Topic	Contact	Information
COVID-19 guidance for Medicaid care providers	COVID-19 Guidance for Medicaid Providers (ny.gov)	Medicaid Managed Care (MMC) Plans will pay care providers no less than the Medicaid fee-for-service (FFS) rate for COVID-19 vaccine administration, in addition to stating, “MMC Plans must cover the cost of vaccine administration by qualified care providers who do not participate in the MMC Plan’s network.” UnitedHealthcare Community Plan will separately reimburse all COVID-19 vaccinations at the published Medicaid rate, regardless of participation status or negotiated reimbursement policy.
Dental care	UnitedHealthcare Dental 1-800-304-0634	Contact UnitedHealthcare Dental for all dental care.
Electronic Data Intake (EDI) Issues	EDI Transaction Support Form UHCprovider.com/edi ac_edi_ops@uhc.com 1-800-210-8315	Contact EDI Support for issues or questions.
Eligibility	UHCprovider.com/eligibility 1-866-362-3368	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.
Foster care liaison	Email: nyfostercare@uhc.com Foster care liaison main number: 1-855-883-5403 . After hours number/Provider Services: 1-866-362-3368 .	Foster care information aligns with New York State standards, regulations and requirements from the New York State Office of Children and Family Services, Department of Health, Office of Mental Health and Office of Addiction Services and Supports.
Fraud, waste, and abuse (payment integrity)	UHCprovider.com/NYcommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud UnitedHealthcare Special Investigations Unit Four Gateway Center 100 Mulberry Street – 4th Floor Newark, NJ 07102 1-844-359-7736 (FWA hotline) or 1-877-401-9430 (vendor hotline)	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.

Topic	Contact	Information
Laboratory services	UHCprovider.com/findprovider > Preferred Lab Network	The Preferred Lab Network webpage provides a full listing of eligible labs.
NY Medicaid [Department of Social Services]	NY Medicaid Medicaid numbers: health.ny.gov/health_care/medicaid/program/contact.htm. Department of Social Services contact information for each county: health.ny.gov/health_care/medicaid/ldss.htm.	Contact Medicaid directly. 1-800-541-2831 Mail: NY State of Health P.O. Box 11774 Albany, NY 12211 Email: 1095B@health.ny.gov
Medical claim, reconsideration and appeal	UHCprovider.com/claims Most care providers in your state must submit reconsideration and appeals requests electronically. For further information on reconsiderations and appeals, see the Reconsiderations and Appeals interactive guide.	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	myuhc.com[®] Community Plan 1-800-493-4647, TTY 711 Monday–Friday, 8 a.m.–6 p.m. ET. Wellness4Me 1-866-433-3413, TTY 711 24 hours a day, 7 days a week. Essential Plan 1-866-265-1893, TTY 711 Monday–Friday, 8 a.m.–6 p.m. ET. Child Health Plus 1-800-493-4647, TTY 711 Monday–Friday, 8 a.m.–6 p.m. ET. Foster Care 1-800-493-4647, TTY 711 Monday–Friday, 8 a.m.–6 p.m. ET. Dual Complete: 1-800-514-4912 October – March: 7 days a week, 8 a.m.–8 p.m. ET. April – September: Monday–Saturday, 8 a.m.–8 p.m. ET. TTY 711 for help accessing member account. UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP): 1-866-547-0772, TTY 711 Monday–Friday, 8 a.m.–8 p.m. ET.	Assist members with issues or concerns.

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-493-4647 , TDD 711	Available Monday-Friday, 8 a.m.–6 p.m. ET, except state-designated holidays.
National Plan and Provider Enumeration System (NPES)	npes.cms.hhs.gov 1-800-692-2326 (TTY for the deaf, hard of hearing or those with speech difficulties).	Apply for a National Provider Identifier (NPI).
Network management	Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal . Home- and Community-Based Services (HCBS) and Long-Term Services and Supports (LTSS): nyhp_hcbspra@uhc.com .	A team of provider relation advocates. Ask about contracting and Provider Services. Ask about HCBS and LTSS care provider relations advocate and contracting services.
Network management support	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at UHCprovider.com/chat .	Self-service functionality to update or check credentialing information.
NurseLine	1-877-597-7801	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy notification form at UHCprovider.com , then sign in to 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.
Office for people with developmental disabilities (OPWDD)	opwdd.ny.gov > Contact Us 1-866-946-9733	Responsible for coordinating services for people with developmental disabilities.
Oncology prior authorization	UHCprovider.com/oncology 1-888-397-8129 , Monday-Friday, 7 a.m.–7 p.m. CT.	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat, with a live advocate, 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.

Topic	Contact	Information
Prior authorization requests/advanced & admission notification	(Does not apply to Medicare HMO). 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" or call 1-800-493-4647. Provider Services: 1-866-362-3368 UnitedHealthcare Dual Complete NY-S002 (HMO-POS D-SNP) 1-800-514-4912 UnitedHealthcare Dual Complete NY-Q001 (HMO-POS D-SNP) 1-800-514-4912 UnitedHealthcare Dual Complete NY-S001 (PPO D-SNP) 1-800-514-4912	Use the prior authorization and notification tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/prior authorization lists: UHCprovider.com/NYcommunityplan > Prior Authorization and Notification
Provider Services	UHCprovider.com/NYcommunityplan 1-866-362-3368	Available Monday-Friday, 8 a.m.-6 p.m. ET.
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 1-866-362-3368	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	UHCprovider.com/nycommunityplan > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Vision services	MARCH® Vision Care 1-844-716-2724	Prior authorization is not required for all routine eye exams and hardware. You must verify eligibility and confirm available benefits.
Technical support	For chat options and contact information, visit UHCprovider.com/contactus . 1-866-209-9320 for Optum support.	Call if you have issues logging in to the UnitedHealthcare Provider Portal , you cannot submit a form.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transmittal forms submission	Email: americhoice_ny_chp@uhc.com and nyfostercare@uhc.com	

Topic	Contact	Information
Utilization Management	Provider Services 1-866-362-3368	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 (VFC) program	Go to the NYC.gov site or call 1-800-KID-SHOTS (1-800-543-7468).	Medicaid enrolled physicians, nurse practitioners and referred ambulatory care providers must be registered with the VFC program to receive payment for VFC-provided vaccines to Medicaid-eligible members younger than 19 years of age. You may also bill Evaluation and Management Service. Call 1-800-543-7468 (1-800-KID-SHOTS) to find VFC information or registration material.
Website for New York Community Plan	UHCprovider.com/NYcommunityplan	Access state-specific Community Plan care provider information.

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 because of age, race, creed, color, national origin, citizenship or immigration status, sexual orientation, gender identity or expression, military status, sex, disability, predisposing genetic characteristics, familial status, marital status, or domestic violence victim status or because the individual has opposed any practices forbidden under the Human Rights Law or has filed a complaint, testified, or assisted in any proceeding under the Human Rights Law. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Screening for behavioral health problems

PCPs are required to screen UnitedHealthcare members for behavioral health problems (i.e., chemical dependence) and mental health. PCPs should file the completed screening tool in the patient's medical record.

Screening tools

UnitedHealthcare recommends the following assessment tools and resources to guide your patient care:

- [Patient Health Questionnaire \(PHQ-9 and PHQ - 2\)](#) - The Patient Health Questionnaire is a self-report instrument used to screen for the presence and severity of depression and to monitor the response to treatment. It is widely used in medical settings.

Initial substance use disorder assessments

Initial substance use disorder (SUD) tools approved by the Office of Addiction Services and Supports (OASAS) for adolescents:

- Car, Relax, Alone, Forget, Friends Trouble Screening (CRAFT)
- Global Appraisal of Individual Needs (GAIN)
- Alcohol Use Disorder Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST-10)
- Refer to **Appendix E** in this manual for links to these and other SUD assessment tools

Assessment tools approved by Office of Addiction Services and Supports for adolescents with co-occurring initial substance use disorder and mental illness

- Pediatric Symptom Checklist (PSC-17)
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Patient Health Questionnaire 9: Modified for Teens (PHQ -9 Modified for Teens)
- Generalized Anxiety Disorder 7 (GAD-7)
- Patient Health Questionnaire 2: Modified for Teens (PHQ-2)
- Center for Epidemiologic Studies Depression Scale for Children (CES-DC)
- Child PTSD Symptoms Scale (CPSS)
- Child and Adolescent Trauma Screen (CATS) Youth Report
- Screen for Child Anxiety Related Emotional Disorders (SCARED)
- Ask Suicide Screening Questions (ASQ)
- Strengths and Difficulties Questionnaire (SDQ) (S17+) (SDQ)
- Refer to the following link for additional information about OASAS-approved screening instruments for co-occurring mental health problems: oasas.ny.gov/system/files/documents/2020/10/adolescent_screening_instruments.pdf

Project TEACH (Training and Education for the Advancement of Children's Health)

Support for PCPs: projectteachny.org

- Call for consultations today
- Speak directly to a child and adolescent psychiatrist
- Enhance the care you provide to kids with mild to moderate mental health concerns

- Set up face-to-face consultations to meet directly with experts

OnTrackNY

Offers specialized clinical service for adolescents and young adults between the ages of 16 and 30 who have been experiencing psychotic symptoms for more than a week but less than 2 years.

To learn more or make a referral visit the OnTrackNY [website](#) and click on the Providers tab.

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. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program. Loss or suspension of your license to practice.
3. Departure from your practice for any reason.
4. Closure of practice.

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

Care authorization for new members

UnitedHealthcare Community Plan will honor plans of care (including DME, prosthetic and orthotic appliances and any other ongoing services) initiated before a new member's enrollment until the PCP evaluates the member and establishes a new plan of care.

Service continuation for new members

If a new member has an existing relationship with a care provider who is not a member of the care provider network, the member is permitted to continue an ongoing course of treatment by the non-participating care provider during a transitional period of up to 60 days from the effective date of enrollment, if:

1. The member has a life threatening disease or condition or a degenerative and disabling disease or condition; or
2. The member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period will include the provision of post-partum care directly related to the delivery. If the new member elects to continue to receive care from the non-participating care provider, care will be authorized for the transitional period only if the care provider agrees to:
 - a. Accept payment at rates established by the Plan as payment in full at no more than the level of payment applicable to a similar care provider within our network for such services,
 - b. Adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care, and
 - c. Otherwise adhere to our policies and procedures including, but not limited to, procedures for referrals and obtaining prior authorization in a treatment plan approved by us. This does not require us to provide coverage for benefits not otherwise covered.

Continuing care when you leave the network

The member may continue treatment with you during a transitional period. This includes when you leave our network for reasons other than imminent harm to members, fraud, or a final disciplinary action from the state licensing board. The transitional period will begin on the date the contract is no longer effective and will continue up to 90 days from the date your contractual obligation to provide member services to our plan's member terminates; or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through post-partum care. If the member elects to continue to receive care from you, care will be authorized for the transitional period only if you agree to:

1. Accept payment at rates established by the Plan as payment in full at no more than the level of payment applicable to similar care providers within our network for such services,
2. Adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care, and
3. Otherwise adhere to our policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by us. This does not require us to provide coverage for benefits not otherwise covered.

Upon termination of the care Provider Agreement, UnitedHealthcare Community Plan will reassign members to an alternative care provider. However, if you leave the network, you must continue to furnish covered services to any member who, at the time of termination of the care Provider Agreement, is an inpatient or other institution until the member's discharge.

Upon termination of the care Provider Agreement, a member may continue an ongoing course of treatment with you, at the member's option, for a transitional period of up to 60 days from the date the member was notified by UnitedHealthcare Community Plan of the termination of the care Provider Agreement.

UnitedHealthcare Community Plan, in consultation with you and the member, may extend the transitional period if clinically appropriate. Continued care will be provided under the same terms and conditions.

Second opinion

Seek a second opinion in the UnitedHealthcare Community Plan network. UnitedHealthcare Community Plan can assist with arrangements for a second opinion outside of the network at no cost. This may be asked for when the member or guardian needs to know more about treatment or thinks the care provider is not giving requested care. Referral for in-network care providers or prior authorization for out-of-network care providers required.

Care provider termination

It is the policy of UnitedHealthcare Community Plan to provide due process to physicians who are terminated by UnitedHealthcare Community Plan for Quality of Care reasons. If UnitedHealthcare Community Plan decides to terminate the participation Agreement for cause and quality of care reasons, you have the right to appeal the determination based on the following protocols:

Quality concerns: Concerns regarding the healthcare professional's competence or professional conduct which could adversely affect, or could adversely affect the health or welfare of an UnitedHealthcare Community Plan member or any other patient of a healthcare professional.

Clinical privileges – The ability to furnish medical care to persons enrolled in UnitedHealthcare Community Plan.

The hearing procedure is not available in any other circumstances, included but not limited to the following:

- When UnitedHealthcare Community Plan has suspended or restricted healthcare professional's privileges for a period of time of no longer than 14 days, during which time an investigation is being conducted to determine the need for action
- When UnitedHealthcare Community Plan decides not to renew a healthcare contract

UnitedHealthcare Community Plan will not terminate or refuse to renew a contract solely because a healthcare professional has:

- Advocated on behalf of a member
- Filed a complaint against UnitedHealthcare Community Plan
- Appealed a decision of UnitedHealthcare Community Plan

- Made a report to an appropriate governmental body regarding the policies or practices of UnitedHealthcare Community Plan that the healthcare professional believes may negatively impact upon the quality of, or access to, patient care.
- Requested a hearing or review

In addition to the information provided in this section, please refer to your Agreement for termination information, including, but not limited to, notice of action, hearings, time of filing a response.

Procedure

UnitedHealthcare Community Plan reserves the right to terminate the participation status of any participating physician without cause upon 90 days prior written notice delivered to the physician, or as otherwise required under the terms of the care provider contract.

UnitedHealthcare Community Plan is legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrence of any of the following:

1. Termination of a health care physician for reasons relating to alleged mental or physical impairment, misconduct or impairment of member safety or welfare
2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures
3. Termination of a health care provider contract, in the case of a determination of fraud or in a case of imminent harm to a member's health

UnitedHealthcare Community Plan cannot prohibit a care provider from the following actions nor may the MCO terminate or refuse to renew a contract solely for the following:

- (a) Advocated on behalf of an enrollee
- (b) Filed a complaint against an MCO
- (c) Appealed a decision of the MCO
- (d) Provided information or filed a report pursuant to PHL4406-c regarding prohibitions of plans
- (e) Requested a hearing or review

A care provider terminated due to a case involving imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or a review.

Immediate termination

UnitedHealthcare Community Plan will immediately remove any care provider from the network who is unable to provide health care services due to a final disciplinary action. UnitedHealthcare Community Plan may immediately terminate a physician's participation in the network if one of the following events occurs:

- The physician fails to maintain any of the licenses, certifications or accreditations required by the care provider's Agreement with UnitedHealthcare Community Plan or by state government programs
- UnitedHealthcare Community Plan determines that immediate termination is in the best medical interest of the members pursuant to the terms of your Agreement and applicable NY state law
- A state licensing board or other agency has made a determination that limits, impairs, or otherwise encumbers the physician's ability to practice his/her profession
- The Centers for Medicare and Medicaid Services determine that the physician has not satisfactorily performed his/her obligations under the physician's Agreement with UnitedHealthcare Community Plan
- There has been a determination of fraud against the physician
- The physician is terminated or suspended by the State of New York Medicaid Program or the federal Medicare Program. In case of immediate termination, UnitedHealthcare Community Plan will notify the physician in the most expeditious manner and by certified letter.
- Care providers who are sanctioned by the DOH's Medicaid Program will be excluded from participation in UnitedHealthcare Community Plan's Medicaid panel

Termination for failure to comply with quality management requirements

The Quality Management Committee, based upon recommendations made by the Provider Affairs Subcommittee, may suspend or terminate any health care physician's participation in the network.

UnitedHealthcare Community Plan may initiate termination proceedings regarding a physician's network participation for several reasons, including failure to implement and comply with his/her corrective action plan, refusal to make medical records available for examination, failure to submit recredentialing information, or failure to comply with and participate in the quality management program. In the case of termination for failure to comply with Quality Management requirements, a medical director or physician reviewer will send the physician a certified letter notifying him/her of the intent to terminate his/her network participation privileges.

Notice of proposed action

The Plan will not terminate a contract with a health care professional unless the Plan provides the health care professional a written explanation for reasons for the proposed contract termination and an opportunity for a review or hearing, at the care provider's discretion, before a panel appointed by the Plan, as described below.

The notice of proposed action will contain the following information:

- Notification that a professional review action has been recommended against the physician
- The reasons for the proposed action and any supplemental materials
- Notification that the physician may request a hearing within 30 days from receipt of the notice; failure to request the hearing will make the termination notice final

UnitedHealthcare Community Plan must include in the termination notice the reasons for the proposed action and:

- (a) Notice that the care provider has the right to request a hearing or review, at the providers discretion, before a panel appointed by the MCO
- (b) A time limit of not less than 30 days within which a healthcare professional may request a hearing.
- (c) A time limit for a hearing date which must be held within 30 days after the date of receipt of a request for a hearing.

Notice of hearing

- After receipt of a physician's request for hearing, a notice of hearing together with any supplemental materials will be served upon the physician
- If a physician requests a hearing within 30 days, UnitedHealthcare Community Plan will notify the physician of the place, time and date of the hearing. The date of the hearing will be no later than 30 days after the request for a hearing, unless otherwise agreed to by the physician and UnitedHealthcare Community Plan.
- UnitedHealthcare Community Plan will include a list of the witnesses (if any) expected to testify at the hearing on behalf of the Quality Management Committee

Time of filing a response

- At least 5 business days prior to the hearing, the physician must file a written response to the Termination Notice
- The Physician's Response must be filed with UnitedHealthcare Community Plan to the person and address identified in the Termination Notice, and a copy served upon each attorney of record and upon each party not represented by an attorney
- The Physician's Response must be in writing, the original being signed by the physician or their representative. The Physician's Response must contain the physician's address, telephone number and, if made by an attorney or if the physician will make use of an attorney, the name and post office address and telephone number of the attorney.
- The Physician's Response must contain a separate and specific response to each and every particular of the Termination Notice or a denial of any knowledge or information thereof sufficient to form a belief
- Any allegation in the Termination Notice which is not denied, will be deemed admitted
- If the Physician fails to respond to the Termination Notice, the Termination Notice will be deemed final

Hearings

Appearances

- All parties to the proceeding may be present and must be allowed to present testimony in person or by counsel and call and question witnesses

- If a respondent fails to appear at the duly noted time and place of the hearing and the hearing is not adjourned, irrespective of whether a response to the Termination Notice has been filed, the hearing must proceed on the evidence in support of the Termination Notice. Upon application, the hearing panel for good cause shown may reopen the proceeding, upon equitable terms and conditions.
- Prior to an order after hearing, a default entered upon a physician's failure to appear may be reopened, for good cause shown, upon written application to the hearing panel

Conducting hearing

The hearing panel will be comprised of 3 persons appointed by the MCO. At least 1 person on the panel in the same discipline or same specialty as the person under review. The panel can consist of more than 3 members, provided the number of clinical peers constitute one-third or more of the total membership.

Form and content of proof

The hearing panel, in conducting the hearing, should use any procedures consonant with fairness to elicit evidence concerning the issues before the panel. The following guidelines must govern:

- This is not an adversarial proceeding, but rather one of inquiry and clarification protected by the peer review privilege and thus confidential
- All witnesses will be sworn in at the commencement of the proceeding
- With the permission of the hearing panel, parties will be allowed to ask clarifying questions throughout the testimony of any particular witness, thus saving hearing time and avoiding confusion on a particular subject of testimony
- Hearsay evidence is fully admissible
- The physician will present their evidence, testimonial and documentary first, followed by the evidence, testimonial and documentary of UnitedHealthcare Community Plan
- UnitedHealthcare Community Plan's representative will prepare a binder of evidentiary exhibits to be shared with the hearing panel at the time of the hearing; a copy of the binder will be sent to the physician or his/her representative prior to the hearing

- Documentary evidence may be admitted without testamentary foundation, where reasonable
- Witness information need not be introduced in the form of question and answer testimony
- Information from witnesses may be introduced in the form of affidavits
- The parties have the right to call and question witnesses
- A stenographic record will be taken of the proceedings
- Written stipulations may be introduced in evidence if signed by the person sought to be bound thereby or by that person's attorney-at-law. Oral stipulations may be made on the record.
- Where reasonable and convenient, the hearing panel may permit the testimony of a witness to be taken by telephone, subject to the following conditions:
 1. A person within the hearing room can testify that the voice of the witness is recognized, or identity can otherwise be established.
 2. The hearing panel, reporter and respective attorneys can hear the questions and answers.
 3. The witness is placed under oath and testifies that he or she is not being coached by any other person.

Powers of the hearing panel

The hearing panel will render a decision in a timely manner. The hearing panel has the following powers to control the presentation of the evidence and the conduct of the hearing:

- To fully control the procedure of the hearing, subject to these rules, and to rule upon all motions and objections, and to issue a final determination affirming, modifying or reversing the Notice of Termination in whole or in part including:
 - Uphold the suspension or termination
 - Reinstate the physician subject to conditions set forth by UnitedHealthcare Community Plan, which may include a corrective action plan
 - Refuse to consider objections which unnecessarily prolong the presentation of the evidence
 - Foreclose the presentation of evidence that is cumulative, argumentative, or beyond the scope of the case
 - Place evidence in the record without an offer by a party
 - Call and to question witnesses

- Have oaths administered by a notary public or stenographic reporter who is also a notary; to exclude non-party witnesses who have not yet testified from the hearing room
- Direct the production of documents and other evidentiary matter
- Propose stipulations of fact for the parties' consideration
- Issue interim or tentative findings of fact at any point during the hearing process
- Issue questions delimiting the issues for hearing
- Direct further hearing sessions for the taking of additional evidence or for other purposes, upon the hearing panel's own finding that the record is incomplete or fails to provide the basis for an informed decision
- Amend the Termination Notice to conform to the proof

Decisions of the panel will include one of the following and will be provided in writing to the health care professional: reinstatement; provisional reinstatement with conditions set forth by the Plan, or termination.

Hearing record

The record of the hearing may be taken by shorthand reporting, tape recording, or other reasonable method. The method chosen must be within the discretion and direction of UnitedHealthcare Community Plan.

Hearings

Hearings will be confidential in support of the peer review privilege which governs this proceeding. The hearing panel may exclude from the hearing room or from further participation in the proceeding any person who engages in improper conduct at the hearing. The hearing must be conducted with dignity and respect.

Settlements

Where the parties agree to a settlement during the course of the hearing, they will so stipulate on the record and the hearing will be closed on that basis.

Oral arguments and briefs

The hearing panel may permit the parties or their attorneys, to argue orally within such time limits as the panel may determine. The parties are free to file pre-hearing or post-hearing letter briefs or memorandum. Any such letter brief or memorandum must be filed in triplicate for distribution to the hearing panel members, with proof of service upon all counsel in the proceeding and parties appearing without counsel. The hearing panel will render a decision in a timely manner.

Decisions will include one of the following and will be provided in writing to the health care professional: reinstatement, provisional reinstatement with conditions set forth by UnitedHealthcare Community Plan, or termination.

Continuations, adjournments and substitutions of hearing panel members

UnitedHealthcare Community Plan may postpone a scheduled hearing, or continue a hearing from day to day or adjourn it to a later date or to a different place, by announcement thereof at the hearing or by appropriate notice to all parties.

Timeframes for hearing panel order

The hearing panel will render a decision on the proposed action in a timely manner. Such decision will include reinstatement of the physician by UnitedHealthcare Community Plan, provisional reinstatement subject to conditions set forth by UnitedHealthcare Community Plan or termination of the physician. Such decision will be provided in writing to the physician. A decision by the hearing panel to terminate a physician will be effective not less than 30 days after the receipt by the physician of the hearing panel's decision. Notwithstanding the termination of a physician for cause or pursuant to a hearing, the physician will continue to participate in the plan on an on-going course of treatment for a transition period of up to 90 days, and postpartum care, subject to care Provider Agreement. In no event will termination be effective earlier than 60 days from the receipt of the notice of termination.

Reinstatement in the UnitedHealthcare Community Plan care provider network

If a physician has been suspended or terminated because of quality of care issues, the physician will not be eligible for reinstatement in the UnitedHealthcare Community Plan network until he/she has developed and implemented an improvement action plan acceptable to UnitedHealthcare Community Plan. If a physician has been suspended or terminated because he/she has been suspended or terminated from a government sponsored health care program, the physician will not be eligible for reinstatement in the UnitedHealthcare Community Plan network until he/she is eligible for participation in the government-sponsored health care program from which he/she was suspended or terminated. Expired contracts are not terminations. Non-renewals for lapsed contracts also do not constitute terminations. For contracts without expiration dates, non-renewal on January 1 after the contract has been in effect for a year or more will not constitute a termination.

Continuity of care for primary care providers

If a primary care provider (PCP) terminates the care Provider Agreement, the care provider will provide services to members assigned through the end of the month in which termination becomes effective. If UnitedHealthcare Community Plan's insolvency or other cessation of operations, the care provider will continue to provide benefits to members through the period for which the premium has been paid, including benefits to members in an inpatient facility. Despite the above provisions, if we terminate the care Provider Agreement for cause, UnitedHealthcare Community Plan will not be responsible for health care services provided to members following the effective date of termination.

Continuity of care during a pregnancy

If a member is in the second or third trimester of pregnancy at the time of notice of the termination, the transitional period will extend through postpartum care related to delivery. Any health service provided during the transitional period will be covered by UnitedHealthcare Community Plan under the same terms and conditions as applicable to participating care providers.

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.

Notifying us when you leave the network

When you leave a participating network Medical Group, your Medical Group is required to notify UnitedHealthcare Community Plan of your departure as described in your Medical Groups' participation agreement.

- You are required to notify UnitedHealthcare Community Plan when you terminate from our network as described in your Agreement
- At least 30 days before the effective date of your termination or your groups' termination from the network, UnitedHealthcare Community Plan will send, by regular mail, notification to our affected members/your patients
- Your affected patients/our members will include those UnitedHealthcare Community Plan members for whom a claim was filed on your behalf or on behalf of your Medical Group within the 6 months before the effective date of termination or departure, or the state statutory look back period, whichever is greater

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 listing of network care providers, review our Provider Directory at UHCprovider.com/findprovider.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health.

To accurately list care providers who treat UnitedHealthcare Community Plan members, we have the right to and may:

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

Changing an existing TIN or adding a care provider

Visit UHCprovider.com/attestation to view ways to update and verify your 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 care provider demographic data electronically
- Connecting 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 particular diseases and conditions. This is determined by the state's government agencies and professional specialty societies. See **Chapter 11** 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 manual. View protocols at UHCprovider.com/protocols.

Office hours

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

Protect confidentiality of member data

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

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

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. 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 10** 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 investigate your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration. If we have a concern about your Agreement, we’ll send you a letter containing the details. If we can’t resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement.

Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member’s benefit contract or handbook. You may locate the Member handbook.

Also reference **Chapter 13** of this manual for information on care 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 care provider security, law enforcement, state and federal regulatory bodies.

Appointment standards (New York State Department of Health access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Non-urgent "sick" visit: within 48–72 hours of request, as clinically indicated
- Routine care appointment: within 4–6 weeks
- Initial office visit for newborns: within 2 weeks of hospital discharge
- Well child care within: 4 weeks of request
- Initial family planning visits within: 2 weeks of request
- Adult (older than 21) baseline and routine physicals: within 12 weeks

- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed 1 hour of the scheduled appointment time

Specialty care

If a member requires the services of a non-participating care provider, the member's PCP can submit a prior authorization request for in-network coverage for services provided by non-network care providers.

UnitedHealthcare Community Plan, based on member benefits and state regulations, will determine whether an in-network care provider is available to treat the patient's condition. If one is not, we will assess whether in-network benefits will be granted for such services from a non-network care provider.

There is a referral process for members who need specialty care. The specialist referral requirement is consistent with the longstanding primary care model detailed in this care provider manual and member handbook. It also enables PCPs to provide value-based care in the health system.

Members only need a referral from their PCP to see health care professionals in the following specialty categories:

- Allergy and immunology
- Dermatology
- Endocrinology
- Gastroenterology
- General surgery
- Neurological surgery
- Orthopedic surgery
- Otolaryngology
- Physical medicine and rehabilitation/physiatry
- Plastic surgery
- Podiatry
- Pulmonary medicine
- Sports medicine
- Urology
- Vascular surgery

The referral must be approved by UnitedHealthcare and will be made pursuant to an approved treatment plan approved by UnitedHealthcare, the PCP and non-participating physician.

The enrollee may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment.

A list of all in-network care providers and UnitedHealthcare Community Plan of New York members for the following product lines include the following:

- UnitedHealthcare Community Plan for Families (Medicaid)
- UnitedHealthcare Community Plan Wellness 4 Me (HARP)
- UnitedHealthcare Community Plan ChildHealthPlus (CHP)
- Dual Eligible plans

Referrals must be submitted through one of the following methods prior to the specialist visit.

Online/electronic (strongly recommended):

Referrals are entered electronically on Referrals Tool through [UHCprovider.com/referrals](https://uhcprovider.com/referrals). A user guide is also available.

Electronic submissions may also be accepted through the Authorization and Referral Request (278) transaction.

Mail

Paper referrals are accepted and must be completed using the specialist referral form.

Mail paper referral to:

P.O. Box 31365

Salt Lake City, UT 84131-1362

Note: Retroactive referrals are not accepted.

Visit [UHCprovider.com](https://uhcprovider.com) for more information, frequently asked questions and referral form.

Questions? Call your network representative directly or Provider Services for UnitedHealthcare Community Plan at **1-888-362-3368**.

Specialists and specialty clinics should arrange appointments for:

- Urgent care: within 24 hours of request
- Non-urgent “sick” visit: within 48–72 hours of request, as clinically indicated
- Non-urgent care: within 4–6 weeks of request

Prenatal care

New York State Medicaid Perinatal Care Standards have been updated, effective February 1, 2026, for New York State (NYS) Medicaid FFS and Medicaid Managed Care (MMC) Plans.

These updates are applicable to all Medicaid perinatal care providers who provide prenatal/antepartum care, intrapartum care or postpartum care. This includes medical care facilities or public or private not-for-profit agencies or organizations, physicians, licensed nurse practitioners and licensed midwives practicing on an individual or group basis, and managed care (MC) plans that contract with these care providers.

For more information, go to health.ny.gov/health_care/medicaid/standards/perinatal_care/.

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 3 weeks of the member’s request
- Second trimester: within 2 weeks of the member’s request
- Third trimester: within 1 week of the member’s request
- High-risk: within 3 calendar days of identification of high risk

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

Behavioral health (mental health and chemical dependence)

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others): immediately upon presentation
- Urgent problems: within 24 hours of member’s request
- Non-urgent problems: within 2 weeks of member’s request
- Following an emergency room visit or hospitalization: within 5 days, or as medically necessary
- Assessments making recommendations for a recipient’s services through Local Department of Social Services (LDSS) within 10 days of member’s request

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 care providers 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 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 care provider information.

We are required to confirm your information.

To help ensure we have your most current care provider information:

Delegated care providers – submit changes to your designated submission pathway.

Nondelegated care providers – visit UHCprovider.com/attestation to view ways to update and verify your care provider demographic data.

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

Care provider attestation

Confirm your data every quarter through the [UnitedHealthcare Provider Portal](https://UHCprovider.com) or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access the [UnitedHealthcare Provider Portal](https://UHCprovider.com) for My Practice Profile App to make many of the updates required in this section.

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

Prior authorization request

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

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 to UnitedHealthcare Community Plan members:

- Verify eligibility using the [UnitedHealthcare Provider Portal](https://UHCprovider.com) or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice
- Get prior authorization from the Provider Portal:
 1. To access the Prior Authorization app, go to UHCprovider.com, then click Sign In on the upper right corner.
 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](https://UHCprovider.com), 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 New York State Department of Health members may seek services from any participating care provider. The New York State Department of Health 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 the number on the back of their card or by visiting the Provider Portal at myuhc.com.

We ask members who don't select a PCP during enrollment to select 1. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Specialists as a PCP or referral to a specialty care center is an option if a member has a life threatening or degenerative and disabling condition or disease that requires prolonged specialized care, the member's specialist may also serve as the PCP. In these cases, a medical director must approve a treatment plan, in consultation with the PCP, the specialist, and the member (or the member's designee).

UnitedHealthcare Community Plan will approve only specialists who are participating in UnitedHealthcare Community Plan's network unless no qualified specialist can be identified in the UnitedHealthcare Community Plan network.

Members have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any issues discovered and treated in the course of receiving women's health care services.

This includes access to ancillary services ordered by women's health care providers (lab, radiology) 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 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

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
 - This should occur within 90 days of a new member's enrollment. PCPs should attempt to schedule this appointment if the new member fails to do so.
- Treat members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, or medical management, as appropriate
- Admit 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 standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the New York State Department of Health Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual.
- Get prior authorization from UnitedHealthcare Community Plan, if required, visit UHCprovider.com/priorauth
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic, federally qualified health 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

Primary care provider checklist

- Verify eligibility and benefits on the [UnitedHealthcare Provider Portal](#), or call **Provider Services**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.

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 members referred 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
- Make no recommendations to patients to other specialists without the approval of the PCP
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the New York State Department of Health Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this care provider 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.
- For non-covered services, inform members before initialing service, that the service is not covered by the Plan, and state the cost of the service

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.

Medical residents in specialty practice

Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

Ancillary care provider responsibilities

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

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

Ancillary care provider checklist

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

Chapter 3: Care provider office procedures and member benefits

Benefits



Go to UHCCCommunityPlan.com/ny to find the member's view of benefits. Go to UHCprovider.com/eligibility to verify member eligibility, access the determine benefits, view care plans and get digital ID cards. Or call **1-866-362-3368**.

Notice regarding the pharmacy benefits for UnitedHealthcare Community Plan members

Beginning April 1, 2023, Medicaid members enrolled in mainstream MC plans, Health and Recovery Plans (HARPs) and HIV-Special Needs Plans (SNPs) will have their [pharmacy benefits transitioned](#) to NYRx, the Medicaid pharmacy program. MLTC, EP and CHP members will continue to receive their pharmacy benefits through UnitedHealthcare. Find more information on the UnitedHealthcare pharmacy program at UHCprovider.com/NYcommunityplan > [Pharmacy Resources and Physician Administered Drugs](#).

Pharmacy program and billing policy and other pharmacy-related information can be found in the [NYS MMIS Pharmacy Provider Manual](#) and the department's [Medicaid Update](#).

You may also contact us at NYRx@health.ny.gov or 1-800-541-2831 for Medicaid pharmacy policy-related questions. The transition will not apply to members enrolled in Managed Long-Term Care (MLTC) plans (e.g., PACE and MAP), the Essential Plan or Child Health Plus.

Unlicensed interns, residents and foreign physicians in training programs are eligible to prescribe for New York State (NYS) Medicaid members in NYRx, the Medicaid Pharmacy program, without enrollment as a NYS Medicaid care provider. In accordance with NYS Education Law, unlicensed interns, residents, and foreign physicians participating in training programs, are authorized to prescribe.

NYS Medicaid recognizes the authority under which these unlicensed care providers may prescribe; however, per federal requirements these physicians are not eligible for enrollment into the NYS Medicaid program without a license.

New York Health Equity Reform (NYHER) 1115 Waiver

UnitedHealthcare Community Plan is happy to be a part of the [New York Health Equity Reform \(NYHER\) 1115 Waiver Demonstration](#) which aims to advance health equity, reduce disparities and support the delivery of health-related social needs (HRSN) services. UnitedHealthcare Community Plan has partnered with each regional [Social Care Network](#) to ensure that our HRSN-eligible members can be screened and navigated to services that may be available to them, including nutrition, housing and transportation.

More information about the waiver demonstration and how providers can participate in the Social Care Network program can be found at the following links:

- [Information for Health Care Providers](#)
- [SCN: Introduction for Health Care Providers Guide](#)

Assignment to primary care provider panel roster

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

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

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 CommunityCare 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 **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.

Additionally, a member diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease may select a specialist to serve as their PCP. If you are a specialist and may be willing to provide all primary care services for a member who meets one of these conditions, provide a written request that states you are willing to act as the member's PCP. Mail this letter to:

Member Services Director
UnitedHealthcare Community Plan
One Penn Plaza, 19th Floor
New York, NY 10119

Primary care provider realignment

On a quarterly basis UnitedHealthcare Community Plan will identify members who have received primary care services from a care provider other than their assigned PCP and will reassign the member to align with the care provider from whom they are receiving care.

We will do this to ensure that the right doctor is assigned to the member.

This reassignment will help us measure practice performance and provide accurate member attribution for our quality initiatives around value-based care.

Members who are reassigned will receive a new ID card to reflect their new PCP. If a patient comes to your office with concerns about their PCP assignment, please direct them to the Member Services phone number on their ID card. Members are free to choose any PCP at any time.

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

Medically necessary means health care and services necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap.

For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability.

Member assignment

Assignment to UnitedHealthcare Community Plan

New York State Department of Health 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. New York State Department of Health 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/ny > Plan Details > Member Resources > View Available Resources.

Immediate enrollment changes

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



Get eligibility information by calling the Medicaid inquiry line.

Disenrollment

New York State supports a 12-month lock-in policy for UnitedHealthcare Community Plan members.

These members can disenroll from UnitedHealthcare Community Plan for any reason in the first 90 days of enrollment. For the remainder of the year, they can only disenroll for good cause. A member wishing to disenroll should call the Member Services number at **1-800-493-4647** for information about who to contact to terminate his or her coverage.

(This information is also in the member handbook.)

Unborn enrollment changes

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



Members may call NY Medicaid at **1-800-541-2831**.

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

Primary care provider selection

Prior to birth, a pregnant mother can enroll the baby. The child will be assigned a case identification number (CIN) and listed as unborn.

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 New York State Department of Health, NY's Medicaid program. The New York State Department of Health determines program eligibility. An individual who becomes eligible for the New York State Department of Health program either chooses or is assigned to one of the New York State Department of health-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.

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 New York State Department of Health Medicaid number is also on the member ID card.

Sample health member ID card

You can view current ID cards for most members when you verify eligibility using the **UnitedHealthcare Provider Portal**.

Restricted recipient program

The restricted recipient program (RRP) applies to Medicaid Managed Care (MMC), Wellness4Me, EP.

The restriction program previously managed by the Office of the Medicaid Inspector General (OMIG) is now administered by UnitedHealthcare Community Plan for our members who are restricted.

These members were auto-assigned to us by the Department of Health. The OMIG program was designed to restrict certain members to particular PCPs, pharmacies or hospitals. This is based on odd utilization patterns or referrals and based on medical review, which indicates over/misutilization or abusive practices defined in the regulations. UnitedHealthcare Community Plan and other Medicaid Managed Care plans are also tasked with developing an internal process that identifies such members. There will be procedures in place to monitor them on an ongoing basis and a monthly reporting mechanism.

The recommendation as to the type of restriction is based on the type of over/misutilization or abusive practice.

Types of restrictions: may be a single restriction type or any combination of primary:

- Medical care provider: this can be a physician, physician group or clinic
- Hospital care provider
- Dental care provider: may be a dental clinic or dentist
- DME supplier
- Podiatrist: this is rarely used

After the member is identified, a complete profile of both claims and encounters is reviewed. The review includes an examination of the member's utilization patterns to determine if there is overutilization of services. We may contact the care providers to get a more complete picture of the member's health care needs versus what they are receiving.

UnitedHealthcare Community Plan is required to notify members when we have placed them under restriction and provide a detailed packet of information outlining the reasons for their restrictions.

Ongoing review will be done, and, when appropriate, these members will be referred into case management.

If members are restricted to the type of service you provide, or you are not the care provider they are restricted to, or you do not have the proper authorization, your services will not be paid. **This is why it is important to always verify eligibility for the member each time they visit your office.**

Call for eligibility at 1-800-493-4647, or verify through our secure web portal at **UHCprovider.com/eligibility**. If you are currently assigned the member's restricted care provider, and the member requires a different non-pharmacy care provider, call **1-866-362-3368**.

Request updates to the pharmacy lock by calling:

- Health benefit exchange (HBE): 1-855-355-5777
- NYC Human Resources Administration (HRA): 1-212-273-0062



For upstate NY non-pharmacy care provider, contact the local district.

These members will have ID cards that will be easy to identify. It will say "Restricted" on their member card.

Call **Provider Services** if you have questions about this program.

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, mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

Mailing address:

UnitedHealthcare Community Plan

Attn: Health Services

P.O. Box 1037

New York, NY 10005

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.

Verifying member enrollment

Verify member eligibility prior to providing services.

Determine eligibility in the following ways:

- UnitedHealthcare Provider Portal: access the UnitedHealthcare Provider Portal through UHCprovider.com/eligibility
- Call **Provider Services**: available Monday-Friday, 8 a.m.–5 p.m. ET
- View plan details: UHCcommunityplan.com/ny

Mandated training for presumptive eligibility care providers

Hospitals (licensed Article 28 care providers of prenatal care services) are mandated to make presumptive eligibility determinations for pregnant women. PE care providers will also provide full Medicaid application assistance and assist pregnant women in choosing a Medicaid managed care health plan. To perform PE determinations, the PE screener must register and enroll for online training at the Training Site for New York State Health Insurance Programs, provided by Maximus, Inc., which is available at nytrainingservices.com/en/trainings/ldss-employees. The New York State Department of Health encourages prenatal care providers who have not recently performed presumptive eligibility determinations for pregnant women to repeat the training modules.

Note: The law permits an Article 28 facility that provides prenatal care to pregnant women to apply to the Commissioner of Health for an exemption from this requirement on the basis of undue hardship.

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

Not covered for most lines of business (LOBs).

Air ambulance may be covered for members in certain benefit plans with certain clinical conditions. Contact prior authorization to determine coverage.



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

Emergency ambulance transportation

An emergency medical condition is a medical or behavioral condition, the onset of which is sudden, that presents with symptoms of sufficient severity. Symptoms including severe pain that an average member could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person with such condition in serious risk
- In the case of a pregnant woman, the health of the woman or her unborn child
- In the case of a behavioral condition, placing the health of the person or others at serious risk
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

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

Non-emergent stretcher/ambulance transportation services may be covered for members in certain benefit plans with certain clinical conditions. Contact prior authorization to determine coverage.



Non-emergent stretcher/ambulance transportation must be requested at least 3 business days in advance. Contact the number on the back of the member ID card.

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

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) may be covered for members in certain benefit plans with certain clinical conditions. Contact Member Services to determine coverage.

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 cardiac procedures are required on an urgent basis (note place of service exclusions) or authorization cannot be obtained because it is outside of UnitedHealthcare Community Plan's normal business hours, the service may be performed and prior authorization requested retrospectively within the following timeframes:

- 2 business days for echocardiography/stress echocardiography
- 15 calendar days for cardiac catheterizations and electrophysiology implants

Documentation must include an explanation regarding why the procedure was required on an urgent basis or could not be submitted for prior authorization during normal business hours.

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](https://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](https://uhcprovider.com/cardiology) > Sign In > Specific Cardiology Programs.

Dental services

Covered

Routine dental services for UnitedHealthcare Community Plan members are covered by UnitedHealthcare Dental. If you'd like to be contracted to provide these services to UnitedHealthcare Community Plan members, please visit uhcdental.com.

A NY dental care provider manual is available for detailed coverage information. See more information at uhcdental.com.

Additional information can be found in the NYS Medicaid Dental Provider Manual located at emedny.org.

Dental care providers should arrange appointments for:

- Urgent care: within 24 hours of request
 - Elective or routine care: within 28 days of request
- 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 women, the blind and nursing facility residents:

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



For more details, go to: uhcdental.com.
To find a dental provider, go to [UHCprovider.com/findprovider](https://uhcprovider.com/findprovider).

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

Prior authorization might be required for certain DME. Contact Prior Authorization at **1-866-362-3368** to determine coverage requirements.

Please visit [UHCprovider.com](https://uhcprovider.com) to review current DME requirements.



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

Emergency/urgent care services

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.

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.

The treating care provider may continue with care until the health plan's medical team is reached, or when one of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.



For a list of urgent care centers, contact **Provider Services at 1-866-362-3368**.

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.



Deliver emergency care 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 at 1-866-362-3368**.

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 at 1-866-362-3368**.



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 and reproductive health services offer, arrange and furnish health services that enable members, including minors who may be sexually active, to help prevent or reduce the incidence of unwanted pregnancies. They also offer education and counseling services as well as screening for pregnancy, cancer, sexually transmissible disease, HIV testing and pre- and post-test counseling.

Parenting/childbirth education programs

- Childbirth education is 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 New York State Department of Health Regulations for more information on sterilization.

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 case management

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 emergency room 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 you 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

To be eligible for Health Home services, individuals must be enrolled in Medicaid and have:

- 2 or more chronic conditions (e.g., SUD, asthma, diabetes) or
- 1 single qualifying chronic condition:
 - Adults: HIV/AIDS or serious mental illness (SMI)
 - Children: Serious emotional disturbance (SED) or complex trauma



For more information about Health Home, go to health.ny.gov/health_care > Medicaid > Health Homes or email NYCHealthHomeTeam_DL@ds.uhc.com.

Hearing services

Medicare and Medicaid hearing services and products, when medically necessary to alleviate disability caused by the loss or impairment of hearing, include selecting, fitting and dispensing; checks following dispensing, conformity evaluations and repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.

HIV/AIDS

Referrals

Call our Case Management hotline to make referrals for members with HIV at **1-800-493-4647**. Members may also call this line directly.

HIV care providers

UnitedHealthcare Community Plan wants to properly identify all of our network care providers who specialize in the care of HIV/AIDS. There is no current credentialing or certification for HIV specialization, so the Plan relies on the criteria established by the HIV Medical Association (HIVMA) to determine expertise in HIV.



For information about the HIVMA criteria, please go to hivinfo.nih.gov.

You are required to offer HIV pre-test counseling with a clinical recommendation of testing for all pregnant women, provide counseling to all pregnant women in your care and offer a prenatal HIV test. You are to refer any HIV positive women in your care to clinically appropriate services for both the women and their newborns.

Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. Counseling and education regarding perinatal transmission of HIV available treatment options for the mother and newborn infant will be made available during the pregnancy or to the infant within the first months of life.

Calling helps ensure access to services for positive management of HIV disease, psychosocial support, and case management for medical, social and addictive services.

Required reporting

State law requires that you report the following results to the New York State Department of Health:

- Positive HIV tests
- Diagnosis of HIV-related illness
- Viral load tests
- Tests showing T-cell counts under 500
- AIDS

To report HIV/AIDS, call 1-212-442-3388. The law further requires you report names of known spouses and sexual or needle sharing partners (contacts). The law states that contacts should not be given the name of the HIV positive patient. Patients have the right to not reveal the names of contacts.

Confidentiality

HIV counseling and testing is a routine part of medical care. All plan members are eligible to receive HIV education, counseling and HIV testing. You must document a refusal of testing in the member's medical record.

All healthcare providers are required to:

- Develop policies and procedures to assure confidentiality, in general, and HIV-related information in particular in accordance with applicable federal and state requirements including Section 2782 of NYS Public Health Law. Policies and procedures must include:
 - (a) Initial and annual in-service education of staff and contractors.
 - (b) Identification of staff allowed access and limits of access.
 - (c) Procedure to limit access to trained staff (including contractors).
 - (d) Protocol for secure storage (including electronic storage).
 - (e) Procedures for handling requests for HIV-related information.
 - (f) Protocols to protect persons with or suspected of having HIV infection from discrimination.

For additional information about testing, reporting and confidentiality of HIV, go to health.ny.gov/diseases/aids.

For assistance with questions regarding HIV confidentiality and disclosure of HIV related information, call the Legal Action Center at 1-212-243-1313.

Additional resources

HIV rapid test information on the CDC website cdc.gov/hiv.

For care provider materials and a downloadable copy of the NYS Dept. of Health HIV Educational Materials, call: 1-212-417-4553 or 1-518-474-9866 or visit: hivguidelines.org.

Clinical practice guidelines:

- health.ny.gov > Information for Providers > Clinical Guidelines & Standards of Care > Clinical Guidelines & Quality of Care
- hivguidelines.org > Guidelines for preventing and treating HIV

- Refer to **Appendix X** in this care provider manual

Long-Term Support Services

Covered: Community Plan/MMC, Wellness4me (HARP), UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP).

What is Long-Term Services and Supports?

Long-Term Services and Supports (LTSS) means health care and supportive services provided to members of all ages with functional limitations or chronic illnesses. They require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications.

LTSS are covered benefits under MMC, Wellness4me and UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP), a Medicaid Advantage Plus Plan. Medicaid Advantage Plus (MAP) is a plan combining a Dual-Eligible Special Needs Plan (D-SNP) and a Medicaid managed long-term care plan with a single point of contact for all Medicare and Medicaid services.

Who is eligible?

Members 18 years or older seeking personal care services (PCS) or consumer-directed personal assistance services (CDPAS) will need an assessment completed by New York Independent Assessor (NYIA). Through a contract with MAXIMUS Health Services, Inc. (MAXIMUS), NYIA conducts independent assessments, provides independent practitioner orders and performs independent reviews of high-needs cases for PCS and CDPAS. This process includes Mainstream/HARP members and anyone seeking to enroll in the Medicaid Advantage Plus program. Once the assessment has been completed in the Uniform Assessment system (UAS), a health plan nurse will be scheduled to create a person-centered service plan (PCSP).

Any members seeking LTSS services that do not fall under the NYIA criteria must be enrolled in Community Plan or Wellness4Me and submit either an M11Q or DOH order form.

For MAP, the member must be enrolled in MAP and clinically qualify for services during their pre-enrollment assessment. You may also speak with a care manager regarding LTSS.

Request for service

A member or designee may request LTSS. The designee may be anyone the member chooses.

How does a member obtain LTSS through UnitedHealthcare Community Plan and Wellness4me?

- The member should contact the NY Long-Term Care Services Team at 1-866-214-1746
- You must submit the following order form based on the member's place of residence
M11Q in the 5 Boroughs (NY City): nyc.gov/assets/hra/downloads/pdf/services/micsa/m_11q.pdf
DOH 4359 out of the 5 Boroughs: health.ny.gov/health_care/medicaid/publications/docs/gis/10oltc-006att.pdf

Please submit completed form to UnitedHealthcare Community Plan:

Email: ny_mdorders@uhc.com

The submission of the M11Q or the DOH4359 form will trigger a state-approved assessment to be performed in the member's home by a registered nurse. This will determine the member's eligibility for services.

All functional needs assessments will be completed face-to-face with the member and will record the member's needs, strengths, preferences, goals and objectives for maximizing independence and community integration.

LTSS services include, but are not limited to:

- Adult day health care
- AIDS adult daycare (covered under MMC and Wellness4Me)
- CDPAS
- Home-delivered and congregate meals (covered under MAP)
- Home health aide
- Medical social services
- PCS
- Personal emergency response services
- Private duty nursing
- Residential healthcare facility services (RHCF)
- Custodial nursing care (covered under MMC and MAP; Wellness4me members who require custodial care must transfer to the MMC plan)
- Social and environmental supports
- Social day care (covered under MAP; has to be combined with another LTSS to qualify)

Custodial nursing care

Covered: MMC and MAP

There are 3 levels of Medicaid. The member must have institutional level of Medicaid approved by HRA or LDSS to qualify for nursing home (NH) service. Request prior authorization when a member is permanently placed in a NH. For members who do not have institutional level of Medicaid at time of admission, UnitedHealthcare provides an initial 90-day approval pending review of Local Departments of Social Services (LDSS) for members outside of NYC or the Human Resource Administration (HRA) for NYC. Proof of your paperwork submission to LDSS or HRA should be sent to your UnitedHealthcare NH liaison. During the 90 days, the nursing home will be responsible for completing the appropriate paperwork.

Required paperwork includes the following:

- **Downstate (NYC) NH form 2159i:** Notice of Long Term Placement Medicaid Managed at a069-marc.nyc.gov/marc
- **Upstate NH form 3559:** Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change at wnylc.com/health/file/714/?f=1
- Any additional documentation required by LDSS or HRA

The NH should also send us a copy of the previous form submission to ensure renewed authorization. If you aren't sure where to submit the form, call Member Services. The phone number is on the back of the member's ID card. If the NH does not submit the form within the 90 days, or if after submission, LDSS or HRA rejects the nursing home level of care application, the plan will not extend the authorization past 90 days. The NH should contact us if LDSS or HRA rejects the application. We may also reach out to LDSS or HRA directly.

Discharge process

Once the member is discharged from the NH, you must notify the member's health plan care manager and submit a discharge form to LDSS or HRA:

- Downstate Discharge NH notice 259f at a069-marc.nyc.gov/marc
- Discharge Notice: Upstate 3559 at wnylc.com/health/file/714/?f=1

Net Available Monthly Income collection

Net Available Monthly Income (NAMI) is determined by LDSS/HRA. The health plan does not determine the NAMI owed. If a member or member's representative has questions regarding how the NAMI was determined, they should contact their local LDSS or HRA directly.

NAMI is like a monthly deductible that will be deducted from the Nursing Facility claims payments. NAMI will not roll over month to month and will not change in the middle of a month. If a member transfers between facilities during a billing period, the NAMI is applied to the first claim received and paid as first in, first out (FIFO).

Therefore, the facilities involved in the transfer must coordinate any liability deductions. NAMI information can be found on the Provider Portal within the deductible section on the members benefits. Primary medical care provider visits, inpatient and outpatient services are not subject to NAMI.

Confirming eligibility

To see if the member is eligible for LTSS, go to New York State Medicaid site, ePACES, at emedny.org/epaces/Login.aspx or UHCprovider.com and select Eligibility or call UnitedHealthcare Community Plan's **Provider Services** at **1-866-362-3368**, Monday-Friday, 8 a.m.-5 p.m. ET.

Prior authorization and payment

Upon obtaining prior authorization, you will perform the services and be reimbursed according to the Home- and Community-Based Services, Long-Term Services and Support Payment Appendix attached to your contract Agreement. Verification of coverage is not a guarantee of benefits.

Pending review of the member's application, the facility will continue to receive reimbursement. However, if the member is determined to be ineligible or the Chronic Care application for NH Medicaid is not completed, payments may be recovered.

Contacts

For LTSS-related service and contract questions, contact Home- and Community-Based Services (HCBS) provider advocate at nyhp_hcbspra@uhc.com.

For claims-related issues, use the UnitedHealthcare Provider Portal at [UHCprovider.com](https://uhcprovider.com) or call **Provider Services** at 1-866-362-3368.

Electronic visit verification

The 21st Century Cures Act was signed into law on Dec. 13, 2016, mandating that states implement electronic visit verification (EVV) for all Medicaid-funded PCS and home health care services (HHCS) that require an in-home visit by a care provider.

New York State's Department of Health implemented EVV use for all Medicaid-funded PCS on Jan. 1, 2021 and will implement EVV use for all Medicaid-funded HHCS on Jan. 1, 2023, which include skilled nursing and private duty nursing (PDN).

To confirm that the services you provide are within the scope of EVV, please see the EVV Applicable Billing Codes [document](#) for affected procedure and rate codes. EVV is required for both Medicaid Managed Care and FFS.

EVV uses technology to record when a caregiver begins and ends an in-home Medicaid service. These systems require a device, such as a smartphone, GPS-enabled tablet or landline to collect 6 data points identified in the 21st Century Cures Act:

1. Service type.
2. Individual receiving the service.
3. Date of service.
4. Location of service delivery.
5. Individual providing the service.
6. Begin and end time of the service.

The goals of EVV include:

- Ensuring timely service delivery for members
- Real-time service gap reporting and monitoring
- Reduction of administrative burden associated with paper timesheet processing
- Helping to prevent fraud, waste, and abuse

If you have any questions or need assistance, please email EVVHelp@health.ny.gov. As with the implementation of EVV for PCS, NYSDOH will continue to hold webinars and technical assistance calls for HHCS, including PDN care providers.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice as per member's specific benefit package.

Diabetes Prevention Program

The National Diabetes Prevention Program (NDPP) is included in the MMC benefit package and applies to mainstream MMC plans, HIV Special Needs Plans (HIV SNPs) and Wellness4me, also known as HARPs. NDPP is an evidence-based, educational and support program, taught by trained lifestyle coaches, designed to prevent or delay the onset of type 2 diabetes. It covers 22 NDPP group training sessions over the course of a calendar year.

Becoming a recognized National Diabetes Prevention Program care provider

Community-based organizations (CBOs), clinics, group practices and sole practitioner groups can provide National Diabetes Prevention Program (NDPP) services to Medicaid members and be reimbursed for these services. Information on obtaining CDC recognition and enrolling with NYS Medicaid as a NDPP care provider is available at emedny.org > Provider Enrollment > [National Diabetes Prevention Program \(NDPP\)](#). You must complete the following steps:

1. Apply to the CDC-Diabetes Prevention Recognition Program (DPRP). Complete the online application at nationaldppcsc.cdc.gov.
2. Enroll as a NYS Medicaid care provider and obtain NDPP NPI number.
 - The eMedNY call center assists you with enrollment, claim submission and payment questions at 1-800-343-9000
 - Find the "Introduction to Provider Enrollment" which walks you through enrollment at emedny.org > Provider Enrollment > [Provider Enrollment Guide](#)
 - Find additional information about Medicaid FFS NDPP care provider enrollment instructions and NDPP enrollment forms at emedny.org > Provider Enrollment > [National Diabetes Prevention Program \(NDPP\)](#)
3. Contact MMC organizations to join the network. Once you are an NDPP-recognized care provider and enroll in Medicaid FFS, you can reach out to UnitedHealthcare Community Plan to join our NDPP care provider network.
 - Community Based Organizations (CBO):
 - Email nyhp_hcbspra@uhc.com and a provider advocate will contact you
 - Physician/nurse practitioner, clinic or facility

- New care providers (out-of-network): Go to UHCprovider.com/join. You can also find information on credentialing, contracting and how to connect with UnitedHealthcare Community Plan.
- Current care providers (in-network): Contact your network manager. If you do not know your network manager, send an email to nyhp_hcbspra@uhc.com.

National Diabetes Prevention Program member eligibility

National Diabetes Prevention Program (NDPP) members may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and:

- Are at least 18 years old
- Are not currently pregnant
- Are overweight
- Have not been previously diagnosed with type 1 or type 2 diabetes

They must also meet one of the following criteria:

- Had a blood test result in the prediabetes range within the past year
- Previously diagnosed with gestational diabetes
- Scored 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test at diabetes.org > [Take Our Risk Test](#)

Member Medicaid eligibility verification process

You are responsible for verifying member eligibility and must establish the member is actively enrolled in Medicaid before providing services for each date of service.

Use the following methods to confirm if a member is actively enrolled with UnitedHealthcare Community Plan at the time of service:

- ePACES: emedny.com > Provider Self Help > [ePACES Help](#)
- **Provider Services: 1-866-362-3368**, Monday–Friday, 8 a.m.–6 p.m. ET

Billing UnitedHealthcare Community Plan for National Diabetes Prevention Program

Only Medicaid enrolled NDPP service care providers may bill for NDPP services. Bill services on a professional/837P claim form. A claim may not include both NDPP services and other Medicaid services on the same form.

Claims must contain the following:

- Date of service for each group session
- UnitedHealthcare Community Plan member ID number (located on the member's UnitedHealthcare ID card) and other demographic information needed to submit the NDPP claim to Medicaid
- Billing care provider NPI, which is the NPI enrolled with NYS Medicaid as a NDPP service care provider
- Rendering care provider NPI, which is the lifestyle coach
- Valid NDPP HCPCS codes for services
 - 0403T: Billed for in-person NDPP group counseling sessions
 - G9880: A one-time per NDPP incentive payment awarded for members who achieved at least a 5% weight loss from their baseline during the 12-month program
- Service location for the NDPP services (the locator and ZIP+4 codes submitted on the Medicaid claims must match the care provider enrollment files)
- Valid diagnosis (DX) code

If you have questions, contact:

- Physician/nurse practitioner, clinic or facility
 - In-network: Contact your network representative directly
 - Out-of-network: Call UnitedHealthcare Community Plan at **1-888-362-3368**
- CBO
 - Email nyhp_hcbspra@uhc.com and a provider advocate will contact you

Laboratory



For a listing of UnitedHealthcare's Preferred Lab Network, go to UHCprovider.com/findprovider > **Preferred Lab Network**.

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 care providers rendering clinical laboratory and certain other diagnostic services.



See the **Billing and submission** chapter for more information.

Maternity/pregnancy/well-childcare

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

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

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

Pregnancy notification

Pregnant UnitedHealthcare Community Plan members should notify their local DSS office of their pregnancy. By doing so, the UnitedHealthcare Community Plan for Families program will create a Medicaid CIN (Case Identification Number) for the unborn child. This CIN will become the child's Medicaid ID number after the birth is reported to UnitedHealthcare Community Plan for Families. Members will need a letter from their OB/GYN confirming their pregnancy and expected date of delivery as proof.

If a UnitedHealthcare Community Plan for Kids member becomes pregnant, please inform the member that they should complete an enrollment application for Medicaid for herself and the unborn child. If the application is not completed, the newborn's medical expenses are not covered under UnitedHealthcare Community Plan for Kids.

Pregnancy/maternity

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

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



For prior authorization maternity care, including out-of-plan and continuity of care, call **1-866-362-3368** or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/NYcommunityplan > Prior Authorization and Notification**.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. Pregnant members may self-refer for prenatal care, 2 routine visits per year and any follow-up care or gynecological care. UnitedHealthcare Community Plan considers exceptions to this policy if:

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

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Call to obtain approval.

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.

Doula services

Effective April 1, 2025, the New York State Department of Health added doula services to the Medicaid Managed Care benefit package. Doula care providers interested in joining the UnitedHealthcare Community Plan care provider network can send an email inquiry to **uhcnynetwork@uhc.com**.

For more information about the doula services benefits and policies, go to: **emedny.org/ProviderManuals/Doula/PDFS/Doula_Policy_Guidelines.pdf**.

Midwifery

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. Chapter 238 Law of New York, 2010 amended the definition of midwifery. For more information, go to **op.nysed.gov/midwifery**.

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 **1-866-362-3368**.

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 cesarean 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 mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a care provider's supervision through an 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.

Post maternity care

In March 2023, the New York State Department of Health provided information that under a new law, the length of the postpartum period is now 12 months. With the 12-month postpartum period beginning on the last day of the pregnancy and ending on the last day of the 12th month.



For more information about this new law, refer to the March 2023, Volume 39, Number 6 New York State Medicaid Update newsletter.

UnitedHealthcare Community Plan covers post-discharge care to the mother and her 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

Hospitals and birthing facilities are required to report births for women who receive Medicaid within 5 business days of the birth to the New York State Department of Health or to the New York City Department of Health and Mental Hygiene for births occurring in NYC. Hospitals and birthing facilities must report the birth using the State Perinatal Data System (SPDS).

If the mother's CIN is unknown, the field should be left blank. If you are unsure of the SSN, it is preferable to leave the area blank to help ensure a system automated match. You should not use a sequence such as 123456789 if the CIN is unknown. Please contact the Bureau of Medicaid at 1-518-474-8887 with any questions.

Newborns of mothers enrolled in a Medicaid managed care plan are automatically enrolled in the mother's health plan unless the newborn appears to meet the criteria for SSI eligibility.

Home care and all prior authorization services

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

Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the woman's life. In this case, follow the NY 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 a care provider network.

Neonatal Intensive Care Unit case management

The Neonatal Intensive Care Unit (NICU) Management program manages inpatient and post-discharge neonatal intensive care unit (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.

Oncology

Prior authorization

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

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 professional 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 care provider per calendar year.

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

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).



Refer to **Appendix E** for links to these and other screening and assessment tools.

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 screened members who have a severe problem or dependence to a licensed and certified behavioral health agency that handles substance abuse assessment and treatment. **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 are met:

- The billing and servicing care providers are SBIRT certified
- The billing care 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 care provider, per year

The SBIRT assessment, intervention, or treatment takes place in one 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 **1-866-362-3368** and enter your TIN. Say “Representative,” and “Representative” a second time. Then say “Something Else” to speak to a representative.

Tuberculosis screening and treatment; Direct Observation Therapy

Guidelines for tuberculosis (TB) screening and Direct Observation Therapy (DOT) 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

The following vision services for UnitedHealthcare Community Plan members are covered by MARCH® Vision Care:

- Routine eye exams
- Medicaid approved frames
- Prescription lenses

If you'd like to be contracted to provide these services to UnitedHealthcare Community Plan members, please complete the [MARCH Provider Location Application](#).

For more information, please call MARCH at 1-844-716-2724, or visit marchvisioncare.com where you can find a full list of care provider resources, including a New York state-specific provider reference guide.

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 **1-866-362-3368**.



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

Concurrent review guidelines

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

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

Concurrent review 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).

Concurrent review details

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 Care Guidelines) for medical care determinations (note: previous use of MCG or other guidelines will follow through the resolution of any disputes). This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Type of request	Decision TAT - notification is by phone and in writing	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 3 business days of receipt of medical record information required, but no longer than 14 calendar days of receipt.	Within 24 hours of the decision.	Within 2 business days of the decision.
Urgent/expedited pre-service	Within 3 calendar days of request receipt.	Within 3 calendar days of the request.	Within 3 calendar days of the request.
Concurrent review	Within 24 hours or next business day following.	Notified within 24 hours of determination.	Notified within 24 hours of determination and member notification within 2 business days.
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information.	Within 24 hours of determination.	Notification must be mailed to member on date of payment denial in whole or in part.

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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.

Services for which members may self-refer: OB/GYN prenatal care, 2 routine visits per year and any follow-up care, acute gynecological condition.

UnitedHealthcare Community Plan for Families members may also self-refer for:

- 1 mental health visit and 1 substance abuse visit with a participating care provider per year for evaluation
- Vision services with a participating care provider.
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from a participating care provider or Medicaid care provider

Care provider payments

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 on UHCprovider.com, contacting UnitedHealthcare Community Plan's Provider Services Department, or the NY 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

Members can obtain second opinions for diagnosis of condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. If we don't have a participating care provider in our network with the appropriate training and experience to provide a second opinion, we will make a referral to an appropriate non-participating care provider. We will pay for the cost of the services associated with obtaining a second opinion regarding medical or surgical care, including diagnostic and evaluation services provided by the non-participating care provider.

Services not covered by UnitedHealthcare Community Plan

To find services not covered under each plan, go to UHCcommunityplan.com/ny:

1. Click on the plan.
2. View plan details.
3. Member resources.
4. View available resources.
5. Member handbook.
6. Services not covered.

For dual eligible:

1. View plan details.
2. Member.
3. View available resources.
4. Summary of benefits.

Services requiring prior authorization



For a list of services that require prior authorization, go to **UHCprovider.com/ NYcommunityplan > 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 services:** Members do not need prior approval
- **Inpatient admissions; after an ER visit or ambulatory surgery:** You should notify the plan if a member is admitted to a hospital within 1 business day
- **In-network:** We cover urgent care from a participating care provider or a participating urgent care center. You do not need to contact us prior to or after your visit.
- **Urgent care:** Covered in or out of our service area at an urgent care center.
 - If urgent care results in an emergency admission, please follow the instructions for emergency hospital admissions described above
- **Non-emergency admissions or outpatient services (except maternity):** At least 5 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Inpatient admission - facility responsibility to notify member

When a member is an inpatient, we may delegate the member's utilization review determination to the hospital facility. In this case, the hospital is acting as the member's care provider based on Public Health Law §4903 requirements.

Care provider and member notice occurs verbally and in writing within 1 business day after receiving required information.

Exceptions include:

- Home health- if information is received on a weekend or holiday, then notice occurs within 72 hours
- Inpatient substance use disorder treatment- if information is submitted at least 24 hours prior to inpatient admission discharge, then notice occurs within 24 hours

Notification of continued or extended services includes the number of extended services approved, the new total of approved services, the date of service onset and the next review date.

Utilization management guidelines

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 teams 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.



See Appeals in **Chapter 13** for more details.

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

New York state's Medicaid program applies EPSDT through the Child Teen Health Program (CTHP). CTHP supports early and periodic screening services and well care examinations, with diagnoses and treatment of mental health programs during exams. The New York State Department of Health provides the CTHP care standards and periodicity schedule. They follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics and recommend Bright Futures to guide your practice and improve health outcomes to the Medicaid population.

Developmental disability services and coordination with regional centers

The New York State Office for People With Developmental Disabilities (OPWDD) is responsible for coordinating services for people with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, Prader-Willi syndrome and other neurological impairments. It provides services directly and through a network of approximately 500 nonprofit service providing agencies, with about 80% of services provided by the private nonprofits and 20% provided by state-run services.

Referral: If you determine supportive services would benefit the member, refer the member to 1 of OPWDD's 5 Developmental Disability Regional Offices (DDROs) located throughout New York state. Members will need to submit materials and records, such as reports of assessments conducted by medical professionals. We will review the member's submission to see if the disability meets the requirements specified in New York state law. If the member meets the requirements, they will be deemed eligible for OPWDD services.

Continuity of care: The OPWDD Home- and Community-Based Services (HCBS) Waiver operated by the OPWDD is a program of support and services that enables adults and children with developmental disabilities to live in the community as an alternative to intermediate care facilities (ICFs). These services are uniquely tailored and individualized to meet each person's needs and include habilitation services, respite care, service coordination and adaptive technologies.

Services are provided either by OPWDD's Developmental Disabilities Services Office (DDSO) staff or through voluntary not-for-profit agencies authorized to provide HCBS waiver services by OPWDD or the NYS Department of Health (DOH). Health Home Care Management services provided by Care Coordination Organizations (CCOs) provide coordination of health care, behavioral health and developmental disability services to New Yorkers who qualify for OPWDD services.

Lead screening/treatment

Call **Provider Services** if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered care coordination.

Sexual Assault Findings Examination /Child Abuse Resource Education 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 NY Medicaid on a fee-for-service basis. Call NY Medicaid for more information. Go to [NY State of Health Department of Health SAFE Program Contact Information](#) or call 1-518-474-0535.



You must report all communicable diseases to the New York City Department of Health (NYCDOH).

Vaccines for children program

The Vaccines for children program (VFC) 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.

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 care provider using a VFC-supplied vaccine.)



See the CDC guidelines at [cdc.gov/vaccines](https://www.cdc.gov/vaccines).

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 **1-866-362-3368** unless otherwise noted.

Adult pain management/chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

Benefit coverage varies by age and plan. For more information call **Provider Services** at **1-866-362-3368**.

Disease management

UnitedHealthcare Community Plan Disease Management (DM) programs are part of our innovative Care Management Program. 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, claims) to identify members with gaps in care or chronic conditions.

Referral – Enter your referrals electronically on ReferralLink through UHCprovider.com or find the user guide.

Health Risk Assessment

The Health Risk Assessment (HRA) identifies a member's health care needs by assigning a score based on their response to a series of health questions. The score helps identify high-risk members who are medically fragile, have multiple co-morbidities and may need complex care management.

The HRA may help connect members with programs to best meet their health care needs. We refer members identified as high risk to Care Management for further evaluation of their specific needs. The member's answers do not lower their benefits and only takes a few minutes of their time.

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.

Mobile apps

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

- **UnitedHealthcare** enables users to review health benefits, access claims information and locate in-network providers. We also allow the member to access a member ID card.
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan's care provider network and obtain travel directions to a care provider's location. The app provides users with the ability to call a care provider by tapping on the search result.

NurseLine

NurseLine is available at no cost to our Medicaid and Wellness4Me 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 emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-877-597-7801** to reach a nurse.

Quit For Life

The Quit For Life® Program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching, and web-based learning tools, the Quit For Life Program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% member satisfaction. Quit For Life is for members 18 years and older.

Nutrition coaching

Healthy eating goes a long way to helping your child grow and stay at their best. A nutritionist can meet with you to review your child's eating habits and food choices.

You'll come away with new ideas to:

- Making good choices for quick meals and snacks
- Preparing healthy meals on a budget

UHC Latino



Latino | UnitedHealthcare (uhc.com), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

State-funded programs

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 1-844-540-3013 or go to health.ny.gov/prevention/nutrition/wic/.

Chapter 7: Mental health, substance use and addiction

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) and addiction 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 care provider 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 and a NY Medicaid (MMIS) ID to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

Professionals with license types eligible for enrollment in NY state Medicaid must have a Medicaid identification number. It is the care provider's responsibility to maintain Medicaid enrollment and monitor eMedNY for changes, including changes to care provider eligibility.



To request an MMIS ID number, go to the New York eMedNY care provider enrollment website to complete an online application at emedny.org/info/ProviderEnrollment.

UnitedHealthcare and participating care providers have a unique opportunity to partner together to help members prevent and manage chronic health conditions and recover from serious mental illness, SUDs and addiction. Care providers should utilize evidence-based practices in their treatment of members, and services should be:

- **Person-centered care** is reflective of an individual's personal goals and emphasizes shared decision-making approaches that empower members, provide choice and minimize stigma
- **Recovery-oriented** approach emphasizes the principle that all individuals have the capacity to recover from mental illness, SUD and addiction
- Service care providers should utilize a **trauma-informed approach** that is supportive and avoids re-traumatization

Interventions and treatment modalities should be flexible, mobile and adapted to meet the specific and changing needs of each individual.



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, substance use disorders and addiction. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health, substance abuse diagnoses, and addiction 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 additional information on covered services, please refer to **Chapter 8**, Foster Care in this manual. UnitedHealthcare also covers benefit for special populations, including children in foster care placements and those transitioning out of care.



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."



Call Optum for assistance in interpreting mental health, substance abuse and addiction benefits or to address concerns regarding services. New York City members can call Optum at **1-866-362-3368**. The rest of the state should call **1-888-291-2506**.

Eligibility

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

Portal access

You can use the [UnitedHealthcare Provider Portal](https://UHCprovider.com) 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 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Rate, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in Chapter 12. For claims submission guidance for behavioral health services provided under the MAP plan, refer to **Chapter 16**.

Monitoring audits

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

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Care provider training materials**
- **Network care provider manuals**

Addressing the opioid epidemic

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

Brief summary of opioid use disorder framework

- **Prevention:**
 - Prevent 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 person and children:**
 - Prevent neonatal abstinence syndrome and support mothers in recovery
- **Enhanced data infrastructure and analytics:**
 - Identify needs early and measure progress

Increasing education and awareness of OUDs

It is critical you are up to date on the cutting-edge research and evidence-based clinical practice guidelines. We keep 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/OUD 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 need behavioral health services to address the psychological aspects of pain. Continuing education is available on our Optum Health education website optumhealtheducation.com 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/pharmacy > Resources > **Drug Lists and Pharmacy**. Click “Opioid Programs and Resources - Community Plan” to find a list of tools and education.



Refer to **Appendix E** for links to these and other screening and assessment tools.

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.

For MLTC, CHP and EP, go to the [Drug Lists and Pharmacy Page](#) to learn more about which opioids require prior authorization and if there are prescription limits. For Medicaid and HARP/Wellness4Me, contact NYRx@health.ny.gov or 1-800-541-2831 for pharmacy policy-related questions.

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 in **Chapter 4**.

Behavioral health services covered in the Medicaid benefit

Adult behavioral health Home- and Community-Based Services

HARP/Wellness4Me-enrolled members may be eligible for adult behavioral health Home- and Community-Based Services (BH HCBS) services. BH HCBS services are person-centered, recovery-oriented and mobile behavioral health supports intended to build skills and self-efficacy to promote and facilitate community participation and independence.



New York State HARP and BH HCBS care provider manual can be found [here](#).

Adult BH HCBS Services include:

- **Habilitation** services (residential supports) are designed to assist individuals with a behavioral health diagnosis in acquiring, retaining and improving independent living
- **Prevocational** services are time-limited services that prepare an individual for paid or unpaid employment
- **Transitional employment** services are designed to strengthen the individual's work record and skills toward the goal of achieving assisted or unassisted competitive employment
- **Intensive supported employment** services assist recovering individuals with MH/SUD to obtain and keep competitive employment
- **Ongoing supported employment** services are provided after an individual successfully obtains and becomes oriented to competitive and integrated employment

- **Educational support** services assist individuals with MH/SUD who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment

Community Oriented Recovery and Empowerment

HARP/Wellness4Me-enrolled members are eligible for Community Oriented Recovery and Empowerment (CORE) services. CORE services are person-centered, recovery-oriented and mobile behavioral health supports intended to build skills and self-efficacy to promote and facilitate community participation and independence. CORE services replaced adult behavioral health Home- and Community-Based Services (BH HCBS) as a benefit for HARP enrollees on February 1, 2022.

CORE services include:

- **Community Psychiatric Supports and Treatment (CPST)** provides mobile treatment services to individuals who have difficulty engaging in site-based programs or who have not been previously engaged in services
- **Psychosocial Rehabilitation (PSR)** assists an individual in improving their functional abilities in settings where they live, work, learn and socialize. PSR can help a member achieve employment or educational goals
- **Family Support and Training** offers instruction, emotional support and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process
- **Empowerment Services – Peer supports** are non-clinical, peer-delivered services with a focus on rehabilitation, recovery and resilience, as well as the utilization of natural supports and community resources

Referral for CORE services can come from any source and does require a NYS Licensed Practitioner of Healing Arts (LPHA) recommendation using the approved [OMH template](#). Care providers should be aware of allowable service combinations, which can be found in the [CORE Services Operations manual](#).

Care providers should notify us within 3 business days after the first date of initiating a new CORE Service utilizing the [OMH CORE Initiation Form](#). Care providers will receive confirmation of receipt of the form. Instructions on how to submit this form via the [PAAN Portal](#) can be found in this manual in **Chapter 7**.

The PAAN behavioral health reference guide can be found on [Provider Express New York Page](#).

The NYS OMH CORE Services Operations manual provides additional descriptions of CORE services, eligibility criteria, referral and LPHA recommendation process. Additional information specific to UnitedHealthcare workflow and guidance is available on [providerexpress.com](#).

For a full description of adult covered services go to [omh.ny.gov/omhweb/bho/billing-services.html](#).



For a full description of covered adult Community Oriented Recovery and Empowerment (CORE) services go to: [omh.ny.gov/omhweb/bho/core/core-services-operations-manual.pdf](#).

To learn about children behavioral health services please go to the New York State Children's Health and behavioral health services billing and coding care provider manual and explore program details under each covered service.

- [health.state.ny.us/health_care/medicaid/redesign/behavioral_health/children/eligibility.htm](#)

For more information about services and billing, visit the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) guidance documents:

- [omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf](#)
- [omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf](#)

Health Homes, State Designated Entity (SDE) and C-Yes: Path to Services

For information, about Health Homes, refer to the "Health, Home Care Management" section in the **Chapter 4**. For additional guidance, please visit the following New York State Department of Health websites:

- [health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf](#)
- [health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children](#)

Clinical guidelines

Level of care guidelines for mainstream Medicaid and HARP

Optum maintains a national library of level of care (LOC) guidelines. LOC guidelines are objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support the members' recovery, resiliency, and wellbeing. New York state has reviewed and approved the LOC guidelines used for Medicaid services.

Each LOC guideline includes these elements:

- A definition of the LOC
- Admission criteria
- Continued service criteria
- Discharge criteria
- Clinical best practices
- References (information sources for the document)

The Level of Care for Alcohol & Drug Treatment Referral (LOCADTR) tool is used to make level of care determinations for all Office of Addiction Services and Supports (OASAS) services. Find information about LOCADTR at oasas.ny.gov/locadtr. Care providers should make sure they are using the correct version of the LOCADTR based on the age and treatment needs of the member.

Other clinical criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties or used in place of clinical criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, you must check the member's specific benefits.

All reviewers, such as you or us, must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using clinical criteria. If the requested service or procedure is limited or excluded from the member's benefit, is defined differently or there is otherwise a conflict between this clinical criteria and the member's specific benefit, the benefit will not be covered.

These clinical criteria are provided for informational purposes and do not constitute medical advice.

You are expected to review and be familiar with the LOC guidelines and clinical practice guidelines posted on Provider Express. Go to providerexpress.com > United States > Our Network > State-Specific Provider Information > New York > Clinical Information > **Level of Care Guidelines or Clinical Practice Guidelines**.

Behavioral health Home-and Community-Based Services workflow

Eligibility assessment

HARP/Wellness4Me members who are interested in BH HCBS will be individually assessed for eligibility using the NYS Eligibility Assessment (EA) tool. Once eligibility is determined based on the completed NYS EA, a Plan of Care (POC) will be developed. The Health Home Care Manager (CM) or recovery coordinator will work in collaboration with the individual and identify the BH HCBS that will be included in the POC.

Completed NYS EA determines Tier 1 or 2 (or not eligible) for BH HCBS including:

- Person-centered discussion about individuals' goal(s) and how state plan, Medical or BH HCBS services may address needs. Discuss engagement in current services and goal achievement.
- CM will work with member, existing providers, other collaterals and UnitedHealthcare to help identify new service needs and any additional referrals that may be required.
- Individual is eligible and elects BH HCBS. CM submits Level of Service Determination (LOSD) request to UnitedHealthcare. A choice of providers for BH HCBS is required.
- Once a member chooses providers, referral(s) should be made. The CM should work to keep the member engaged and ensure linkage (e.g., reminders, phone calls, offering transportation).

Reassessment for BH HCBS eligibility should be conducted by the CM or recovery coordinator on an annual basis or after a significant change in the member's condition warrants a change be made to the member's POC. The updated EA should be submitted via ECG Quick Connect.

Level of service determination

Once the EA is completed and determines eligibility and interest in BH HCBS, the CM or recovery coordinator should submit a [BH HCBS Level of Service Determination request](#) (LOSR). The LOSR should be submitted via ECG Quick Connect. At minimum, the request must include all of the following elements:

- BH HCBS eligibility report summary, including tier 1 or tier 2 eligibility
- All services a member is currently receiving
- The member's recovery goal(s)
- Specific BH HSBC services being recommended

Care providers should be aware of allowable service combinations, which can be found in the [harp-mainstream-billing-manual.pdf](#) (ny.gov).

We will review the request within 3 business days of receipt of all information, but no more than 14 days of request when more information is required, to make a determination or extension in the member's best interest. The LOSD is not authorization for services but acts as an Agreement that confirms the level of BH HCBS requested is appropriate. Every BH HCBS service identified in the POC should be reflected on the LOSR, and an LOSR can include more than 1 BH HCBS service. If a care provider identifies additional BH HCBS services that are appropriate for the member, a separate LOSR should be submitted. All services listed in the POC are available to the member but must be authorized before initiation of that service.

We will actively work with the health home care manager or recovery coordinator to resolve any issues impacting LOSD. If a LOSR request is denied, an adverse determination will be issued and the care provider can follow the appeals and fair hearing process outlined in this care provider manual. At any point, if a BH HCBS service needs to be added to the member's POC, the health home care manager or recovery coordinator must submit an updated LOSR which should include previously approved BH HCBS to provide a full picture of all BH HCBS services. A new LOSD will be issued.

Member must be given the choice of BH HCBS care providers using a conflict-free approach, per State requirements.

Prior authorization

Prior authorization is required for BH HCBS, and care providers should utilize the adult behavioral health (BH) HCBS: Prior or continuing authorization request form. Please ensure that you are using the correct version of this form. Instructions on how to submit this form via the [PAAN Portal](#) can be found in this care provider manual in **Chapter 7**. The PAAN behavioral health reference guide can be found on [Provider Express New York page](#).

Within 14 days of expiration date of initial treatment episodes, and all subsequent treatment episodes, the care provider should submit the notification form through the PAAN portal. Failure to submit this form may result in claim denial.

Care provider participation

Network participation requirements

You must meet the network requirements as outlined in the Optum National Network Manual at [providerexpress.com](#) > Clinical Resources > Guidelines/Policies & Manuals > Network Manuals > [Optum National Network Manual](#). Credentialing is done at the group level when a behavioral health care provider is OMH Licensed, OMH or Department of Health (DOH) operated, or OASAS certified. Individual employees, subcontractors and agents do not require separate credentialing.



An overview of policies for credentialing, recredentialing, ongoing monitoring and actions can be found in the Credentialing and Recredentialing Plan ("Credentialing Plan") at [United Behavioral Health Credentialing Plan](#).

Optum is required to collect program integrity related information, such as the Disclosure of Ownership and Control Interest Statement. The statement is sent as part of a larger credentialing application. Optum also requires you not employ or contract with any employee, subcontractor or agency who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.

Care providers of services to children younger than age 21 will be required to receive criminal history record checks (CHRC), statewide central register (SCR) Checks and staff exclusion list (SEL) checks. They will also be required to be mandated reporters. For more information, please review the following resources:

- CHRC: criminaljustice.ny.gov > Community Resources > [Request Your Criminal History](#)
- SCR: justicecenter.ny.gov > Providers & Staff > Responsibilities > [Request a Criminal Background Check](#)
- SEL: justicecenter.ny.gov > Providers & Staff > Responsibilities > [Check Staff Exclusion List](#)
- Mandated reporters: ocfs.ny.gov/main > Child Abuse Prevention > How to report child abuse > [Summary Guide for Mandated Reporters](#)

Re-credentialing

- NCQA requires re-credentialing every 36 months (3 years)
- You should receive a re-credentialing packet several months in advance. If you do not receive it, please proactively reach out to your network manager.
- Failure to complete re-credentialing paperwork or participate in the re-credentialing site audit (when applicable) will affect your status in the network
- You must complete all re-credentialing paperwork
- A site audit may be required
- The re-credentialing process takes time, so it is important to complete and submit required documentation as soon as possible

Find additional information about credentialing in the Optum National Network Manual. Go to providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Network Manuals > **National Network Manual**.

Access to care

You are required to maintain availability to members as outlined in the UnitedHealthcare access to care standards. Members with appointments should not routinely be made to wait longer than 1 hour. You are encouraged to address all walk-in appointments (for non-urgent care) in a timely manner to promote access to appropriate care and actively engage the member in treatment. Provider policies need to address both member access to care and engagement in treatment.

You must provide or arrange for member assistance in emergency situations 24 hours a day, 7 days a week. You must notify members about your hours of operation and how to reach you after hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the member regarding what to do in an emergency. When you are not available, arrange emergency coverage with another participating care provider.

You are prohibited from balance billing any member for any reason for covered services.

You are expected to follow-up with members who miss their aftercare appointment and document and track their outreach in those cases.

Your physical site(s) must be accessible to all members as defined by the Americans with Disabilities Act (ADA). You are required to support members in ways that are culturally and linguistically appropriate, and to advocate for the member as needed. You can find more information about ADA at dol.gov > Topics > Disability Resources > [American with Disabilities Act](#).

You are required to notify us at providerexpress.com within 10 calendar days whenever you make changes to your practice, including office location, weekend or evening availability, billing address, phone number, tax ID number, entity name, or active status (e.g., close your business or retire). If your hours of operation change, contact Network Management at:

Phone: Behavioral health Provider Services:
1-877-614-0484

Email: nynetworkmanagement@optum.com

Care provider training requirements

You are required to participate in a comprehensive care provider training and support program to gain appropriate knowledge, skills, and expertise to comply with state requirements. We will offer training to a full range of care providers. When possible, Optum will work in collaboration with the Community Technical Assistance Center of New York (CTAC)/Managed Care Technical Assistance Center of New York (MCTAC) and Center for Practice Innovation to develop and provide education opportunities. Find CTAC and MCTAC resources at ctacny.org/about-us.

Training topics include:

- Orientation to Optum
- Credentialing and recredentialing

- Care provider website orientation
- Member eligibility verification
- Utilization management
- Quality improvement
- Clinical model and vision
- Cultural competency
- Complex and high-need population
- Use of evidence-based practices
- Supplementary supports
- Claims, billing guidelines, and coding
- Home- and Community-Based Services (HCBS)
- Care provider directory and online resources

You are invited to participate in state-required online standardized evidence-based behavioral health training available through Center for Practice Innovations (CPI) at practiceinnovations.org.

Additional training for medical care providers is available through the OMH training and education for the Advancement of Children’s Health program (Project TEACH) at projectteachny.org.

Utilization management and prior authorization requirements

The following grid reflects authorization and notification requirements for in-network care providers. Failure to get prior authorization or provide initial notification within the indicated timeframe may result in utilization management activities. Additionally, if you fail to obtain or otherwise follow the required administrative procedures for notification or prior authorization, Optum may, based on applicable law, apply a reduction of payment to you up to 100% of your payment rate. Network care provider payment reductions for failure to complete notification or obtain pre-authorization are solely your liability (i.e., the member cannot be billed for these reductions in payment). See **Optum National Provider Manual** for more information.

Care providers who are out-of-network or not contracted for services must request prior authorization. Refer to the out-of-network section for more information. Collaborative calls with you can occur to share relevant information supporting the member’s treatment, care coordination and discharge planning.

You should respond in a timely manner for a member’s clinical consultation regardless of whether the member has triggered formal utilization review. The following chart lists inpatient concurrent review information for in-network care providers.

Inpatient service	Prior authorization	Initial notification	Concurrent review
Inpatient mental health	Adults: Yes Children: No	Within 2 business days of admission.	Adults: Yes Children: Beyond 15th day of admission.
Inpatient detoxification	No	Within 2 business days of admission.	Beyond 29th day of admission.
Inpatient rehabilitation	No	Within 2 business days of admission.	Beyond 29th day of admission.

Prior authorization for outpatient service requests

Request prior authorization and find supporting documents in the Electronic Prior Authorization and Notifications (PAAN) system: UHCprovider.com/priorauth. You must be registered to submit authorization requests. A care advocate will contact you for additional information, if needed.

For additional information on how to use the Prior Authorization and Notification (PAAN) system, go to: providerexpress.com > Our Network > State-Specific Provider Information > New York > **Clinical Information**.

Instead of PAAN, you may also get authorization by calling the care provider number on the back of the member ID card at **1-866-362-3368**.

- Question: “Why are you calling?”
- Say: “Prior authorization”
- Question: “What type?”
- Say: “Behavioral health”
- Question: “What’s the DOB/MM-DD-YYYY?”
- Say or enter: Member’s DOB using the dial pad
- Question: “What type of behavioral health?”
- Say: “Level of care being requested
- Question: “What’s the NPI?”
- Say or enter: NPI using the phone dial pad (if the caller fails to enter the NPI 2 times, then the IVR will ask the caller to enter the care provider TIN)

Chapter 7: Mental health, substance use and addiction

For Child Health Plus (CHPlus) members only:

Instructions for submitting prior authorization for children's HCBS environmental modifications, vehicle modifications and adaptive and assistive equipment:

Prior authorization is required for obtaining environmental modifications, vehicle modifications and adaptive and assistive equipment. To initiate a prior authorization, you may call **1-866-362-3368** or email the prescription detailing the member's needs to: nyltc_admin@uhc.com.

The following table lists outpatient service information:

Adult and children outpatient service	Prior authorization	Initial notification	Concurrent review
Mental health outpatient treatment and rehabilitation services (MHOTRS): Services including initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy, and Licensed behavioral practitioner (LBHP)	No	No	No
MHOTRS: Psychiatric assessment; medication management	No	No	No
Psychological testing	Yes, for any hours beyond 5.	Yes, for the first 5 hours.	N/A
Electroconvulsive therapy (ECT)	No	N/A	Yes
Mental health partial hospitalization	*Yes, when Guiding Principles are met.	Within 2 business days of admission.	Yes
Mental health continuing day treatment (CDT)	Yes	N/A	Yes
Mental health intensive outpatient	Yes	N/A	Yes
Personalized recovery oriented services (PROS) Pre-admission status (18+ years old)	No	N/A	No
PROS admission: individualized recovery planning (18+ years old)	No	N/A	No
PROS: active rehabilitation (18+ years old)	No	N/A	No
Assertive community treatment (ACT) (18+ years old)	No	N/A	No
Youth assertive community treatment (ACT) (10-20 years old)	No	N/A	No

Chapter 7: Mental health, substance use and addiction

Adult and children outpatient service	Prior authorization	Initial notification	Concurrent review
Assertive community treatment for transitional age youth (ACT - TAY) (16-26 years old)	No	N/A	No
OASAS outpatient rehabilitation programs	No	No	No
OASAS outpatient and opioid treatment program (OTP) services	No	No	No
OASAS residential supports and services (820)	No	Within 2 business days of admission.	Beyond 29th day of admission.
Crisis intervention	No	No	No
Crisis residence	No	Within 2 business days of admission.	No
Therapeutic repetitive transcranial magnetic (TMS) stimulation treatment (Ages 18+)	Yes	No	Yes

* Refer to Provider Express for information on guiding principles: public.providerexpress.com/content/ope-provexpr/us/en/Top-of-Mind/2025/February/Northeast/OMH-guiding-principles.html.

Children and family treatment and support services (children only)	Prior authorization	Initial notification	Concurrent review
Other licensed practitioner (OLP)	No	No	No
Community psychiatric supports and treatment (CPST)	Before the 4th visit.	After the 1st visit.	Yes
Psychosocial rehabilitation (PSR)	Before the 4th visit.	After the 1st visit.	Yes
Family peer supports and services (FPSS)	No	No	No
Youth peer support (YPS)	No	No	No

Effective 8/18/25, UnitedHealthcare Community Plan will conduct Children and Family Treatment and Support Services (CFTSS) Utilization Management on 2 of the 6 CFTSS services: Community Psychiatric Supports and Treatment (CPST H0036) and Psychosocial Rehabilitation (PSR H2017) (0-20 years of age) in accordance with the medical necessity guidelines set forth with the Office of Mental Health (OMH), Office of Addiction Services & Support (OASAS), Office of Children & Family Services (OCFS) and the Department of Health (DOH) guidance in the NYS Children and Family Treatment and Support Services (CFTSS) Service and Billing Manual August 2025 found here:

- health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/updated_spa_manual.htm”Children and Family Treatment and Support Services
- health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/updated_spa_manual.htm”(CFTSS) Service and Billing Manual

Chapter 7: Mental health, substance use and addiction

HCBS Services (adults only)	Prior authorization	Initial notification	Concurrent review
Education support services	No	Within 14 days of first visit.	Yes
Employment supports: • Pre-vocational • Transitional employment • Intensive supported employment • On-going supported employment	No	Within 14 days of first visit.	Yes
Habilitation	Yes	Within 14 days of first visit.	Yes
Non-medical transportation	Refer to the following link for guidance for Non-Medical Transportation: Non-Medical Transportation Guidance for HARP Enrollees & HARP-Eligible HIV-SNP Enrollees.		
CORE services (adults only)	Prior authorization	Initial notification	Concurrent review
Community psychiatric supports and treatment (CPST)	No	Within 14 days of first visit.	Yes
Empowerment services – peer supports	No	Within 14 days of first visit.	Yes
Family support and training	No	Within 14 days of first visit.	Yes
Psychosocial rehabilitation	No	Within 14 days of first visit.	Yes

Chapter 7: Mental health, substance use and addiction

HCBS service (children only)	Prior authorization	Initial notification (24/96/60)	Ongoing authorization	Concurrent review
Caregiver/family advocacy and support services	Prior authorization is not required however initial notification is required when the first appointment is established. The HCBS Authorization and Care Manager Notification Form must be submitted for authorization of services beyond the initial 24 hours/60 days/96 units.	Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Community habilitation		Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Palliative care (counseling and support services, pain and symptom management, expressive therapy, massage therapy)		Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Prevocational services		Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Respite services (planned and crisis)		Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Supported employment		Initial service period of 24 hours/96 units/60 days.	Prior to the exhaustion of the initial services.	Within 14 days prior to the end of the authorization.
Non-medical transportation services	Yes	N/A	N/A	Yes

NYS template children's HCBS authorization and care manager notification form, CFTSS notification request form, and CFTSS authorization form can be found at: providerexpress.com.

Available to CHPlus members only - HCBS service (children only)	Prior authorization	Initial notification (24/96/60)	Ongoing authorization	Concurrent review
Environmental modifications	Yes	N/A	N/A	Yes
Vehicle modifications	Yes	N/A	N/A	Yes
Adaptive and assistive technology	Yes	N/A	N/A	Yes

Initial notification for mainstream Medicaid and HARP

Instructions for submitting initial notification for inpatient mental health:

- Give notification within 2 business days of admission to mental health inpatient clinic
- You must provide phone notification or submit it through the PAAN portal
- For members younger than age 18 who are admitted to in-network inpatient hospital facilities, you must include the initial treatment plan. Use the NYS template admission notification form for inpatient and partial hospitalization to notify us within 2 business days of covered patient admission. You can find this form at omh.ny.gov > Behavioral Health Providers > Behavioral Health Managed Care > Behavioral Health Parity > [Addendum A: Two-Day Notification and Initial Treatment Plan – fillable PDF](#).

Instructions for submitting initial notification for inpatient and residential SUD services:

- Give notification within 2 business days of admission to SUD inpatient and residential level of care
- You must submit LOCADTR and treatment plan A through the PAAN portal or provide phone notification

Instructions for submitting initial notification for inpatient and residential gambling treatment and recovery services:

- Members with primary gambling diagnosis or primary SUD and secondary gambling diagnosis are eligible to receive OASAS gambling treatment and recovery services at OASAS Gambling Designation Part 822 Outpatient, Part 818 inpatient (including ATCS) and Part 820 stabilization or rehabilitation programs
- UM protocols are consistent with SUD services, and programs should utilize the gambling LOCADTR to determine need for admission and treatment and submit through the PAAN Portal or provide phone notification



List of OASAS Approved Gambling Screening/Assessment Tools.

Instructions for submitting initial notification for crisis residential:

- Give notification within 2 days of admission to this level of care
- Submit the completed NYSOMH template Crisis residential notification form (adult or children) through PAAN portal

- Find a copy of the form: providerexpress.com > Our Network > State-Specific Provider Information > [New York](#) > Clinical Information

Instructions for submitting initial notification for adult HCBS services 14 days from first visit:

- Submit the adult behavioral health HCBS prior or continuing authorization notification form within 14 days of first visit through PAAN portal
 - After entering service request details into the PAAN system, you will click the “Submit” button. Once submitted, you will receive a reference number and the option to attach document(s) including the adult behavioral health HCBS prior or continuing authorization notification form
- If form is not attached, request will be not be considered complete
 - Even though there is a 3 visit assessment period, the date on the form must reflect the first date the member was seen
 - Find a copy of that form at: providerexpress.com > Our Network > State-Specific Provider Information > New York > [Clinical Information](#) OR can be accessed directly at the DOH website: health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/bh_hcbs_authorization_request_form.pdf
- Notification of treatment episode is reviewed and approved to reflect scope, duration and frequency as indicated on the form
- Please check eligibility on a regular basis and get appropriate PCP information from the referring provider field during the BH PAAN submission
- **Within 14-days** of expiration date of initial treatment episodes, and all subsequent treatment episode, submit the notification form through email, fax, or the PAAN portal:
 - **Email:** nyharpauthorizations@uhc.com
 - **Fax:** 1-877-339-8399
 - **PAAN Portal:** UHCprovider.com/priorauth

Instructions for submitting initial notification for adult CORE services 3 business days after the first intake and evaluation session:

The care provider is responsible for notifying UnitedHealthcare within 3 business days after the member's first intake and evaluation session. This notification is completed using the Provider Service initiation form which can be submitted electronically through the PAAN portal. For more information about the Provider Service initiation form, go to omh.ny.gov.



Adult CORE service requests can be obtained by calling **1-866-362-3368**

Instructions for submitting initial notification for children's HCBS services that do not require prior authorization:

- Submit the completed children's HCBS authorization and care manager notification form through email, fax, or the PAAN portal within 14 days of start of service (e.g., member started services 11/1, submit notification no later than 11/14)
 - **Email:** nyharpauthorizations@uhc.com
 - **Fax:** 1-877-339-8399
 - **PAAN Portal:** UHCprovider.com/priorauth
- After entering service request details into PAAN system, you will be prompted to submit. Once submitted, you will see a reference number with a link with an option to attach document(s) including the children's HCBS authorization and care manager notification form.
- The request is only complete if you attach the form
 - Even though prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS the form must reflect the date the form was submitted
 - Service request above soft limits require a letter from an LPHA with supporting documentation of need to exceed soft limits and is subject for review
 - Find a copy of the form at: providerexpress.com > Our Network > State-Specific Provider Information > New York > **Clinical Information**
- Notification of treatment episode is reviewed and approved to reflect scope, duration and frequency as indicated on the form. Reference number is provided for billing purposes.
- As you provide services to the member, please check eligibility on a regular basis and update appropriate PCP information in the referring care provider field during behavioral health PAAN submission. Submit the notification form through PAAN immediately upon first scheduled appointment and no later than 1 business day.
- Submit **POC** no later than when you request authorization. POC should include:
 - Member's full name, Medicaid # and date of birth
 - Member's diagnosis, if available
 - Member's HCBS service needs
 - Member's goals that relate to HCBS engagement
- Health home care manager name and contact information

- HCBS care provider name and contact information

Method to submit a POC:

- Please submit to UnitedHealthcare Community Plan through our Secure File Transfer Protocol (SFTP), ECG Quick Connect (to lead health homes: This is a separate SFTP than the one you may currently have access to for regular health home information)

We will review POC to help ensure all federal requirements are included based on the state's guidance. It is a best practice to include name and phone number of the health home CMA care manager and supervisor on the plan of care. Our clinical team will call the health home CMA care manager directly if we have questions.

Instructions for submitting initial notification for children's CFTSS services

Complete notification form after the 1st visit and submit via email, fax, or through the PAAN portal.

Before the 4th visit submit:

- Care provider assessment
- CFTSS treatment plan
- CFTSS authorization request form

Concurrent review

The purpose of concurrent review is to help ensure the clinical appropriateness of continued care based on the member's current condition, effectiveness of previous treatment, environmental and family supports, and desired outcomes. As members achieve recovery goals, you should ensure you are adjusting services to meet their individual needs. This allows continued improvements when the expectation is that withdrawal or premature service reduction will remove any gains or goals the member has achieved. Activities may include:

- Collecting information from the care team about the members condition and progress
- Determining coverage based on this information
- Informing everyone involved in the member's care about coverage determination
- Identifying a discharge and continuing care plan early in the treatment episode
- Assessing this plan during the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review

- Identifying members for referral to our covered specialty care programs

Utilization review appeals for mainstream Medicaid and HARP

Contact options for submitting appeals:

Phone: 1-866-362-3368

- Say Claims Appeal Status when prompted. This will correctly route your call to appeal an UM decision.
- Use the phone number to check status of an appeal and verbally submit an appeal
 - Note: You must follow up a verbal appeal with a written, signed appeal
- Enrollees/care providers have 60 calendar days from the date of denial to request an appeal
- Only 1 internal appeal is allowed
- Clinical appeal turnaround time is 72 hours

Concurrent review for CFTSS

- Concurrent review requests should be submitted at least 14 days prior to the concurrent authorization end date
- Treatment plans: A treatment plan review must be completed within 180 days of the previous treatment plan's completion date

Mail: Send UM appeals for ALL behavioral health services to:

UnitedHealthcare Community Plan
Attn: UM Appeals Coordinator
P.O. Box 31364
Salt Lake City, UT 84131

Accessing services from an out-of-network care provider

Medicaid does not offer out-of-network or out-of-state benefit coverage. If the requested service is materially different than that provided by an in-network care provider, or addresses a gap in care, you must request a Single Case Agreement (SCA). An SCA can only offer the established Medicaid rate and you must be a New York State registered Medicaid care provider. An OON care provider must request prior authorization and SCA before providing any service.

We will review in a timely manner, as appropriate for a member's condition. Please indicate if this is an emergency case. This is defined as a health service necessary to treat a condition or illness that, without medical attention, would seriously jeopardize the patient's life, health or ability to regain maximum function, or would cause the member to be in danger to self or others.

Units of service SCAs with non-participating care providers will be executed to meet clinical needs of members when in-network services are not available. Optum will monitor the use of SCAs to identify high-volume, non-participating care providers for contracting opportunities and to identify network gaps and development needs.

To request an SCA, please call **Provider Services at 1-866-362-3368**.

If the member's or your referral request to an OON care provider is denied and you do not agree with our decision, the member or member's representative may request a grievance review. This is the process for asking us to reconsider a decision.

Submit a grievance request within 180 days from when the denial is received for a referral to an OON care provider due to network inadequacy.

Billing and claims

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

Claim type:

- Institutional (UB-04) – OMH, OASAS licensed, adult CORE and HCBS designated care providers
- Professional (1500) – individual practitioners

All required fields are:

- Complete
- Legible

All claim submissions must include, but not limited to:

- Member's name, identification number and date of birth
- Provider's federal TIN
- National provider identifier (NPI) or unlicensed practitioner ID
- Taxonomy code
- A complete diagnosis (ICD-10-CM)

- Value, rate code, revenue, CPT/HCPCS, procedure code, modifiers
- Date(s) of service
- Servicing care provider
- Timely filing guidelines (within 120 days of date of service)

You should refer to your Agreement with Optum for contracted rates. Although claims are reimbursed based on the network fee schedule, facility contracted rate, ambulatory patient groups (APG) payment or established government rate, bill claims based on the contract or state billing requirements.

You must adhere to timely filing guidelines as outlined in your contract with the Medicaid Managed Care Plan (MMCP). When a clean claim is received by the MMCP, you must adjudicate per prompt pay regulations.

Contracted facilities: After receipt of all of the above information, participating facilities are reimbursed based on the appropriate rates from the facility's Agreement.

Contracted agencies: Agency (including OMH, OASAS and FQHC) claims are subject to APG payment methodology or government rates based on regulations established in New York state billing manuals.

Individual care provider: Please refer to OPTUM National Provider Manual at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Network Manuals > **National Network Manual**.

You are responsible for billing based on nationally recognized CMS Correct Coding Initiative (CCI) Standards. Additional information is available at [CMS.gov](https://www.cms.gov) > Medicare > Coding > **National Correct Coding Initiative Edits**.

Changes to state Medicaid rates and payment methodologies

United behavioral health independent physician associations (IPA) of New York Participation Agreements ("Agreement") that are based on state Medicaid rates and payment methodologies, contracted rates and payment methodologies will be adjusted with changes made by New York state.

Upon notification of rate change, Optum needs 60 days to update internal systems. That includes changes to APG payment or government rates. Rate changes received directly from the state of New York will be automatically incorporated into your Agreement within 60 days of notification.

Once Optum updates the internal systems, Optum will process the retrospective rate adjustments to the effective APG payment date or to the government rate change.

Allowable billing combinations for Home- and Community-Based Services and Community Oriented Recovery and Empowerment

Certain combinations of HCBS, adult CORE and state plan services are allowed by Medicaid. For adults, refer to New York State HARP/Mainstream behavioral health billing and coding manual for allowable service combination grid. You can find this at omh.ny.gov > Behavioral Health Providers > Behavioral Health Managed Care > Behavioral Health Resources > Policy Guidance > **Behavioral Health Billing Manual**. For children, refer to New York State children's health and behavioral health services billing and coding manual for allowable service combination grid at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > Billing Guidance > **Billing Manual**.

Prior to enrolling a member in adult CORE services, CORE care providers are required to check member enrollment with any OASAS, OMH and HCBS services in compliance with the state's allowable service combination guidelines.

Post-claim reconciliation will be conducted and could potentially result in recoupment of adult CORE services payment.

Use modifier 25 when billing more than 1 service on the same day, as allowed in NYS allowable service combination grid.

For information about allowable billing combinations for HCBS and CORE services covered by the NY MAP plan, refer to the **New York State Medicaid Advantage Plus (MAP) Plans Behavioral Health Billing and Coding Manual**.

Claims submission

Electronic claim submission (837i):

EDI is the exchange of information for routine business transactions in a standardized computer format. Submit electronic claims using payer ID 87726.

Electronic clean claims, including adjustments, will be adjudicated within 30 days of receipt.

Paper claim submission (UB-04):

If you are unable to file electronically, use the UB-04 paper claim form. Use an original UB-04 Claim Form (no photocopies). Type the information for maximum legibility and complete all required fields.

When submitting paper claims to UnitedHealthcare, you must include .00 following the rate code.

Mail paper claims to:

Optum behavioral health

P.O. Box 30760

Salt Lake City, UT 84130-0760

Paper clean claims, including adjustments, will be adjudicated within 45 days of receipt.

For claim submission guidance for behavioral health services covered under the MAP plan, refer to the Dual Eligible section in **Chapter 15**.

Additional billing requirements

These billing requirements do not apply to office-based practitioner billing (e.g., outpatient professional claims). It applies only to behavioral health services billed under Medicaid fee-for-service (FFS) by OMH-licensed or OMH-designated, OASAS-certified and DOH-licensed programs.

At the time of enrollment in Medicaid, you will receive notification of rate codes and rate amounts assigned to their category of service.

When submitting a claim, enter the 4-digit rate code on a claim, plus value code 24. Access additional billing requirements and specific UB-04 submission instructions MCTAC Billing Matrix at ctacny.org > Tools > Billing Tool. For more information about rate codes and forms, go to emedny.org > Provider Manuals > Information for all Providers > General Billing Guidelines INSTITUTIONAL.

Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following: use of the clearinghouse 837i claim form (or google claim form 837 for a sample), Medicaid fee-for-service rate code, valid procedure code(s) and procedure code modifiers (as needed).

Each service has a unique rate code. You must submit multiple rate codes on separate claims; **1 rate code per claim**. If a member receives multiple services in the same day with the same CPT code, but separate rate codes, all services are payable. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.

Unlicensed practitioner ID as attending

OASAS Unlicensed Practitioner ID: 02249145

OMH Unlicensed Practitioner ID: 02249154

OCFS Unlicensed Practitioner ID: 05448682

Contact Provider Services for claims

Phone: 1-866-362-3368

Mailing address: Optum behavioral health

P.O. Box 30760

Salt Lake City, UT 84130-0760

Billing appeals

Process by which member, or a care provider on behalf of member, requests a review of adverse determination(s) on the health care services or any amount the member must pay toward a covered service. Appeal of claim payment (amount, partial) or denial must be submitted **within 60 days of receipt** of Provider Remittance Advice (PRA).

Submit appeals to:

United Healthcare Community Plan Appeals

P.O. Box 31364

Salt Lake City, UT 84131-0364

Quality improvement

Quality assurance reviews

Quality assurance reviews may occur for a variety of reasons:

- Optum, New York state or its designee, including local government units, will review quality assurance claims audits to help ensure you comply with the rules, regulations, and standards of the program. Quality review may be conducted without prior notice.
- Sentinel events may result in quality reviews.
- Optum quality assurance reviews resulting from quality of care, quality of service, regulatory concerns as well as best practice reviews.
- The quality assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements. Managed care plans may also be developing protocols to oversee the provision of these services in care provider networks.

Sentinel event reporting

A sentinel event is serious and unexpected and occurs when the member receives behavioral health treatment. This event may create a quality of care issue for you or the facility providing services. It also may create deleterious effects on the member, such as death or serious disability. Examples include, but are not limited to, suicide, medical error, fall, assault, rape, or homicide.

We have established processes and procedures to investigate and address sentinel events. This includes a centralized review committee, chaired by medical directors within UnitedHealthcare Community Plan, and incorporates appropriate representation from the various behavioral health disciplines. As a network care provider, you are required to cooperate with sentinel event investigations.

If you are aware of a sentinel event involving a member, you must notify UnitedHealthcare Community Plan within 1 business day of the occurrence.

Send standardized reporting forms directly to the quality department through secure email:

Email: nybh_qidept@uhc.com

The Sentinel event reporting form is located on providerexpress.com. To locate the form from the home page of Provider Express, go to: providerexpress.com > Our Network > State-Specific Provider Information > New York > Quality Improvement > **Sentinel Event Reporting Form**.

Complaints – quality of service and quality of care

A member, a designee (with written consent), or plan representative can initiate a quality of service or quality of care complaint.

- Urgent complaints are resolved within 48 hours after receipt of all necessary information and no more than 7 days from the receipt of report
- Non-urgent complaints are resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of report

You are required to cooperate with all aspects of the investigation process, including providing requested charts, policies and other documentation in a timely manner and provide corrective action plans within the required timeframe.

Report quality of service and quality of care complaints to Member Services.

Call the member phone number on the member ID card.

Submit written complaints to:

United Healthcare Community Plan of New York

P.O. Box 31364
Salt Lake City, UT 84131-0364

Provider Advisory Committees

- Provider Advisory Committee (PAC) performs peer review activities, review credentialing and recredentialing, and review disposition of concerns about quality of clinical care provided to members as requested by UnitedHealthcare Community Plan's Chief Medical Officer. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network
- Behavioral health advisory subcommittee's (BHAS-child) mission is to advise and assist the plan in identifying and resolving issues related to the management of children's health and behavioral health benefits. It is reflective of UnitedHealthcare Community Plan's entire New York geographic service area and reports to the quality management committee (QOC). Participants include care provider representative(s), youth and family members who have been served in the child welfare and behavioral health system, trained peers with lived experience, children's service providers, voluntary foster care agencies (VFCAs), foster/adoptive family members and other stakeholders as appropriate.

Provider performance review

A care provider performance review can occur at time of credentialing and re-credentialing, as part of ongoing monitoring efforts and as part of a Quality of Care (QOC) investigation or other complaint.

Areas that are evaluated include office environment, policies and procedures, member records, and personnel files. Audit tools and documentation guidelines are located on providerexpress.com > Our Network > State-Specific Provider Information > New York > **Quality Improvement**.

Documentation that you provide should include:

- Plan of care with goals, reflective of progress/challenges
- Start/stop time or length of time of service encounter
- Medical necessity
- Psychiatric and medical history
- Presenting problem
- Assessment and risk assessment (initial and ongoing)
- Medication information
- Care coordination with PCP and other treating providers (refusal of care coordination)
- Substance use screening
- Legible, ideally electronic health record (EHR)
- Signed by provider
- Discharge plan

Chapter 8: Foster care

Foster care information within this chapter aligns with New York State standards, regulations and requirements from the New York State Office of Children and Family Services, Department of Health, Office of Mental Health and Office of Addiction Services and Supports. This information should serve to enable you to meet the health needs of youth in foster care in compliance with all of New York State and UnitedHealthcare Community Plan's expectations and requirements.

For the most up-to-date information regarding health facility UnitedHealthcare Community Plan operational and payment policies, please refer to [UHCprovider.com](https://www.uhcprovider.com).

Article 29-I license services

All voluntary foster care agencies (VFCAs), serving principally as facilities for the care of, or boarding out of children, are subject to the provisions of Article 29-I of the NY Public Health Law and applicable state and federal laws, rules and regulations. Find Article 29-I health facility operational guidelines at [health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility \(VFCA transition\) > 29-I Health Facility Guidance and Rates > Article 29-I VFCA health facilities license guidelines final draft](https://health.ny.gov/health_care/medicaid/redesign/Behavioral%20Health%20Transition/29-I%20Health%20Facility%20(VFCA%20transition)/29-I%20Health%20Facility%20Guidance%20and%20Rates/Article%2029-I%20VFCA%20health%20facilities%20license%20guidelines%20final%20draft).

Agencies that do not obtain Article 29-I licensure are not authorized to receive a Medicaid per diem to provide services.

What is Article 29-I?

Article 29-I licensure authorizes 29-I health facilities to provide core limited health-related services, such as nursing and skill building, and other limited health related services.

Scope of benefits

UnitedHealthcare Community Plan covers the 29-I health facility based on the NY Medicaid program 29-I health facility billing guidance. Find this guidance at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29i_billing_manual_final.pdf.

Core limited health-related services

The following are 5 core limited health-related services (detailed in [Article 29-I VFCA Health Facilities License Guidelines Final Draft](https://health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29i_billing_manual_final.pdf) located at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29i_billing_manual_final.pdf).

- Skill building
- Nursing services
- Medicaid treatment planning and discharge planning
- Clinical consultation/supervision services
- 29-I health facility Medicaid managed care liaison/administration

All 29-I health facilities are required to provide the core limited health-related services to all children residing in the facility. Services are standardized across each facility type and are reimbursed based on a standardized Medicaid residual per diem rate schedule. Find core limited health-related services (Medicaid per diem) rates at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm.

The following services are included in the preventive or rehabilitative residential supports of mandatory core limited health services:

- Skill building activities (provided by licensed behavioral health practitioners [LBHPs])
- Medicaid treatment planning
- Discharge planning, including
 - Medical escorts
 - Clinical consultation/supervision services

Other limited health-related services

The following are other limited health-related services provided by a 29-I health facility to meet a child/youth's individualized treatment goals and health needs. All other limited health-related services that a 29-I health facility provides must be included in the 29-I license and may require separate state designation prior to delivery of services.

Children's Home- and Community-Based Services

Find the children's HCBS care provider manual at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/manuals.htm.

For more information about core and other limited health services, refer to the training provided by the CTACNY at ctacny.org.

Children's waiver HCBS include:

- Caregiver/family advocacy and support services
- Respite (planned and crisis)
- Prevocational services
- Supported employment
- Community habilitation
- Palliative care: Bereavement services
- Palliative care: Counseling and support services
- Palliative care: Expressive therapy
- Palliative care: Massage therapy
- Palliative care: Pain and symptom management
- Environmental modifications
- Vehicle modifications
- Adaptive and assistive technology
- Nonmedical transportation

Children and Family Treatment and Support Services

Children and Family Treatment and Support Services (CFTSS) Provider Manual for EPSDT services can be found at health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm.

CFTSS include:

- Other licensed practitioners (OLP)
- Community psychiatric supports treatment (CPST)
- Psychosocial rehabilitation (PSR)
- Family peer supports and services (FPSS)
- Youth peer support and training (YPST)
- Crisis intervention (CI)

Effective 8/18/25, UnitedHealthcare Community Plan will conduct CFTSS Utilization Management on 2 of the 6 CFTSS services: Community Psychiatric Supports and Treatment (CPST H0036) and Psychosocial Rehabilitation (PSR H2017) (0-20 years of age) in accordance with the medical necessity guidelines set forth with the Office of Mental Health (OMH), Office of Addiction Services & Support (OASAS), Office of Children & Family Services (OCFS) and the Department of Health (DOH) guidance in the NYS Children and Family Treatment and Support Services (CFTSS)

Service and Billing Manual August, 2025 found here: [Children and Family Treatment and Support Services \(CFTSS\) Service and Billing Manual](#).

Medicaid state plan services

Additional Medicaid state plan services include:

- Screening, preventive, diagnostic and treatment services related to physical health, including but not limited to:
 - Ongoing treatment of chronic conditions as specified in treatment plans
 - Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
 - Primary pediatric/adolescent care
 - Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
 - Reproductive health care
 - Medical nutrition therapy
- Screening, preventive, diagnostic and treatment services related to developmental and behavioral health. This includes the following:
 - Psychiatric consultation, assessment and treatment
 - Psychotropic medication treatment
 - Developmental screening, testing and treatment
 - Psychological screening, testing and treatment
 - Smoking/tobacco cessation treatment
 - Alcohol or drug screening and intervention
 - Laboratory tests



Refer to **Appendix E** for links to these and other screening and assessment tools

Specialty Medicaid participating providers (i.e., essential community providers) should be licensed to provide the following specialty services:

- Surgical services
- Dental services
- Orthodontic care
- General hospital services including emergency care
- Birth center services
- Emergency intervention for major trauma
- Treatment of life-threatening or potentially disabling conditions

Specialty Medicaid services are billed directly to UnitedHealthcare Community Plan and are not considered “other limited health related services.”

Other limited health-related services may be provided to UnitedHealthcare Community Plan members in the care of any 29-I Health Facility, including children/youth in foster care, children/youth placed in a 29-I health facility by committee on special education (CSE), babies residing with their parent who are placed in a 29-I health facility and in foster care, and children/youth in foster care placed in a setting certified by the Local Department of Social Services (LDSS).

Go directly to the NY Medicaid State Plan Services website at [health.ny.gov > regulations > state_plans](https://health.ny.gov/regulations/state_plans).

Additional information regarding core limited health-related services and other limited health-related services is available in the 29-I health facility operational guidelines. Refer to the New York State Department of Health 29-I Health Facility at [health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility \(VFCA transition\) > 29-I Health Facility Guidance > Article 29-I VFCA Health Facilities License Guidelines Final Draft](https://health.ny.gov/health_care/medicaid/redesign/Behavioral%20Health%20Transition/29-I%20Health%20Facility%20(VFCA%20transition)/29-I%20Health%20Facility%20Guidance/Article%2029-I%20VFCA%20Health%20Facilities%20License%20Guidelines%20Final%20Draft) for more information about the core limited and other limited health related services.

Covered behavioral health services

Refer to the NY State Children's Health and Behavioral Health Services Billing and Coding Manual for a full description of covered behavioral health services, or go to [health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > Billing Guidance > Billing Manual > New York State Children's Health and Behavioral Health Services Billing and Coding Manual](https://health.ny.gov/health_care/medicaid/redesign/Behavioral%20Health%20Transition/Billing%20Guidance/Billing%20Manual/New%20York%20State%20Children's%20Health%20and%20Behavioral%20Health%20Services%20Billing%20and%20Coding%20Manual).

Health homes and C-Yes: Path to services

For further guidance, please refer to the New York State Department of Health, Health Home Serving Children Manual at [health.ny.gov > Individuals/Families > Health Insurance Programs > Medicaid > Health Homes > Health Homes Serving Children \(HHSC\)](https://health.ny.gov/Individuals/Families/Health%20Insurance%20Programs/Medicaid/Health%20Homes/Health%20Homes%20Serving%20Children%20(HHSC)).

Clinical vision

Level of care guidelines

You are expected to review and be familiar with the **level of Care (LOC) guidelines** and **clinical practice guidelines** posted on [providerexpress.com > United States > Our Network > State-Specific Provider Information > New York > Clinical Information > Level of Care Guidelines or Clinical Practice Guidelines](https://providerexpress.com/United%20States/Our%20Network/State-Specific%20Provider%20Information/New%20York/Clinical%20Information/Level%20of%20Care%20Guidelines%20or%20Clinical%20Practice%20Guidelines).

Additional information is available in the New York Medicaid care provider resources-children under 21 behavioral health provider manual posted on provider express at [providerexpress.com > United States > Our Network > State-Specific Provider Information > New York](https://providerexpress.com/United%20States/Our%20Network/State-Specific%20Provider%20Information/New%20York).

Foster care liaison

The foster care liaison is available to the LDSS and 29-I health facility during regular business hours to address any issues for UnitedHealthcare members in foster care and is the direct UnitedHealthcare Community Plan contact for care coordinators and care providers. The contact information for the foster care liaison is:

Foster Care Liaison UnitedHealthcare Community Plan

One Penn Plaza, 19th floor
New York, NY 11905

Email: nyfostercare@uhc.com

Foster care liaison main number: **1-855-883-5403**.

After-hours contact: Care providers: **1-866-362-3368**, select option 8.

Members: **1-800-493-4647**, select option 8.

For additional information, refer to the **Optum Provider Express Foster Care Toolkit** at [providerexpress.com > United States > Our Network > State-Specific Provider Information > New York > Clinical Resources > Foster Care Toolkit](https://providerexpress.com/United%20States/Our%20Network/State-Specific%20Provider%20Information/New%20York/Clinical%20Resources/Foster%20Care%20Toolkit).

Behavioral or medical case management

Case records are routinely reviewed to determine eligibility for UnitedHealthcare Community Plan case management. When a member enrolled in foster care is identified as eligible, the foster care liaison will outreach to the LDSS or 29-I Health Facility. Additionally, any local DSS or 29-I health facility can request UnitedHealthcare case management for a member by contacting the foster care liaison.

Foster Care Liaison UnitedHealthcare Community Plan

One Penn Plaza, 19th floor
New York, NY 11905

Email: nyfostercare@uhc.com

Foster care liaison main number: **1-855-883-5403**.

After-hours contact: Care providers: **1-866-362-3368**, select option 8.

Members: **1-800-493-4647**, select option 8.

HIPAA notice of privacy practices and website privacy policy

Refer to the UnitedHealthcare privacy policy online at uhc.com/privacy.

Quality improvement

Refer to the Quality Improvement tab under the New York Medicaid Provider Resources – Children Under 21 section on the [New York Page of Provider Express](https://providerexpress.com) at providerexpress.com for more information about the quality improvement process.

Provider Advisory Committees

A Provider Advisory Committee (PAC) performs peer review activities, credentialing and recredentialing, and concerns about quality of clinical care provided to members as requested by UnitedHealthcare Community Plan's chief medical officer.

In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization and cost of the medical care rendered within the network.

The behavioral health advisory subcommittee's (BHAS-Child) mission is to advise and assist the plan in identifying and resolving issues related to the management of children's health and behavioral health benefits and is reflective of UnitedHealthcare Community Plan's entire New York geographic service area and reports to the quality management committee (QOC). Participants include care provider representative(s), youth and family members who have been served in the child welfare and behavioral health system, trained peers with lived experience, children's service providers, 29-I health facilities, foster/adoptive family members and other stakeholders as appropriate.

Complaints: Quality of service and quality of care

A member, a designee (with written consent) or plan representative can initiate a quality of service or quality of care complaint.

- Urgent complaints are resolved within 48 hours after receipt of all necessary information and no more than 7 days from the receipt of report

- Nonurgent complaints are resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of report

You must cooperate with all aspects of the investigation process, including providing requested charts, policies, other documentation and corrective action plans within a timely manner.

Sentinel event reporting

Sentinel events are serious, unexpected occurrences involving a member caused by a possible quality of care issue on the part of the practitioner/facility providing services.

These events may have deleterious effects on the member, including death or serious disability, that occur while a member is receiving behavioral health treatment.

We established processes and procedures to investigate and address sentinel events. Find the policy on providerexpress.com website.

If you are aware of a sentinel event involving a member, you must notify UnitedHealthcare Community Plan within 1 business day of the occurrence. Send standardized reporting forms directly to the quality department through secure email:

Email: nybh_qidept@uhc.com

The sentinel event reporting form is located on providerexpress.com. To locate the form go to providerexpress.com > United States > Our Network > State-Specific Provider Information > New York > Quality Improvement > [Sentinel Event Reporting Form](#).

Care provider participation

Network participation

UnitedHealthcare Community Plan follows credentialing and contracting requirements outlined in the NY Medicaid Program 29-I health facility billing guidance found at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Rates and Billing Guidance > [New York Medicaid Program 29-I Health Facility BILLING GUIDANCE](#).

UnitedHealthcare Community Plan requires care providers to comply with all [Medicaid rules, regulations and laws](#) according to New York State and [Center for Medicare and Medicaid Services Federal Regulations](#).

29-I health facilities should contact their network manager with questions.

Email: nynetworkmanagement@optum.com

Phone: Provider Services Behavioral Health Service: **1-877-614-0484**

Provider Services Medical Services: **1-866-362-3368**

After-hours contact:

Care providers: **1-866-362-3368**, select option 8.

Members: **1-800-493-4647**, select option 8.

To get additional contact information about network managers, go to matrix.ctacny.org.

Recredentialing

Follow the recredentialing rules:

- As established by NCQA, recredentialing occurs every 36 months (3 years)
- You should receive a recredentialing packet several months in advance. If you do not, please proactively reach out to your network manager.
- Failure to complete recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact your status in the network
- Complete all recredentialing paperwork. Site audit may be required.
- The recredentialing process takes time, so it is important to complete and submit required documentation as soon as possible

Find more information in the **Optum National Network Manual** at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > **Network Manual**.

Access to care

You must meet the timeframes for completion of required diagnostic assessments upon intake into foster care and any additional assessments mandated by OCFS/LDSS/29-I health facility and outlined in the 29-I health facilities license guidelines located at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance > **Article 29-I VFCA Health Facilities License Guidelines Final Draft**.

Training requirements

You are required to participate in a comprehensive care provider training and support program to gain appropriate knowledge, skills and expertise to comply with state requirements. A schedule of trainings will be available on the **New York homepage** of Provider Express at providerexpress.com > Our Network > State-Specific Provider Information > **New York** which will be updated as needed. Training will be offered to a full range of service providers. When possible, Optum will work through the **regional planning consortiums (RPC)** to deliver care provider education opportunities, as well as additional collaboration with the **Community Technical Assistance Center of New York (CTAC)/Managed Care Technical Assistance Center of New York (MCTAC)** and **Center for Practice Innovation**. Find more information about RPC at clmhd.org/rpc. Find more information about CTAC/MCTAC resources at ctacny.org/about-us. Additional information about the Center for Practice Innovation is at practiceinnovations.org.

Training topics developed for all care providers and staff include:

- Orientation to Optum
- Credentialing and recredentialing
- Care provider website orientation
- Member eligibility verification
- Utilization management
- Quality improvement
- Clinical model and vision
- Cultural competency/awareness
- Complex and high-need population, including transition-age youth (TAY)
- Use of evidence-based practices
- Supplementary supports
- Claims, billing guidelines and coding
- HCBS care provider directory and online resources
- Routine management and training regarding chronic conditions
- Trauma informed care
- Developmental level of population served
- Title III ADA compliance
- Unique service needs of the foster care population
- Timeframe for initial health activities to be completed upon placement to 29-I health facility
- Mandated reporter
- Risk and safety
- Trauma informed care

- Family engagement
- Basic child development
- Age and need appropriate healthcare for children

In addition to the above-mentioned trainings, specialized trainings and educational resources are designed to help ensure PCPs possess appropriate skills and knowledge. Training topics include:

- Diagnostic techniques
- Measures and resistance testing
- Strategies to promote treatment adherence
- Management of HIV-infected patients with comorbid conditions
- Care coordination and medical case management
- Patient education needs including primary and secondary prevention, risk reduction and harm reduction
- Family-centered psychosocial issues
- Mental health and chemical dependence issues (to include training in formal mental health and chemical dependence assessment instruments)
- Timeframe for initial health activities to be completed upon placement to 29-I health facility
- Title III ADA compliance
- Unique service needs of the foster care population

Center for Practice Innovations

5 core trainings are available for children's behavioral health clinical staff free of charge, through Center for Practice Innovations (CPI):

- Family-driven and youth guided practice
- Recovery and resilience for children and youth
- Understanding family engagement and best practices
- Coordination/collaboration across child serving systems
- Trauma informed care in the child/adolescent behavioral healthcare system

For information and instructions to register go to practiceinnovations.org.

- Select children UCNPT trainings

Evidence-based practices

- Optum recognizes the effectiveness of therapeutic interventions identified as evidence based practice and encourages all care providers to obtain training in these strategies and incorporate them into their practices

- NY state licensed providers are eligible to obtain evidence-based practice (EBP) trainings through the Center for Practice Innovation at practiceinnovations.org

Additional care provider support and educational resources include the following:

- **Provider Express** is your public page designed for behavioral health providers for Optum and its affiliates. Provider Express allows care providers (psychologists, psychiatrists, social workers and other mental health providers) to interact with United Behavioral Health (UBH) through the internet. Access account activity and browse through online health content. UBH care provider network clinicians and staff can check and submit claims, check authorization or certification status and check payment status online.
- **Healthcare Education and Training page** includes free educational courses, including topics such as how to use UnitedHealthcare Community Plan's self-service tools, clinical trainings and toolkits, policy and procedures, coding and more. Review this information by going to UHCprovider.com.
- **Optum Health Education (OHE)** provides medical, nursing, pharmacy, psychology and social work continuing education activities. OHE is a full-service care team of continuing medical and interprofessional education that leads to improved health care delivery and better patient outcomes.
 - OHE is accessed through the following website: optumhealtheducation.com

Trauma-informed care

As a UnitedHealthcare Community Plan provider, you may find yourself in a position to provide trauma-informed care to Medicaid Managed Care (MMC) enrolled children/youth in direct placement foster care and in the care of Voluntary Foster Care Agencies (VFCAs).

Provision and coordination of services for children/youth in foster care, must be done in compliance with the [New York Medicaid Program 29-I Health Facility Billing Manual](#) and the [Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care](#) guidance documents located at health.ny.gov.

Pharmacy benefit requirements

The pharmacy benefit requirements include, but are not limited to, rapid replacement of medically necessary prescriptions and transitional fills. Effective April 1, 2023, pharmacy benefits for MMC members, were transitioned to NYRx, the Medicaid pharmacy program. However, physician administered drugs, durable medical equipment, prosthetics, orthotics, and supplies are still covered by UnitedHealthcare Community Plan when billed as a medical or institutional claim. The pharmacy procedure code manual can be found at [emedny.org](https://www.emedny.org).

Fiscal responsibility

When a community care provider (dental, vision, PCP) accepts an MMC enrollee as a patient, the community care provider agrees to bill the MMC plan for services provided.

The community care provider is prohibited from requesting any monetary compensation from the beneficiary, foster parent, foster care youth, the VFCA or Local Departments of Social Services (LDSS). The community care provider will not require the child/youth's responsible relative, foster parent, foster care youth, or VFCA to sign any documents that would indicate a financial responsibility for any services that are covered under Medicaid or the MMC Plan.

Consent

The foster parent is not permitted to consent to medical treatment on behalf of the child/youth in foster care. Community providers must contact the VFCA Managed Care Liaison before any community care provider appointment to ensure any needed consents are signed by the medical consentor (i.e., birth parent, if parental rights are not terminated, or a designee from the agency, if parental rights are terminated).

Initial medical assessment

Upon placement in foster care, a child/youth is required to have an initial medical assessment within the first 30 days of placement. The child/youth may utilize any PCP or qualified practitioner in the MMC plan's network for the purposes of this initial medical assessment.

Vision

Emergency, preventive, and routine eye care services are covered by Medicaid Managed Care. Eye care coverage includes the replacement of lost, damaged, or destroyed eyeglasses.

For children in foster care, replacement of eyeglasses or contact lenses must immediately be authorized as necessary upon placement into foster care, return from trial discharge, or return from home visit.

Children/youth in foster care are not required to continuously use the same community vision care provider and may access these services from any appropriate participating provider.

Additional information can be found in the Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan Model Contract located at [health.ny.gov](https://www.health.ny.gov).

If there are any questions or concerns, please call **Provider Services** at **1-866-362-3368**.

Orthodontic treatment

For ongoing community orthodontic care for children/youth, it is desirable and recommended to continue and finish the active orthodontic treatment utilizing the existing functional orthodontic appliances.

In a situation when the new orthodontist cannot continue the active orthodontic treatment with the existing orthodontic appliances due to multiple missing brackets or different treatment plans, then a detailed narrative substantiating the need for new orthodontic appliances must be submitted with a prior approval request. Additional information can be found in the NYS Medicaid Dental Policy and Procedure Manual located at [emedny.org](https://www.emedny.org). If there are any questions or concerns, please call **Provider Services** at **1-866-362-3368**.

Member eligibility

Children/youth placed in foster care, including those in direct placement foster care and placement in the care of 29-I health facilities statewide, will be mandatorily enrolled in managed care unless the child/youth is otherwise exempt or excluded from enrollment.

UnitedHealthcare Community Plan will accept the following as appropriate notification of the child/youth's placement in the care of the 29-I health facility or as eligible for CLHRS/other limited health related services or assessments (OLHRS):

- A transmittal form from the state, LDSS or 29-I health facility indicating such placement; refer to Attachment D – Transmittal Form and Instructions on page 35 in the NY State Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care located at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance and Rates > Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 1.0.
- An enrollment notification from New York Medicaid Choice (NYMC) or the state indicating such placement
- Direct notification from the 29-I health facility/LDSS liaison or the state
- The member appears on the state's monthly foster care reconciliation report as placed in such facility 29-I health care facility need to notify UnitedHealthcare Community Plan regarding placement in to 29-I health care facility or placement change through submission of a Transmittal Form: health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance > [29-I Health Facility Transmittal Form Instructions](#).
- Member is placed in the care of 29-I health care facility
- Member is discharged from Foster Care or 29-I health care facility
- Member is moving to another 29-I health care facility
- Member is moving to LDSS county
- Member is returning home
- Member ages out

The most recent transmittal form will be considered the source of truth for the member's current placement. You must complete and submit the transmittal form to the UnitedHealthcare Community Plan within 5 business days of the change. Liaisons must communicate with one another regarding any discrepancies between the most recent transmittal form and monthly foster care reconciliation report.

The [transmittal form](#) should include the following essential information:

- 29-I health facility evaluations
- Member demographic fields (known)
- Medicaid client identification numbers (known)
- PCP name or change in PCP
- Other pertinent clinical or medical information

For more information about the transmittal form or for detailed instructions for completion and submission go to health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance > [29-I Health Facility Transmittal Form Instructions](#). Submit transmittal forms to: americhoice_ny_chp@uhc.com.

Benefit coverage of 29-I health facility services, CLHRS and OLHRS ends when:

- The child/youth has been disenrolled from UnitedHealthcare Community Plan
- The child/youth enters a non-reimbursable absence or setting
- For CLHRS, the child/youth has been discharged from foster care or the 29-I health facility
- The child/youth is no longer eligible for OLHRS

Consent for routine medical services for children/youth in foster care

Because children enrolled in foster care are predominantly minors, and the LDSS becomes their legal guardian, obtaining legal consent for routine medical services is dependent upon many factors. Refer to health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance > [29-I Health Facility Transmittal Form Instructions](#) or health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance > Webinars and Technical Assistance > [Article 29-I Health Facilities Licensure May 2018](#) for more information.

Benefit coverage after discharge from 29-I Health Facility

Children/youth who are discharged from a 29-I health facility can receive OHLRS from any 29-I health facility up to 1 year post discharge, except for HCBS and CFTSS services.

These services may continue beyond the 1 year post discharge date, if any of the following apply:

- The child/youth is younger than 21 years old and in receipt of services through the 29-I health facility for an episode of care and has not yet safely transitioned to an appropriate care provider for continued necessary services
- If the member is 21 years or older, you may bill for OLHRS when the following applies - member:
 - Has been placed in the care of the 29-I health facility and has been in receipt of other limited health-related services prior to turning 21
 - Has not yet safely transferred to another placement or living arrangement and/or
 - Their authorized representative is compliant with a safe discharge plan
- Prior authorization is required for out-of-network care providers

In addition, the 29-I health facility continues to work collaboratively with UnitedHealthcare Community Plan to explore options for the member's safe discharge, including compliance with court ordered services, if applicable.

Submit transmittal forms to
americhoice_ny_chp@uhc.com.

Send questions related to the transmittal form to
nyfostercare@uhc.com.

The Medicaid residual per diem is not reimbursable after the individual turns 21. An **episode of care** is a course of treatment that began prior to discharge by the same facility to the child/youth for the treatment of the same or related health or behavioral health condition and may continue within 1 year after the date of the child/youth's discharge from the 29-I health facility.

Transition-age youth

UnitedHealthcare Community Plan will work closely with 29-I health facilities to assist in transition planning for youth based on section III:

Health/Health Insurance/Health Care Proxy in the NYS OCFS Administrative Directive 15-OCFS-ADM-20, located at ocfs.ny.gov/main/policies/external > 2010-2019 > 2015 Policy Directives > Administrative Directives (ADM) > 15-OCFS-ADM-15 Continuation of the Kinship Guardianship Assistance Program (KinGAP) to a successor guardian.

Utilization management

UnitedHealthcare Community Plan will accept communication from the LDSS or 29-I health facility liaison regarding placed children/youth enrolled with us. Communication will facilitate or arrange continued access to requested services without interruption and without conducting utilization review for LTSS, HCBS or OLHRS at least 180 days from the effective date of enrollment.

The following grid reflects authorization and notification requirements for in-network care providers.

For more information, refer to the Foster Care Initial Health Services table in the Article 29-I VFCA health facilities license guidelines final draft, located at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Guidance and Rates > [Article 29-I VFCA Health Facilities License Guidelines Final Draft](#).

Care providers who are out-of-network or not contracted must request prior authorization for services. Refer to the out-of-network section in this care provider manual for more information.

Services	Prior authorization	Concurrent review
Core limited health related services (CLHRS)	No	No
Other limited health related services (OLHRS) – behavioral health services	No	No
Other limited health related services (OLHRS) – medical services	No (with exceptions of CPT codes 92521-92526 with rate code 4598).	No (with exceptions of CPT codes 92521-92526 with rate code 4598).
Children and family treatment support services	No	No
Home- and Community-Based Services	Refer to HCBS guidance.	Refer to HCBS guidance.
Out-of-network services	Yes	Yes
OLHRS members post discharge	Yes	Yes
Specialty care	No	No

Notifications and requests for authorizations

Electronic request:

Submit your medical and behavioral notification and authorizations request using the electronic prior authorization and notifications (PAAN) system at UHCprovider.com/priorauth. You must be a registered user to submit authorization requests. A care advocate will contact you for additional information, if needed.

For additional information on how to use the PAAN system, go to: providerexpress.com > United States > Our Network > State-Specific Provider Information > New York > **Clinical Information**.

Children/youth in foster care can access specialty care providers for covered medically necessary services without first requiring a PCP referral.

Telephonic request:

For medical notifications and requests for services that require authorization, call **Provider Services** at **1-866-362-3368**.

For behavioral health notifications and requests for services that require authorization, call BH **Provider Services** at **1-866-362-3368**.

- Enter TIN
- Select “Care Notifications and Prior Authorizations”

- Enter member ID
- Enter member birth date
- Select “Mental Health”
- Out-of-network: Call UnitedHealthcare Community Plan to build authorization and secure claims payment

Medical and behavioral health utilization review appeals

Options for submitting appeals:

Phone: 1-866-556-8166, TTY 711

Use phone number to check status of an appeal and verbally submit an appeal.

- **Note:** Follow up a verbal appeal with a written, signed appeal
- Members/care providers have 60 calendar days from the date of denial to request an appeal
- Only 1 internal appeal allowed
- Clinical appeal turnaround time is 72 hours

Mail: UnitedHealthcare Community Plan

Attn: UM Appeals Coordinator
P.O. Box 31364
Salt Lake City, UT 84131

Out-of-network care provider/single case Agreements

An out-of-network (OON) care provider must request prior authorization before providing any service. Requests will be reviewed in a timely manner, as appropriate for a member's condition. Please be sure to indicate if this is an emergency. Care providers delivering a service that they are not contracted for must request an SCA.

A single case Agreement (SCAs) is required to facilitate payment to a 29-I health facility that has not contracted with us and will deliver services to a child/youth.

New York State rules according to the Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I health facility Services into Medicaid Managed Care will apply.

To request an SCA, please contact:

Medical services: **1-866-362-3368**.

Behavioral health services: **1-866-362-3368**.

Peer-to-peer review

All denial, grievance and appeal decisions are subject to specific behavioral health requirements including peer-to-peer review.

When there is disagreement about the frequency, duration or level of care requested, a peer-to-peer review is scheduled.

- A physician who is board certified in child psychiatry must review all inpatient denials for psychiatric treatment
- A physician who is certified in addiction treatment must review all inpatient denials for substance use disorder treatment
- A physician must review all denials for services for a medically fragile child
- Determinations will take into consideration the needs of the family/caregiver
- All other denials are reviewed by an independently licensed psychologist (PhD) or a board-certified psychiatrist or physician who is certified in addiction treatment

Referrals to specialists

Access to care from specialists for covered medically necessary services without first requiring a PCP referral is based on:

- The LDSS/29-I Health Facility

- The child/youth's treatment plan or proposed treatment plan
- Any services that are court-ordered or mandated by the LDSS or OCFS

Specialty care services are subject to MMCP notification and authorization requirements, where applicable. The LDSS/29-I health facility will make reasonable efforts to facilitate coordination between the specialist and the child/youth's PCP.

Billing and claims

29-I health facilities will submit claims to UnitedHealthcare Community Plan for services provided to members according to the 29-I billing guidance and our billing procedures.

You are prohibited from balance billing any member for any reason for covered services.

A clean claim is a claim with no defect or impropriety (including any lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payments.

Claim type:

- Institutional (UB-04) – 29-I healthcare facility, OMH, OASAS licensed and HCBS-designated care providers

All required fields are:

- Complete
- Legible

All claim submissions must include, but not limited to:

- Member's name, identification number and date of birth
- Your taxpayer identification number (TIN)
- National provider identifier (NPI) or unlicensed practitioner ID
- Taxonomy code
- A complete diagnosis (ICD-10-CM)
- Value, rate code, revenue, CPT/HCPCS, procedure code, modifiers
- Date(s) of service
- Servicing care provider
- Timely filing guidelines (within 120 days of date of service)

Although claims are reimbursed based on the network fee schedule, facility contracted rate, APG or established government rate, bill claims based on the contract or state billing requirements. Bill claims with your usual and customary charges indicated on the claim. You must adhere to timely filing guidelines as outlined in the contract with UnitedHealthcare Community Plan.

You are responsible for billing with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at [cms.gov](https://www.cms.gov) > Medicare > Coding > National Correct Coding Initiative Edits.

Concurrent billing

If the child is receiving services from an Article 29-I Health Care facility and a community care provider, such as an Article 31 or Article 28, simultaneously, there should be no duplication of services. When a clinical need is identified that is distinctly different and not duplicative to those needs being addressed through the 29-I Health Facility, it may be determined medically necessary for both services to be provided concurrently.

Core limited health-related services: per diem

Core limited health-related services are included in the residual per diem rate paid to 29-I health facilities. These rates are billed as pass through on a per child/per day basis to cover the costs of nonencounter services. 29-I health facilities are categorized by the level of care provided and rates are assigned based on that level of care. Because an agency may operate more than 1 facility, the per diem will be reimbursed at the established government rate for each facility.

29-I health facilities will be reimbursed to provide the core health-related services under the Article 29-I licensure through the residual per diem, which will be paid by UnitedHealthcare Community Plan to the 29-I health facilities.

There are 13 rate codes corresponding to the level and facility type. You must adhere to the procedure and modifier code combinations to help ensure appropriate rate payment. Find the rate codes, CPT codes and modifier code combinations that Medicaid requires to bill for the Medicaid residual per diem in the [NY State 29-I Billing Manual](#).

Level	Description	Facility type
Level 1	General treatment	• Foster boarding home

Level	Description	Facility type
Level 2	Specialized treatment	• Therapeutic boarding home (TBH)/AIDS • Medically fragile (former border babies) • Special needs
Level 3	Congregate care	• Maternity • Group home (GH) • Agency operated boarding home (ABH) • Supervised independent living program (SILP)
Level 4	Specialized congregate care	• Group residence (GR) • Diagnostic • Institutional • Hard to place/ other congregate • Raise the age

Other limited health-related services billable units

In addition to the core limited health-related services (Medicaid residual per diem), 29-I health facilities may bill for encounter-based other limited health-related services provided to meet a child/youth's individualized needs and included in the facility's 29-I license. Find more information about OLHRS coding by going to the following links.

Find rates and rate codes for:

Children and family treatment and support services (CFTSS) at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > Children and Family Treatment and Support Services.

Children's HCBS at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 1915(c) Children's Waiver and 1115 Waiver Amendments.

Timed units per encounter of services

All unit limits are “soft limits,” which means they can be exceeded with medical necessity. If a service or procedure code requires time beyond the 15-minute unit in the fee schedule, the 29-I health facility may add additional 15-minute units to the claim in accordance with [NY 29-I Health Facility Billing Guidance](#).

Claims submission

Electronic claim submission (837i)

EDI is the exchange of information for routine business transactions in a standardized computer format. Submit electronic claims utilizing Payer ID 87726.

EDI support:

Phone: 1-800-210-8315

Email: ac_edi_ops@uhc.com

Electronic clean claims, including adjustments, will be adjudicated within 30 days of receipt.

Paper claim submission

If you are unable to file electronically, use the UB-04 paper claim form. Make sure information is typed for maximum legibility and all required fields are completed.

Mail paper claims for:

Medical services to:

UnitedHealthcare Community State

P.O. Box 5240

Kingston, NY 12402

Behavioral health services to:

Optum behavioral health

P.O. Box 30760

Salt Lake City, UT 84130-0760

Paper clean claims, including adjustments, will be adjudicated within **45 days of receipt**.

Additional billing requirements

Additional billing requirements are available at the 29-I MCTAC billing tool at ctacny.org > 29ibilling.

Unlicensed practitioner ID as attending

OASAS unlicensed practitioner ID: 02249145

OMH unlicensed practitioner ID: 02249154

OCFS unlicensed practitioner ID: 05448682

Changes to state Medicaid rates and payment methodologies

The United behavioral health IPA of New York Participation Agreement, based on state Medicaid rates and payment methodologies, contracted rates and payment methodologies, will be adjusted consistent with changes made by New York State.

When there is a rate change, UnitedHealthcare Community Plan needs 60 days to update internal systems, including changes to APG payment or government rates. Rate changes received directly from the State of New York will be automatically incorporated into your Agreement within 60 days of notification.

UnitedHealthcare Community Plan will process retrospective rate adjustments to the effective date of APG payment or government rates change, upon update of Optum internal systems.

Billing appeals

Process by which a member, or you, on behalf of a member, requests a review of adverse determination(s) on the health care services or any amounts the member must pay toward a covered service. The LDSS/29-I health facility may file a complaint with UnitedHealthcare Community Plan on behalf of the child/youth in foster care.

Appeals: 1-866-556-8166, TTY 711

- Use phone number to check status of an appeal and verbally submit an appeal. You must follow up an appeal filed verbally with a written, signed appeal.
- You have 60 calendar days from the date of denial to request an appeal
- Only 1 internal appeal allowed
- Clinical appeal turnaround time is 72 hours

Submit a claim payment appeal (full or partial amount) or denial **within 60 days of receipt** of care provider remittance advice (PRA).

Submit medical and behavioral health care provider claim appeals to:

UnitedHealthcare Community Plan

Attn: Complaint and Appeals Department

P.O. Box 31364

Salt Lake City, UT 84131-0364

Impact of absences on billing

For information about the impact of absences on claims, refer to the NY Medicaid program 29-I health facility billing guidance document at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Rates and Billing guidance > [New York Medicaid Program 29-I Health Facility Billing Guidance](#).

29-I health facilities state billing guidance

You must adhere to the billing and coding manual requirements within this manual as well as clean claiming rules as outlined in the billing manual found at health.ny.gov/health_care/medicaid/redesign > Behavioral Health Transition > 29-I Health Facility (VFCA transition) > 29-I Health Facility Rates and Billing guidance > [New York Medicaid Program 29-I Health Facility Billing Guidance](#).

Chapter 9: 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 information 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: UHCcommunityplan.com/ny.

Native American and Alaskan Natives access to care

Native American members can access care to tribal clinics and Indian hospitals without approval. Native Americans and Alaskan Natives are exempt from all co-payments.

Member rights

Members have the right to:

- Receive information about UnitedHealthcare Community Plan; its services, practitioners and providers; and member rights and responsibilities
- Be cared for with respect, dignity and privacy without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation
- Receive information about where, when and how to get the services needed from UnitedHealthcare Community Plan
- Receive information from the PCP about what is wrong, what can be done and what will likely be the result in language the member understands
- Get a second opinion about care from an in-network provider, or from OON at no additional cost if an in-network provider is not available
- Consent to any treatment or plan for care after that plan has been fully explained
- Refuse care and receive information about risks
- Receive a copy of the medical record, discuss it with the PCP, and ask, if needed, that the medical record be amended or corrected
- Ensure the medical record is private and will not be shared with anyone except as required by law, contract or with the member's approval
- Use the UnitedHealthcare Community Plan complaint system, New York State Department of Health or the local Department of Social Services to settle any complaints any time they feel unfairly treated
- Make recommendations regarding the organization's member rights and responsibilities policy
- Use the State Fair Hearing system
- Appoint someone (relative, friend, lawyer) to speak if they are unable to speak for themselves about care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- Have a candid discussion of appropriate or medically necessary treatment options for condition, regardless of cost or benefit coverage

Member responsibilities

Members should:

- Work with their PCP to guard and improve health
- Supply true and complete information that the organization and its practitioners and care providers need to provide care
- Follow plans and instructions for care agreed upon with practitioner
- Understand health problems and participate in developing mutually agreed-upon treatment goals
- Learn how the health care system works
- Listen to PCP's advice and ask questions when in doubt
- Call or see PCP again if not feeling better or ask for a second opinion
- Treat health care staff with respect
- Call Member Services if they have problems with any health care staff
- Keep appointments. If cancellation is necessary, call as soon as possible.
- Use the emergency room only for real emergencies
- Call PCP when medical care is needed, even if it is after hours

Chapter 10: 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. A separate medical record for each member is required. You must retain medical records 6 years after the member’s date of service; for a minor, keep medical records 3 years after the age of 18 or 6 years after the date of service, whichever is later.

Prenatal care only: Medical records for prenatal care and all other services must be accessible to UnitedHealthcare Community Plan for UM and QA, and to NYSDOH, CMS and LDSS (UnitedHealthcare Community Plan for Families only). You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health 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**

Member copies

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

Chapter 11: 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 enhancing 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
- Cooperating with quality-of-care investigations. For example, responding to questions or completing quality-improvement action plans. Participating in quality audits, such as site visits, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, or secure email.

- Completing practitioner appointment access and availability surveys

We require your cooperation 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 meeting

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

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

Clinical practice guidelines

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

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable New York State Department of Health (DOH) statutes and the National Committee for Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement

- Current medical license
- Current Drug Enforcement Administration (DEA) certificate, if applicable
- 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)
- NPs and PAs who practice independently
- 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; or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

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

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or another recognized accrediting agency
- CMS site survey, if applicable
- 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.

Care providers who want to join the network

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. During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, National Credentialing and its vendors will make every effort to obtain such information as soon as possible.

National Credentialing and its vendors notify you of the missing information through written correspondence or phone call. Notification includes whether or not you are credentialed, and if not, whether the plan is not in need of additional care providers. If additional information is required, you are notified as quickly as possible, but not more than 90 days from receipt of your application.

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 you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

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

Applicant rights and notification

UnitedHealthcare Community Plan will make available on a periodic basis and upon request of the care provider the information, profiling data and analysis used to evaluate the care provider's performance. Each care provider is given the opportunity to discuss the unique nature of the care provider's professional patient population, which may have bearing on the care provider's profile and to work in partnership with UnitedHealthcare Community Plan to improve performance.

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 Provider Agreement.

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

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

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

Arbitration

Any arbitration proceeding under your Agreement will be conducted in New York under the auspices of the American Arbitration Association, as further described in our agreement.

For more information on the American Arbitration Association guidelines, visit their website at adr.org. If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member's benefit contract or handbook.

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

Ethics and integrity

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

Care provider compliance program requirement

The Office of the Medicaid Inspector General (OMIG) requires that certain providers maintain a compliance program and attest to all Medicaid Plans with which they participate that they have met this requirement on an annual basis.

The following link identifies the care providers who must meet this requirement:

From [omig.ny.gov/media/80411/download?attachment_!!IqUcNYopQPk7!Kg7TKmi9r4Tdpnecrq-cByGJKmTZU131vfj6X48_N1Gwmjww2D2230TlpD4J0hCh22AvJS_NCS_7ITp6nSnIA_8bGmqpWOF0TOaSb3Y\\$](https://omig.ny.gov/media/80411/download?attachment_!!IqUcNYopQPk7!Kg7TKmi9r4Tdpnecrq-cByGJKmTZU131vfj6X48_N1Gwmjww2D2230TlpD4J0hCh22AvJS_NCS_7ITp6nSnIA_8bGmqpWOF0TOaSb3Y$) 18 NYCRR Part 521.

If you are a care provider that falls into one of the identified categories, you can find the required certification at emedny.org/info/providerenrollment/ProviderMaintForms/490501_ETIN_CERT_Certification_Statement_Cert_Instructions_for_Existing_ETINs.pdf.

Please submit your completed attestation to UnitedHealthcare at this email address, annually: uhc_provider_compliance@uhc.com.

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 at UnitedHealthcareCompliance@uhc.com.

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 hotline at **1-844-359-7736** or uhc.com/fraud.

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

An important aspect of the compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities.

This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of New York 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 NY 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 NY 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 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 NY program standards.

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

These entities may, at all reasonable times, enter your premises.

You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

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

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this care provider 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 determine 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 12: Billing and submission

Our claims process



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

We follow the same claims process as UnitedHealthcare. See the claims process chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP 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 and taxonomy codes

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

In addition, starting August 1, 2025, UnitedHealthcare Community Plan care providers must include an NPI and taxonomy code when submitting claims.

How to obtain an National Provider Identifier number and register your taxonomy code

- Apply for an NPI number with the [National Plan and Provider Enumeration System \(NPPES\)](#)

- During the application process, you will register your taxonomy code with NPPES
- Once approved, NPPES will send you a confirmation notice with your assigned NPI number
- You can have multiple taxonomy codes, but each one must be registered with NPPES
- Make sure to use the correct registered taxonomy code that matches your specialty when submitting claims
- Check the [NPI Registry](#) website to review your current NPI number and taxonomy status or view a list of [provider taxonomy codes](#)

Submitting a claim

We suggest submitting claims electronically. If the taxonomy code is missing on an electronic submission, we will reject the claim as incomplete. However, if you submit a paper claim missing the taxonomy code, we will deny the claim. You can resubmit both electronic and paper claims to include a missing taxonomy code.

If you bill electronically, taxonomy codes should be reported in the below Loops and Segments:

Professional claims:

Loop 2000A / Segment PRV = Billing care provider taxonomy code

Loop 2310B / Segment PRV = Rendering care provider taxonomy code (claim level)

Loop 2420A / Segment PRV = Rendering care provider taxonomy code (line level)

Institutional claims:

Loop 2000A / Segment PRV = Billing care provider taxonomy code

Loop 2310A / Segment PRV = Attending care provider taxonomy code

For paper claims, taxonomy codes should be reported in the below boxes/fields:

Professional claims:

Box 33b = Billing care provider taxonomy code with ZZ qualifier.

Box 24J = Rendering care provider taxonomy code with ZZ qualifier in box 24I.

Institutional claims:

Field 81 = Billing care provider taxonomy code with B3 qualifier.

Claim submission resources

To assist with this process, please refer to the following resource:

- [UHCprovider.com](#) > **HIPAA Companion Guides for Electronic Data Exchange (EDI) transactions**

This guide provides specific technical details to help ensure your electronic transactions are processed effectively and efficiently.

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 repayment for overpayments or offset future payments as allowed by law.

Surprise billing

If you are a doctor and are billing a patient for what could be a surprise bill, you must include an assignment of benefits form and a claim form for a third-party payor with the patient's bill. For more information, visit [dfs.ny.gov](#) > Consumer Information > Healthcare > Surprise Medical Bills.

If you are a participating provider, you're required to coordinate member care within the UnitedHealthcare Community Plan network. We put this requirement in place to help our members keep their costs down and reduce the frequency of surprise bills. For more information, review [UHCprovider.com](#) > **Prior Authorization for Referrals of Non-Urgent/Emergent Services: Important Reminder to Care Providers.**

Fee schedule

Payments 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 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 EDI. EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as “commercial” through the clearinghouse
- Our payer ID is 87726
- Clearinghouse acknowledgment reports and payer-specific acknowledgment reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms

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

EDI companion documents

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

UnitedHealthcare Community Plan uses companion documents to:

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

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

The companion documents are located on UHCprovider.com/edi > **EDI transaction and code sets**.

Clearinghouse and status reports

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

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

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 electronic payments OptumPay™ 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.

For more information, please go to [Optum.com](https://www.optum.com) or contact EPS customer service at **1-877-620-6194**.

Why choose automated clearinghouse/direct deposit?

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

What does this mean to you?

- If your practice/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](https://www.UHCprovider.com/payment)
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/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](https://www.UHCprovider.com/payment).

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on [UHCprovider.com/edi](https://www.UHCprovider.com/edi).

Visit the [National Uniform Claim Committee](https://www.nationaluniformclaimcommittee.org) website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

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

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

Capitated services

Capitation is a payment arrangement for 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, care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

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

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

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

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

Form reminders

- Note the attending care 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 care provider NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending care 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 statutes and 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 payment, 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. For more information, visit UHCprovider.com > [CCI Editing Policy, Professional and Facility](#).

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.

You will only be reimbursed for the services that you are certified through the CLIA to perform, and you must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

Reimbursement policy

Reimbursement policies available at: UHCprovider.com/policies > For Community Plans >

Reimbursement Policies for Community Plan, set for all markets based on correct coding guidelines, the reimbursement committee/national reimbursement forum third-party authority.

Reimbursement policies are set for all markets, unless prohibited by state regulations.

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

The reimbursement policy for obstetrical services can be found at UHCprovider.com/policies > For Community Plan > **Community Plan Reimbursement Policies** by searching for “obstetrical services.”

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

An accurate National Drug Code (NDC) must be reported for all physician-administered drugs billed on the Institutional Claim form. This is required to align with the [New York State Medicaid Update - July 2022 Volume 38 - Number 8](#).

Drugs obtained at the 340B price, indicated by the UD modifier, will also require the NDC. There will be no exceptions to this policy.

In the case where an NDC to J-Code mismatch occurs, the claim will not pay. To prevent mismatches, CMS maintains a crosswalk which providers should review regularly to obtain information about new updates: [ASP Pricing Files | CMS](#).

For more information, please view UHCprovider.com/policies > For Community Plan > **National Drug Code (NDC) requirement policy, professional and facility**.

Medical necessity

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

Place of service codes

Go to cms.gov for place of service codes.

DRG validation process

UnitedHealthcare Community Plan notifies you that New York County Health Services Review Organization (NYCHSRO)/MedReview is assisting UnitedHealthcare Community Plan in its DRG validation process with claims for services provided to UnitedHealthcare Community Plan for Families, UnitedHealthcare Community Plan for Kids, and UnitedHealthcare Dual Complete members. NYCHSRO/MedReview requests chart documentation to conduct-coding validation reviews and readmission reviews.

Documentation request

NYCHSRO/MedReview notifies you, by certified mail, of cases selected for review. Case identification information: Patient names, medical record number, admit/discharge date, member's ID, and date of birth are supplied to assist the care provider in chart retrieval. You will be requested to send a photo copy of the medical chart documentation within 45 business days to:

NYCHSRO/MedReview
199 Water Street, 27th Floor
New York, NY 10038

Initial review process

Upon receipt of the complete medical chart, NYCHSRO/MedReview will complete its initial review

within 30 business days for post pay review and 15 business days for prepay review.

If not approved as billed, you are notified, in writing, of the initial review results and given the opportunity to submit additional information within 45 business days. If you do not respond within the specified time frame, the case is considered closed and payment is made based on the initial review findings.

MedReview provides notice to pay at the assumption code rate.

You may submit medical records using the appeal process for claim reconsideration.

Appeal process

If you file an appeal within the designated time frames, you will receive notification of the appeal determination within 30 business days of receipt of the appeal. The appeal information is reviewed by a coder or physician advisor not involved in the original decision. The review determination will indicate whether the initial review determination has been upheld, modified, or reversed in addition to a rationale determination. The case is considered closed and UnitedHealthcare Community Plan will process payment based on the final appeal determination.

Cost outlier review process

Claims are reviewed based on the DRG Validation process described above. An inlier and day outlier payment is made according to the determination made during review. You must follow the claim administrative appeal process noted on the remittance advice and send an appeal for payment of the cost outlier to the claims administrative appeal address listed on the remittance advice.

Appeals are received and reviewed for timeliness of submission and if compliant, is then forwarded with your submitted documentation to NYCHSRO/MedReview for review of the cost outlier.

Documentation request

NYCHSRO/MedReview notifies you, by certified mail, of the intent to review the cost outlier appeal and requests the documents necessary to complete the review. You are requested to send the documentation, within 30

business days, to the following address:

NYCHSRO/MedReview - Attn: Cost Outlier Unit
199 Water Street
New York, NY 10038

If you fail to submit the requested documentation within the designated time frame, missing information notification is submitted to you, by certified mail, requesting the documents necessary to complete the review.

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. Limit phone calls to 5 issues per call.

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

screenshot 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 Provider Agreement.

Balance billing

UnitedHealthcare Community Plan contracted care providers are generally prohibited by the terms of their contract and by state and **federal regulations from billing our members for any costs related to services they provide, other than any applicable deductible or copayment amount.**

For covered services, payment by UnitedHealthcare Community Plan is considered payment in full.

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

Please remember to obtain the member copay as indicated on the member's identification card at the time of service.

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 13: 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/claims. Please use our online options or phone numbers.

Timeliness of utilization review determination

If UnitedHealthcare fails to make a utilization review (UR) determination within the time periods prescribed in this section, it is deemed to be an adverse determination. In this case, the determination is subject to appeal rights.

UnitedHealthcare Community Plan: MCO must send notice of denial on the date review time frames expire.

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

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

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

Appeals and grievances standard definitions and process requirements								
Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider corrected claim resubmission	Creating a new claim. If a claim was denied and you resubmit the claim as a new claim, then you will receive a duplicate claim rejection on your resubmission, unless there is corrected information.	Care provider	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402-5240	UHCprovider.com/claims	1-866-362-3368	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or UHCprovider.com/claims .	Must receive within 45 business days.	30 business days.
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with, when you have additional details.	Care provider			1-866-362-3368	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . For further information on reconsiderations, see the Reconsiderations and Appeals interactive guide .	Must receive within 90 business days.	45 business days.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim formal appeal (step 2 of claim dispute)	A second review when you do not agree with the outcome of the reconsideration.	Care provider			1-866-362-3368	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations. For further information on appeals, see the Reconsiderations and Appeals interactive guide.	60 calendar days.	30 business days.
Member appeal - Medicaid managed care (MMC) - Health and recovery plan (HARP)	An appeal of an Initial Adverse Determination (IAD) means an appeal of a denial of a Service Authorization Request by the health plan or an approval of a Service Authorization Request in an amount, duration or scope that is less than requested. This method applies to medical necessity, experimental, investigational, OON and administrative (non UR) decisions.	*Member *Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	Most care providers in your state submitting an appeal on behalf of a member must submit appeal electronically. Members as well as *care providers exempted from the electronic submission requirement may send to the following address: UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364 *Care providers can only submit appeals on behalf of a member to this address. All other appeals must be submitted electronically. Resolution of appeals incorrectly sent to this address may be delayed.	providerforms.uhc.com *AOR Consent Form on this site for member appeals	1-866-362-3368	Providers submitting on member's behalf, refer to the Pre-service appeals section on the Pre- and Post-Service Appeals & Reconsiderations page. IMPORTANT NOTE **Care providers must have UnitedHealthcare Community Plan member written consent in order to submit an appeal.	60 calendar days.	Urgent appeals – 2 business days after all information is received; not greater than 72 hours.* Standard appeals – 30 days *If additional time is needed to obtain info on behalf of the enrollee, then an "Extension" of up to 14 days is permitted in certain circumstances.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeals - Child health plus (CHPlus) - Essential plan program (EPP)	A request to dispute the initial adverse determination by the health plan that an admission, extension of stay or other health care service, upon review based on the information provided, is not medically necessary; has been determined to be experimental or investigational; and is an OON initial appeal decision that meets certain criteria (see following pages). Expedited review must be conducted when UnitedHealthcare or the care provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functions. Member has the right to request expedited review, but UnitedHealthcare may deny and notice will process under standard timeframes. Non-medical necessity decisions are handled as grievances for CHP and EPP.	*Member *Health care professional or authorized representative (such as friend or family member) on behalf of a member with member's written consent	Most care providers in your state submitting an appeal on behalf of a member must submit appeal electronically. Members as well as care providers exempted from the electronic submission requirement may send to the following address: UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364 *Care providers can only submit appeals on behalf of a member to this address. All other appeals must be submitted electronically. Resolution of appeals incorrectly sent to this address may be delayed.	providerforms.uhc.com *AOR Consent Form on this site for member appeals.	1-866-362-3368	Providers submitting on member's behalf, refer to the Pre-service appeals section on the Pre- and Post-Service Appeals & Reconsiderations page. IMPORTANT NOTE **Care providers must have UnitedHealthcare Community Plan member written consent in order to submit an appeal.	180 calendar days.	Urgent appeals An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or 2 business days of receipt of the information necessary to conduct the appeal. Substance use appeal—If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, as the provider, you can file an expedited internal appeal of our adverse determination. We will decide the appeal within 24 hours of receipt of the appeal request. Standard appeal—30 days of receipt of the appeal request. Retrospective appeal—If a member appeal relates to a retrospective claim, the appeal will be decided within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided within (2) business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member complaint and complaint appeal - Medicaid Managed Care (MMC) - Health and Recovery Plan - Child Health Plus (CHPlus) - Essential Plan Program (EPP)	A member's expression of dissatisfaction regarding the plan or health care professional, including quality of care concerns. A Complaint Appeal means a request for a review of a complaint determination.	*Member *Health care professional or authorized representative (such as friend or family member) on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	providerforms.uhc.com *AOR Consent Form on this site for member appeals.	1-866-362-3368	Care providers appealing on behalf of UnitedHealthcare Community Plan Member Online Appeal Submission Process: Go to providerforms.uhc.com and submit for Standard pre-service and Expedited pre-service appeal requests. IMPORTANT NOTE **Care providers must have UnitedHealthcare Community Plan member written consent in order to submit an appeal. You can find a member Appointment of Representation (AOR) consent form available on the pre-service submission page providerforms.uhc.com to ensure member consent can be included along with appeal request submission.	No limit. Complaint appeal–60 business days.	Expedited–48 hours after all information is received; not greater than 7 days. Standard–45 days after all information is received; not greater than 60 days. COMPLAINT APPEAL Expedited–2 business days after all information is received. Standard–30 business days after all information is received.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member grievance and grievance appeal - Child Health Plus (CHPlus) - Essential Plan Program (EPP)	Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers. A grievance appeal is to dispute or grieve the grievance decision.	*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 P.O. Box 31364 Salt Lake City, UT 84131-0364	providerforms.uhc.com *AOR Consent Form on this site for member appeals.	1-866-362-3368	Care providers appealing on behalf of UnitedHealthcare Community Plan Member Online Appeal Submission Process: Go to providerforms.uhc.com and submit for standard pre-service and expedited pre-service appeal requests. IMPORTANT NOTE **Care providers must have UnitedHealthcare Community Plan member written consent in order to submit an appeal. You can find a member Appointment of Representation (AOR) consent form available on the pre-service submission page providerforms.uhc.com to ensure member consent can be included along with appeal request submission.	Grievance—180 calendar days from the date of receiving the non UR/ administrative adverse decision you are asking us to review to file the grievance. Grievance appeal—60 business days from receipt of the grievance determination to file a Grievance Appeal.	Expedited/urgent grievances: By phone, within 48 hours of receipt of all necessary information or 72 hours of receipt of a grievance. Written notice will be provided within 72 hours of receipt of the enrollee's grievance. Pre-service grievances: (A request for a service or treatment that has not yet been provided.) - In writing, within 30 calendar days of receipt of the enrollee's grievance. Post-service grievances: (A claim for a service or treatment that has already been provided.) - In writing, within 30 calendar days of receipt of all necessary information, but no later than 60 days of receipt of the enrollee's grievance. All other grievances: (That are not in relation to a claim or request for a service or treatment.) - In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of the enrollee's grievance. Grievance appeals—An appeal of the grievance decision.

Appeals and grievances standard definitions and process requirements								
Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
(continued) Member grievance and grievance appeal - Child Health Plus (CHPlus) - Essential Plan Program (EPP)								Expedited/urgent grievances: Within 2 business days of receipt of all necessary information or 72 hours of receipt of the enrollee's appeal. Pre-service grievances: (A request for a service or a treatment that has not yet been provided.) 15 calendar days of receipt of the enrollee's appeal. Post-service grievances: (A claim for a service or a treatment that has already been provided.) 30 calendar days of receipt of the enrollee's appeal. All other grievances: (That are not in relation to a claim or request for a service.) 30 business days of receipt of all necessary information to make a determination.

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Reversal of pre-authorized treatment

UnitedHealthcare may reverse a pre-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- Relevant medical information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the pre-authorization review, and the information existed at the time of the pre-authorization review but was withheld or not made available.
- UnitedHealthcare was not aware of the existence of the information at the time of the pre-authorization review. Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

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.

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. If a claim was denied and you resubmit the claim as a new claim, then you will receive a duplicate claim rejection on your resubmission. Submit a claim reconsideration when you think a claim has not been properly processed if you have additional information to provide.

The limit for reconsideration is 2 years from date of service; per NYS Regulation-Billing for Medical Assistance Title 18, Section 540.6(a).

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:

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

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see Administrative Appeals).

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 screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
 - Correct member name.
 - Correct date of service.
 - Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

Direct Connect is a web-based platform in the UnitedHealthcare Provider Portal that helps providers and UnitedHealthcare communicate effectively, automate workflows and drive overpayment resolutions.

By using this new tool, you can go to a single location to resolve suspect credit balance and overpaid claims and manage overpayments in real time.

Access Direct Connect through the UnitedHealthcare Provider Portal, the self-service platform that you're already leveraging.

Contact the Optum Direct Connect team by email at directconnectaccess@optum.com for more information.

Self-identified overpayments

Take control of your overpayment submissions with our secure upload feature. Easily submit unsolicited/self-identified overpayment details and manage multiple payments through the UnitedHealthcare Provider Portal in 1 streamlined submission.

Note: If you send your overpayment refund by check through the mail, you'll need to download and complete the **Overpayment refund/notification form**.

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 1, use the claim appeal process.

How to use:

All claims administrative appeals must be filed within 60 days of the date of the UnitedHealthcare Community Plan care provider remittance.

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. The cover letter should state that a claims administrative appeal is being made. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

State the specific reason for denial as stated on the remittance. We do not accept appeals that fail to address the reason for the denial as stated on the remittance.

For appeals of payment rates, state the basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules.

If you are appealing a claim that was denied because filing was not timely, for:

Electronic claims: include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.

Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

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

Questions about your appeal or need a status update?

Call **Provider Services** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure **UnitedHealthcare Provider Portal**.

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone: Provider Services at 1-866-362-3368**
- Mail: Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan

Attn: Claims Administrative Appeals

P.O. Box 31364

Salt Lake City, UT 84131-0364

You may only file a grievance on a member's behalf with the written consent of the member. See member appeals and grievances definitions and procedures.

Adverse determinations

A written notice of an adverse determination (initial adverse determination) will be sent to the member and provider and will include:

- The reasons for the determination including the clinical rationale, if any
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals
- Notice of the availability, upon request of the enrollee or the enrollee's designee, of the clinical review criteria relied upon to make such determination

The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, UnitedHealthcare in order to render a decision on the appeal.

For UnitedHealthcare Community Plan for Families, the notice will also include:

- Description of action to be taken
- Statement that UnitedHealthcare will not retaliate or take discriminatory action if appeal is filed
- Process and time frame for filing/reviewing appeals, including enrollee right to request expedited review
- Member's right to contact DOH, regarding their complaint
- Description of the Fair Hearing and, if applicable, aid to continue rights
- Statement that notice is available in other languages and formats for special needs and how to access these formats

- For UnitedHealthcare Medicaid Advantage, offer of choice of Medicaid or Medicare appeal processes if service is determined by UnitedHealthcare to be either Medicare or Medicaid

With notice that:

- Medicare appeal must be filed 60 days from denial
- Filing Medicare appeal means the enrollee cannot file for a state fair hearing
- The enrollee may still file for Medicare appeal after filing for Medicaid appeal, if within the 60-day period

An adverse determination will be made by a clinical peer reviewer.

Reconsideration of adverse determination

When an adverse determination is rendered without care provider's input, the provider has the right to reconsideration. The reconsideration shall occur within 1 business day of receipt of the request and shall be conducted by the member's care provider and the clinical peer reviewer making the initial determination.

Written notice of final adverse determination concerning an expedited UR appeal shall be transmitted to member within 24 hours of rendering the determination. For Medicaid, UnitedHealthcare Community Plan will make reasonable effort to provide oral notice to enrollee and provider at the time the determination is made.

Each notice of final adverse determination will be in writing, dated and include:

- The basis and clinical rationale for the determination
- The words "final adverse determination"
- UnitedHealthcare Community Plan contact person and phone number
- Enrollee coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/provider, date of service and developer/manufacturer of service as available
- Statement that enrollee may be eligible for external appeal and time frames for appeal

- If health plan offers 2 levels of appeal (group insurance only), cannot require enrollee to exhaust both levels. Must include clear statement, in bold, that enrollee has 45 days from the final adverse determination to request an external appeal and choosing second level of internal appeal may cause time to file external appeal to expire.
- Standard description of external appeals process attached

For Medicaid, notice will also include:

- Summary of appeal and date filed
- Date appeal process was completed
- Notice of Fair Hearing with aid continuing, if applicable
- Right of enrollee to complain to the Department of Health at any time
- Statement that notice is available in other languages and formats for special needs and how to access these formats

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

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

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

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

When to use:

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

Where to send:

Most care providers in your state submitting an appeal on the member's behalf are required to submit appeal requests electronically. For instructions, refer to the Pre-service appeals section on the [Pre- and Post-Service Appeals & Reconsiderations page](#) or the member may call or mail the information, in the time frames noted in the table in the beginning of this chapter based on the date of the adverse benefit determination.

Should UnitedHealthcare Community Plan fail to make a determination within the applicable time periods, the determination is deemed to be a reversal of the utilization review agent's adverse determination.

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing. A provider may file a UR appeal for a retrospective denial.

How to use:

Whenever we deny a service, we must provide the member (and copy the care provider) 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
- A member may file an expedited appeal in the following cases:
 - A delay would seriously risk the member's health, life or ability to function
 - The care provider advises that the appeal needs to be expedited
 - The member is requesting a higher level of service
 - The member is asking for home care services after discharge from the hospital
 - The member is requesting additional inpatient substance abuse treatment at least 24 hours before discharge
 - For mental health or substance abuse services that may be related to a court appearance

- For UnitedHealthcare Community Plan for Families, if UnitedHealthcare denies a member's request for an expedited appeal, UnitedHealthcare must notice, by phone immediately, followed by written notice in 2 days
- **If MMC or HARP enrollee:** 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 an expedited or standard appeal as described in the previous table.

Expedited and standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. The clinical peer reviewer must be available within 1 business day.

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 UnitedHealthcare Community Plan requires information necessary to conduct a standard internal appeal, the MCO will notify the enrollee and the enrollee's health care provider, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information. In the event, that only a portion of such necessary information is received, UnitedHealthcare Community Plan shall request the missing information, in writing, within 5 business days of receipt of the partial information.

If UnitedHealthcare Community Plan requires information necessary to conduct an expedited appeal, UnitedHealthcare Community Plan shall immediately notify the member and the member's health care provider by telephone or facsimile to identify and request the necessary information followed by written notification.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed through the external appeal process.

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

The member and UnitedHealthcare Community Plan may jointly agree to waive the internal appeal process. If this occurs, UnitedHealthcare Community Plan must provide a written letter with information regarding filing an external appeal to the member within 24 hours of the Agreement to waive the UnitedHealthcare Community Plan's internal appeal process.

External appeal process

UnitedHealthcare Community Plan members have the right to an external appeal of a final adverse determination.

The external appeal must be submitted within 4 months upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.

A member, the member's designee and – in connection with concurrent and retrospective adverse determinations – a member's physician, will have the right to request an external appeal when:

- (a) The member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary and
- (b) The health care plan has rendered a final adverse determination with respect to such health care service or
- (c) Both the plan and the member have jointly agreed to waive any internal appeal.

An external appeal may also be filed when:

- (a) The member has had coverage of a health care service denied on the basis that such service is experimental or investigational.
- (b) The denial has been upheld on appeal or both UnitedHealthcare Community Plan and the member have jointly agreed to waive any internal appeal.
- (c) The member's attending physician has certified that the member has a life-threatening or disabling condition or disease (1) for which standard health services or procedures have been ineffective or would be medically inappropriate or (2) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan or (3) for which there exists a clinical trial.

- (d) The member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life-threatening or disabling condition or disease, must have recommended either (1) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b) (B), that based on 2 documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (2) a clinical trial for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation.
- (e) The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

Out-of-network member appeals

Under NYS Public Health Law, an enrollee or the enrollee's designee may appeal an out-of-network denial by a health care plan by submitting:

- A written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area appropriate to treat the enrollee for the health service needed. The requested out-of-network health service is different from the health service the health care plan approved to treat the insured's health care needs.
- Two documents with medical and scientific evidence that the out-of-network health service will be more beneficial to the enrollee than the in-network health service recommended and that the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

An enrollee or the enrollee's designee may appeal a denial of an out-of-network referral by a health care plan by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area appropriate to treat the enrollee for the health service needed, provided that:

- The in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service
- The in-network health care provider or care providers recommends an out-of-network provider with the appropriate training and experience to meet the health care needs of the enrollee and who is able to provide the requested health service



A copy of the AOR form is online at providerforms.uhc.com.

Member grievance system

What is it?

A complaint 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 anytime in the time frames noted in the table at the beginning of this chapter.

Right to Aid Continuing

MMC and HARP

Members may receive continuation of benefits, known as Aid Continuing (AC). Right to Aid Continuing does not apply to Child Health Plus, Essential Plan or Medicare. Members must meet filing requirements and receive notice regarding the right to AC within a 10-day notice when the plan decides to:

- Terminate, suspend, or reduce a previously authorized and approved service or
- Partially approve, terminate, suspend, or reduce level or quantity of long-term services and supports or a nursing home stay (long-term or short-term) within a specified time frame

New York State Medicaid Managed Care plans are required to provide AC immediately:

- Upon receipt of a plan appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (initial adverse determination), or the effective date of the action, whichever is later, unless the member indicates they do not wish their services to continue unchanged
- Upon receipt of a plan appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a specified period of time, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the member indicates they do not wish their services to continue unchanged.
- As directed by the NYS Office of Administrative Hearings (OAH). The OAH may determine provisions of AC, including, but not limited to, a home bound individual who was denied an increase in home care services.

The member has a right to AC when they have exhausted the health plan's appeal process and have filed a request for a state fair hearing.

The Medicaid Managed Care and Health and Recovery plan must continue the member's services provided under AC until one of the following occurs:

- The member withdraws the request for aid, plan appeal or a fair hearing
- The member fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (final adverse determination)
- OAH determines the member is not entitled to continued aid
- OAH completes the administrative process or issues a fair hearing decision adverse to the member
- The care provider order has expired, except in the case of a home bound member

If the final appeal or fair hearing upholds an adverse benefit determination, the member may be held liable for services.

State fair hearings

What is it?

A state fair hearing lets members share why they think NY Medicaid and Wellness4Me services should not have been denied, reduced or terminated. (Fair hearing rights are never applicable to UnitedHealthcare Child Health Plus, Essential Plan or Dual Special Needs plan members.)

When to use:

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

Members must exhaust internal plan appeals process before proceeding to state fair hearing.

How to use:

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

New York State Office of Temporary
and Disability
Assistance Office of Administrative Hearings
P.O. Box 22023
Albany, NY 12201-2023

- The member may ask UnitedHealthcare Community Plan customer 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.

To file a state fair hearing orally, call the office of Administrative Hearings at 1-800-342-3334.

Find and complete the form on the web at: otda.ny.gov or complete and fax to: 1-518-473-6735, Attn: Office of Temporary and Disability Assistance Office of Administrative Hearings.

A request for a fair hearing may also be made in person at the following locations:

New York City:

Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place, 1st floor
Brooklyn, NY 11201

Albany:

Office of Administrative Hearings
99 Washington Ave, 12th floor
Albany, NY 12260

Assistance

UnitedHealthcare Community Plan is available to assist members in filing complaints, complaint appeals, grievances, grievance appeals and member appeals. Members may call **Member Services** at **1-800-493-4647**.

Processes related to reversal of our initial decision

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

As quickly as the member's health condition requires or

- 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 at **1-844-359-7736** 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/NYcommunityplan](https://uhcprovider.com/NYcommunityplan) > 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 14: 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/nycommunityplan**: The UnitedHealthcare Community Plan of New York page: has resources, guidance and rules specific to New York. Be sure to check back frequently for updates.
- **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 (Twitter)

- **Health plans by state**: **UHCprovider.com/ny** is the fastest way to review all of the health plans UnitedHealthcare offers in New York. To review plan information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (Commercial, 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/news**. 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 one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**. Already have an ID? To review or update your email, simply sign in to the portal. Go to Profile & Settings, then Account Information, to manage your email.
2. **Subscribe** to Network News email briefs to receive regular email updates. 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 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 resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services**.

State websites and forms

Please visit New York State Department of Health at health.ny.gov for state specific information.

Member Services

Enrollment

Our team of marketing representatives coordinate with community-based organizations and you to educate potential members about UnitedHealthcare Community Plan. You are welcome to contribute to this process, but you must comply with the marketing rules set forth by the counties with which UnitedHealthcare Community Plan contracts.

These rules include, but are not limited to: no cold-call telephoning, no door-to-door solicitation, mailings sent only at the request of the potential member, all materials and incentives must be pre-approved, and physicians or other care providers must tell patients about all the managed care organizations with which they contract and must help individuals choose a plan best suited for them based on their individual needs.

The best way for PCPs to view and export the full member roster is using CommunityCare, which allows you to:

- See a complete list of all members, or members added in the last 30 days
- Export the roster to Excel
- View most Medicaid and Medicare SNP members' plans of care and health assessments
- Enter plan notes and view notes history (for some plans)
- Obtain HEDIS information for your member population
- Access information about members admitted to or discharged from an inpatient facility
- Access information about members seen in an emergency department

For help using CommunityCare, please see our **UnitedHealthcare Community Care Provider Portal user guide**.

Chapter 15: Products

UnitedHealthcare Community Plan

The New York State Medicaid Managed Care Plan is offered through UnitedHealthcare Community Plan. It's for New York State residents who meet the income or disability requirements.

This plan is available in the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming, and Yates. For more information, visit uhcommunityplan.com/ny.

UnitedHealthcare Wellness4Me

The Wellness4me Plan is offered through UnitedHealthcare Community Plan. Wellness4Me is a HARP, approved by New York State. HARPs are plans that provide Medicaid members with their health care plus care for behavioral health, including serious mental illness and substance use disorders. This plan is for New York residents age 21 and older and who qualify for Medicaid coverage.

This plan is available in the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming, and Yates. For more information, visit uhcommunityplan.com/ny.

Child Health Plus

The New York State Child Health Plus program from UnitedHealthcare Community Plan is for children up to age 19. Members must be residents of New York and are not eligible for Medicaid or enrolled in or access to NYSHIP benefits. You can choose your child's doctor, and your child gets many services to stay healthy.

This plan is available in the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Fulton, Genesee, Herkimer, Jefferson, Kings, Lewis, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Oswego, Queens, Rensselaer, Richmond, Rockland, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, and Westchester. For more information, visit uhcommunityplan.com/ny.

Essential Plan

The Essential Plan is offered through UnitedHealthcare Community Plan. It's for lower income individuals in New York who meet the income or citizenship status requirements. There are no monthly premiums for Essential Plan coverage, and all Essential Plan enrollees have dental and vision benefits with no premium or cost sharing for covered services.

The Essential Plan is available in the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming, and Yates. For more information, visit uhcommunityplan.com/ny.

UnitedHealthcare Dual Complete NY-S002 (HMO-POS D-SNP)

This Dual health plan is for people who qualify for full Medicaid benefits and Medicare Parts A & B (original Medicare). This is a Health Maintenance Organization (HMO) plan. With an HMO plan, members must use network care providers to receive medical care and services.

This plan is available in the following counties: Albany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Suffolk, Sullivan, Tioga, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates. For more information, visit uhcommunityplan.com/ny.

UnitedHealthcare Dual Complete Plan 2 (HMO-POS D-SNP)

This Dual Complete® health plan is for people who qualify for Medicaid benefits through Qualified Medicare Beneficiary (QMB) Program and Medicare Parts A & B (Original Medicare). This is a Health Maintenance Organization (HMO) plan. With an HMO plan, members must use network care providers to receive medical care and services.

This plan is available in the following counties: Albany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Suffolk, Sullivan, Tioga, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates. For more information, visit uhcommunityplan.com/ny.

UnitedHealthcare Dual Complete NY-S001 (PPO D-SNP)

This Dual health plan is for people who qualify for both Medicaid and Medicare Parts A & B (original Medicare). This is a Preferred Provider Organization (PPO) plan. Members have access to a local network of doctors and hospitals. Plus, members can see any care provider outside the network nationwide that participates in Medicare and accepts the plan. Members may pay a higher copay or coinsurance when they see an out-of-network care provider.

This plan is available in the following counties: Albany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Sullivan, Tioga, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates. For more information, visit uhcommunityplan.com/ny.

Chapter 16: UHC Dual Complete NY-Y001 (HMO D-SNP)

For general information about D-SNP, go to [uhc.com](https://www.uhc.com) > Explore Health Plans > Individual and Family > Health Insurance Plans > **Medicare-Medicaid Overview**.

Program description

UHC Dual Complete® NY-Y001 (HMO D-SNP) offers an opportunity for Medicaid and Medicare dual eligibles, meeting eligibility criteria, on a voluntary basis, to enroll in UnitedHealthcare for most of their Medicare and Medicaid benefits. Through this plan, UnitedHealthcare provides dually eligible persons a uniform Medicare Advantage Product (UnitedHealthcare Dual Complete NY-Y001 [HMO D-SNP]) and a supplemental Medicaid product (UnitedHealthcare Medicaid Advantage Plus). A Medicaid Advantage Plus (MAP) plan is a type of integrated dual-eligible Special Needs Plan (general) combined with a type of Medicaid MLTC plan offered through the same insurance company. In MAP, 1 private plan administers your Medicare, Medicaid, long-term care benefits and drug coverage. MAP plans cover doctor office visits, hospital stays, Part D benefits, home health aides, adult day health care, behavioral health care, dental care and nursing home care. (See MAP contract for full coverage.) Some services not covered by MAP, including certain behavioral health services, may be covered under your traditional fee-for-service (FFS) Medicaid benefit. UnitedHealthcare Medicaid Advantage Plus covers benefits not covered by Medicare and beneficiary cost sharing (copays/deductibles, and premiums, if any) associated with the uniform UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP). Some Medicaid services are available to UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) members on a FFS basis.

***UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) is part of the Medicaid Advantage Plus (MAP) plan, which UHC will participate in 2023.*

Eligibility requirements for enrolling in UnitedHealthcare Dual Complete (HMO D-SNP)

Through a contract with MAXIMUS Health Services, Inc. (MAXIMUS), New York Independent Assessor (NYIA) has been created to conduct independent assessments, provide independent practitioner orders and perform independent reviews of high-needs cases for PCS and CDPAS.

All other LTSS assessments will be conducted by the health plan.

To be eligible for enrollment, a member must:

- Be 18 and older
- Qualify as a Full Benefit Dual-Eligible entitled to both Medicare Parts A and B or be enrolled in a Part C plan
- Have full benefits from New York State Medicaid
- Be enrolled in the plans Medicare Advantage, UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP), H3387-013
- Live in Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming, and Yates counties
- Be eligible for nursing home level of care at the time of enrollment - UnitedHealthcare or the NYIA will determine the potential member's nursing home level of care eligibility based on needs
- Be permanently placed in a nursing home or be capable, at the time of enrollment, of returning to or remaining in their home and community without jeopardy to their health and safety and require 1 of the following Community Based Long Term Care Services (CBLTCS) for more than 120 days from the effective date of enrollment
 - Adult day health care
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Private duty nursing
 - Consumer directed personal assistance services
 - Social day care (SDC)*

*SDC is not a standalone service under the plan. Members must receive another CBLTCS to qualify.

Covered services

Through UnitedHealthcare Dual Complete NY-Y001 (HMO-POS D-SNP), members can access core Medicaid Long-Term Support Services to support adult daily living skills at no extra cost to the member. See LTSS section for more information.

Covered service areas

This plan is available for members who meet the previous eligibility criteria and reside in 1 of the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming, and Yates.

Confirming eligibility

Always check eligibility before providing services. Participants enrolled in UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) have an NYSDOH Medicaid identification card and UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) identification card with a Group Number of 90150.

The card itself is not a guarantee of eligibility. You can request eligibility and benefit plan information for participants using existing eligibility verification processes. For additional questions, call **Provider Services** at **1-866-362-3368**, 8 a.m.-8 p.m. ET, or use UHCprovider.com/eligibility.

Billing a patient

Care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare for Medicare and Medicaid benefits, can take advantage of single-claim submission.

Claims submitted to UnitedHealthcare for dual-enrolled members process against Medicare benefits under UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) first, and then automatically process against Medicaid benefits under the appropriate Medicaid benefits.

The following is an example of a UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) member card:



For electronic submission of claims, access **UnitedHealthcare Provider Portal** and sign up for electronic claims submission. If you have questions about gaining access to UnitedHealthcare Provider Portal, choose the UnitedHealthcare Provider Portal tab and follow the instructions to gain access.

Please mail your paper claims to:

UnitedHealthcare of New York
P.O. Box 5240
Kingston, NY 12402-5240

For services covered under the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP), go to UHCprovider.com/eligibility.

Benefits

Find benefits online at UHCprovider.com/eligibility.

Services covered on a fee-for-service basis

You will not bill, charge, collect a deposit from, seek compensation, remuneration or payment from, or have any recourse against any UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) member eligible for both Medicare and Medicaid, their representative, or the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) organization for Medicare Part A and B cost sharing (e.g., copays, deductibles, coinsurance) when the state is responsible for paying such amounts.

You will either:

- Accept payment made by or on behalf of the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) organization as payment in full; or
- Bill the appropriate state source for such cost sharing amount

Bill the Medicaid covered services shown in the following table directly to Medicaid. For UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) benefits available with Medicaid fee-for-service identification, go to UHCprovider.com/eligibility.

Premium and copay amounts

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) covers all Part C member cost sharing, including deductibles, copays and coinsurance amounts, as well as any subscriber premium.



Call **Provider Services** at **1-866-362-3368**, 8 a.m.–8 p.m. ET for additional information.

Regulatory requirements

Adverse payment change : An adverse payment change means it could affect the payment amount we give you for services. You will receive written notice from us at least 90 days prior to an adverse payment change in your contract. If you object to the change, then you may, within 30 days of the date of notice, give us written notice to terminate your contract when the adverse payment change is active.

Claims processing timeframes: Pay claims submitted electronically within 30 days, and paper submissions within 45 days.

Coordination of benefits: UnitedHealthcare Community Plan denies claims, in whole or in part, when coordinating benefits and when the member has insurance, unless we have a reasonable basis to believe the member has primary health insurance coverage for the claimed benefit. In addition, if we request information from the member regarding other coverage, and do not receive the information within 45 days, we will adjudicate the claim. However, we will not deny the claim on the basis of non-receipt of information about other coverage.

Timeframe for care provider claims submission: You must submit claims within 120 days after the date of the service to be valid, unless you or we agreed to a better time frame or it was required by law.

If we denied a late claim and you can prove it was due to unusual circumstances and have a pattern of timely claims, we will consider paying it. However, we may reduce the payment of a claim by up to 25%.

Reconsideration does not apply to a claim submitted 365 days after the service and we may deny the claim in full.

Overpayment recovery: The health plan provides you the opportunity to challenge the overpayment recovery.

Claims from a participating hospital association with a non-participating care providers claim; and claims from participating care providers associated with a non-participating hospital claim: We cannot treat a claim from a network hospital as out-of-network solely because a non-participating care provider treated the member.

Likewise, we cannot treat a claim from a participating care provider as out-of-network solely because the hospital is non-participating with us.

Credentialing: If we do not approve or decline a newly licensed health care application within 90 days, then you are provisionally credentialed on the 91st day. This includes care providers who relocate from another state or join a group practice of in-network care providers. During the 90-day provision, you are considered in-network providing covered services to members, but may not act as a PCP.

If we deny your application, then you revert back to non-participating status. If you are part of a group practice, then that practice must refund any Community Plan payments for in-network services above any out-of-network benefits.

In addition, the group must hold the member harmless for payment of any services denied during the provisional period except for payable copayments if the member received services from an in-network care provider.

Care provider external appeal rights: You are responsible for the full cost of an appeal for a concurrent adverse determination upheld in our favor. We are responsible for the full cost of an appeal that is overturned; you and we must evenly divide the cost of a concurrent adverse determination that is overturned in-part. The fee requirements do not apply to care providers acting as the member's designee, in which case, we are responsible for the cost of the external appeal. A final adverse determination appeal made on behalf of the member requires an external appeal. For more information, go to nysenate.gov/legislation/laws/PBH/4914.

Alternative dispute resolution: A facility licensed under Article 28 of the Public Health Law (PHL) and the MCO may agree to alternative dispute resolution (ADR) in lieu of an external appeal under PHL §4906 (2). This provision does not impact a member's external appeal rights or right of the member to establish the care provider as their designee and if applicable will be communicated in the notice with an initial adverse determination.

External appeal rare disease treatment: Members can appeal a rare disease treatment determination through an external appeal. We must provide notice of our determination within 1 business day after receiving the necessary information, or 72 hours if the day after the request for services falls on a weekend or holiday. However, if a member submits a request for home health care services and provides all necessary information to us before their inpatient hospital discharge, we cannot deny the request due to a lack of medical necessity or a lack of prior authorization while the UR determination is pending. There may be other reasons for denying the service such as exhaustion of a benefit. We must expedite denial for home health services appeal following a hospital admission discharge.

Non-covered benefits and exclusions

Some medical care and services are not covered or are limited by UnitedHealthcare Dual Complete NY-Y001 (HMO-D-SNP).

The following list describes services not covered under any conditions, and some services covered only under specific conditions.

UnitedHealthcare Dual Complete NY-Y001 (HMO-D-SNP) will not pay for the exclusions listed in this section and neither will Medicare unless an appeal proves the services should have been covered.

Services not covered by UnitedHealthcare Dual Complete NY-Y001 (HMO-D-SNP)

- Services not covered under Medicare unless such services are specifically listed as covered
- Services members receive from non-plan care providers, except for medical emergency and urgently needed care, renal (kidney) dialysis services provided when you are temporarily outside the plan's service area, and care from non-plan care providers arranged or approved by a plan care provider
- Services members receive without prior authorization when prior authorization is required for getting those services
- Services not reasonable and necessary under Medicare standards unless otherwise listed as a covered service
- Emergency facility services for a non-authorized, routine condition not based on a medical emergency
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UnitedHealthcare Dual Complete and Medicare not generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under Medicare
- Private room in a hospital, unless medically necessary
- Private duty nurses
- Personal convenience items, such as a telephone or television in your room at a hospital or SNF
- Nursing care on a full-time basis in your home
- Custodial care is not covered by UnitedHealthcare Dual Complete unless provided in conjunction with skilled nursing care or skilled rehabilitation services. Custodial care includes care that helps with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, using the bathroom, preparation of special diets and supervision of medication that is usually self-administered.
- Homemaker services
- Charges imposed by immediate relatives or members of your household
- Meals delivered to your home
- Elective or voluntary enhancement procedures, services, supplies and medications unless medically necessary (e.g., weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance)
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
- Routine dental care (such as cleanings, fillings or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.

- Chiropractic care is generally not covered under the plan (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the leg brace, or orthopedic or therapeutic shoes for people with diabetic foot disease
- Supportive devices for the feet, except orthopedic or therapeutic shoes for people with diabetic foot disease
- Hearing aids and routine hearing examinations
- Routine eye examinations and eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and service
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hypogasmia
- Reversal of sterilization procedures, sex change operations and non-prescription contraceptive supplies and devices (medically necessary services for infertility are covered)
- Acupuncture
- Naturopath services
- Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under UnitedHealthcare Dual Complete, we will reimburse veterans for the difference. Members are still responsible for the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) cost sharing amount.
- Participating in a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Receiving timely access to their PCP and recommendations to specialists when medically necessary
- Receiving emergency services when the member reasonably believes an emergency medical condition exists
- Actively participating in decisions regarding their health and treatment options
- Receiving urgent services when traveling outside UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)'s service area or in UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)'s service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating care provider
- Requesting the number of grievances and appeals and dispositions in aggregate
- Requesting information regarding physician compensation
- Requesting information regarding the financial condition of UnitedHealthcare Dual Complete

Treatment with dignity and respect

Members have the following rights related to being treated with dignity and respect:

- Being treated with dignity and respect and having their right to privacy recognized
- Exercising these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for care
- Receiving confidential treatment of all communications and records pertaining to the member's care
- Accessing, copying or requesting amendment to the member's medical records consistent with the terms of HIPAA
- Extending their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care

Members' rights and responsibilities

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) members have the right to timely, high quality care, and treatment with dignity and respect. Participating care providers must respect the rights of all UnitedHealthcare Dual Complete members.

Timely quality care

Members have the following rights related to timely quality care:

- Choosing a qualified contracting PCP and contracting hospital

- Refusing treatment or leaving a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision)
- Completing an advance directive, living will or other directive to the member's medical care team

Member satisfaction

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating care providers. Survey information is reviewed by UnitedHealthcare Dual Complete and results are shared with the participating care providers.

The Centers for Medicare and Medicaid Services (CMS) conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from participating care providers. Surveys results are available upon request.

Member responsibilities

Member responsibilities include the following:

- Reading and following the Evidence of Coverage (EOC)
- Treating all UnitedHealthcare staff and care providers with respect and dignity
- Protecting their Medicaid or DDD ID card and showing it before obtaining services
- Knowing the name of their PCP
- Seeing their PCP for their healthcare needs
- Using the emergency room for life threatening care only and going to their PCP or urgent care center for all other treatment
- Following their doctor's instructions and treatment plan and telling the doctor if the explanations are not clear
- Bringing the appropriate records to the appointment, including, if applicable, their child's immunization records until the child is 18 years old
- Making an appointment before they visit their PCP or any other UnitedHealthcare care provider
- Arriving on time for appointments
- Calling the office at least 1 day in advance if they must cancel an appointment

- Being honest and direct with their PCP, including giving the PCP the member's health history as well as their child's
- Telling their Medicaid, UnitedHealthcare and their DDD support coordinator if they have changes in address, family size or eligibility for enrollment
- Tell UnitedHealthcare if they have other insurance
- Give a copy of their living will to their PCP

Services provided in a culturally competent manner

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) is obligated to help ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating care providers must cooperate with UnitedHealthcare Dual Complete in meeting this obligation.

Member complaints/grievances

UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) tracks all complaints and grievances to identify areas of improvement for UnitedHealthcare Dual Complete.

This information is reviewed by the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UnitedHealthcare Dual Complete Board of Directors. Please refer to **Chapter 13** for a member's appeal and grievances rights.

Introduction to Understanding the Medicaid Advantage Plus Program [brand name "UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)"]

The Centers for Medicare & Medicaid Services (CMS) and the State of New York, Department of Health (NYSDOH) created a Federal-State partnership to implement a "New York Integrated Appeals and Grievances Demonstration" to streamline and simplify existing grievance and appeals processes for enrollees in both Medicare and Medicaid (dually eligible) programs.

The federal-state partnership integrates appeals and grievance processes for Medicaid Advantage Plus (MAP) plans and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs).

The UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) Integrated Appeals and Grievances process does not apply to:

- Medicare and Medicaid items and services that are excluded from the Health Plan's benefit packages
- Medicare Part D benefits

For dispute methods/ appeals that are external to the Health Plan, a streamlined process will replace the separate Medicare and Medicaid processes.

Assisting a UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) enrollee to understand the service authorization process for a medical item or service

Service authorization request (coverage decision request)

These processes apply to all Medicare and most enrollee's Medicaid benefits covered by the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) program.

Prior authorization, concurrent or retrospective service requests:

Service authorization requests can be submitted by calling **1-866-362-3368** or by submitting the request in writing.

If approved, we will authorize services for a specific amount and a specific time period. This is called the authorization period.

Decisions on service authorization requests will be communicated by both phone and in writing if the health plan approves or denies an enrollee's service request. The written notification will include the specific reason for the decision and steps to dispute the Health Plan's decision.

Service authorization request - standard process

- A standard review for a prior authorization request will be decided within **3 business days** of when the health plan receives all information needed, but no later than **7 calendar days** after the health plan receives the request
- If the case is a concurrent review request (a change to a service the enrollee is already receiving), the health plan will make a decision **within 1 business day** of when the health plan has all the information needed and render a decision no later than **14 calendar days** after the health plan gets the enrollee's service request
- An **"extension" of 14 calendar days** can occur if the enrollee asks for more time or if the health plan needs information (such as medical records from out-of-network providers) that may benefit the enrollee. If the health plan decides to take extra days to make the decision, the enrollee will be notified in writing what information is needed and why the delay is in enrollee's best interest. The health plan will make a decision as quickly as feasible after receiving all the necessary information, but no later than 14 days from the day the health plan asked for more information. Extensions do not apply to Part B Pharmacy requests.
- The enrollee can file a **"fast complaint"** if they disagree with extending the timeframe; the health plan will respond to the enrollee's complaint **within 24 hours**
- If the health plan does not give the enrollee our answer within the timeframes noted, the enrollee has the right to file an internal appeal (**level 1**)
- Written notices of the decision will be sent to the enrollee and provider, and verbal notice will also be made to notify both enrollee and care provider of the decision

Fast track or expedited service request process

If an enrollee's health requires it, a **"fast service authorization"** can be requested.

- A fast review of a prior authorization or new request means the health plan will give the enrollee an answer within 1 business day of when the health plan has all necessary information, but no later than **72 hours** from when the health plan receives the enrollee's request

- We can take **up to 14 calendar days** if the health plan finds that some information that may benefit the enrollee is missing (such as medical records from out-of-network providers) or if the enrollee or their designee needs time to get information to the health plan for the review
- If the health plan decides to take extra days, the health plan will tell the enrollee in writing what information is needed and why the delay is in the enrollee's best interest. The health plan will make a decision as quickly as feasible when the health plan receives the necessary information, but no later than **14 days** from the day the health plan asked for more information.
- The enrollee can file a “**fast complaint**” if they disagree with extending the timeframe, and the health plan will respond to the enrollee's complaint within **24 hours**
- If the health plan does not render a decision within 72 hours (or, if there is an extended time period, by the end of that period) the enrollee or their authorized representative (including the enrollee's health care provider) can file an appeal on the enrollee's behalf
- To get a fast service authorization, an enrollee's request must meet 2 requirements:
 - It must be a pre-service or new request for coverage for medical care the enrollee has not yet received
 - Using the standard deadlines could cause serious harm to enrollee's life or health or hurt enrollee's ability to function
- If the care provider requests a “fast service authorization,” the health plan will assign the request as a fast service authorization or expedited request
- A **fast service authorization or expedited request** will be rendered within **72 hours** the request
- If the health plan extended the time needed to make a decision on the service authorization request for a medical item or service, the answer will be made by the end of that extended period
- If the enrollee, their authorized representative, or care provider (on behalf of the enrollee) disagree with the Health Plan's decision, an appeal can be filed. Failure to render a timely decision of a Service Authorization Request, an appeal can also be filed.
- In most cases, a decision to reduce, suspend or stop a service that an enrollee is receiving when it has already been approved requires that a notification of that decision be made at least **15 days** before the health plan changes the service
- A retrospective review decision will be rendered in **30 days** of getting necessary information. The enrollee will not have to pay for any care they received that the health plan or Medicaid covered even if the health plan later denies payment to the provider
- Additionally, the enrollee may have special Medicare rights if the enrollee's coverage for hospital care, home health care, skilled nursing facility care or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending

Assisting a UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) enrollee to file a UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) enrollee appeal of a service request for a medical item or service

If UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) denies a request for coverage for a medical item or service, the enrollee and their designee (healthcare provider or authorized representative) can decide if they want to make an appeal:

- The first step of the Appeals Process is called “**level 1**” details follow
- UnitedHealthcare can also explain the complaints and appeals processes available to the enrollee depending on enrollee's complaint
- The enrollee or their designee can call Enrollee Services at **1-866-547-0772**, TTY **711** to get more information on the enrollee's rights and the options available to the Health Plan

At any time in the process, the enrollee or their designee can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Level 1 appeals (health plan level appeal)

Information in this section applies to all the UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP) enrollee's Medicare and most of enrollee's Medicaid benefits covered by UnitedHealthcare This information does not apply to enrollee's Medicare Part D prescription drug benefits.

A Service Authorization Request Decision (also known as Coverage Decision Request) will be communicated with a written notice called an “Integrated Coverage Determination Notice (ICDN).”

If the enrollee disagrees with our decision, the enrollee (or their authorized representative or healthcare provider on their behalf) have a right to request an appeal.

Filing a level 1 appeal:

A level 1 appeal is the first level to appeal the Health Plan’s decision and request a re-review of the information and criteria made to make the decision. A level 1 appeal is conducted by the health plan but by a different reviewer than made the Service Authorization decision.

Steps to file a level 1 appeal:

- A level 1 appeal must be filed within **60 calendar days** from the date on the Integrated Coverage Determination Notice to file an appeal
- If the enrollee misses this deadline and has a good reason for missing the required timeframe, the health plan may consider granting more time for the enrollee to request an appeal. Examples of good cause for missing the deadline may include a serious illness that kept the enrollee from asking for the appeal or if the health plan gave the enrollee (or the authorized representative and healthcare provider) incorrect or incomplete information about the deadline for asking for an appeal.

Fast track or expedited appeal process:

- The requirements and procedures for getting a “fast appeal” are the same as for getting a “fast track service authorization request”
- Similarly, as a provider, if a “fast track appeal” is requested, the health plan will assign the request as a fast service authorization or expedited request
- If the enrollee’s case was a **concurrent review**, the appeal will automatically be handled as a fast track appeal
- A level 1 appeal can be filed by:
 - Calling the health plan at **1-866-547-0772, TTY 711**. The enrollee or health care provider can also call that number if assistance is needed.
 - Sending a written level 1 appeal request to:
UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)
P.O. Box 6103
Mail Stop CA124-0187
Cypress, CA 90630-0016

- An enrollee can have an authorized representative or their health care provider file their appeal. Only someone designated in writing can represent the enrollee during an enrollee’s appeal.
- If the enrollee wants a friend, relative or other person to be the enrollee’s representative during enrollee’s appeal, the enrollee can complete the “Appeal Request Form” that is included in the Integrated Coverage Determination Notice, complete the “Appointment of Representative” form also included or write and sign a letter naming the enrollee’s representative.
- To get an “Appointment of Representative” form, if the enrollee needs a copy, they can call the health plan’s Member Services number previously noted and ask for the form
- The enrollee or their designee can also obtain the Appointment of Representative form on the Medicare website at [cms.gov](https://www.cms.gov)
- After the appeal is filed by phone, the health plan will send the enrollee and their designee a form that summarizes the enrollee’s appeal. If changes are needed to the summary, they can be made before signing and returning the form to the Health Plan.
- No one filing an enrollee appeal will be treated any differently, and the health plan will not act adversely toward that individual because a Level 1 Appeal was filed

Continuing enrollee’s service or item while appealing a decision about enrollee’s care:

If the Integrated Coverage Denial Notice indicated the health plan would stop, suspend or reduce services or items that the enrollee was receiving, it may allow the enrollee to keep those services or items during the enrollee’s appeal.

- If the health plan decided to change or stop coverage for a service or item that the enrollee is currently receiving, the enrollee will receive a notice before the health plan takes action. If the enrollee or their designee disagree with the action, a level 1 appeal can be filed.
- The health plan will continue covering the service or item if a level 1 appeal was filed within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later
- The enrollee will also keep getting all other services or items (that are not the subject of enrollee’s appeal) with no changes

Note: If the enrollee's care provider is asking that the health plan continue a service or item the health plan are already getting during enrollee's appeal, the enrollee may need to name enrollee's care provider as enrollee's representative and provide the appropriate consent or authorization of a representative to handle the appeal filing on the enrollee's behalf

Level 1 appeal process:

- Within 15 calendar days when asking for a standard appeal, the health plan will send a letter to acknowledge receipt of the enrollee's level 1 appeal and that it is under review. If additional information is needed to make our decision, a request for that information will be communicated.
- Upon request, the health plan will send the enrollee a copy of the enrollee's case file, free of charge, which includes a copy of the medical records and any other information and records the health plan will use to make the appeal decision
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least 1 will be a clinical peer reviewer.
- The enrollee, authorized representative or healthcare provider can also supply information to be used in making the decision in person or in writing
- Call the health plan at **1-866-547-0772**, TTY **711** if it is unclear what information is needed
- Once the level 1 appeal is reviewed and a decision is made, the health plan will communicate the reasons for our decision and our clinical rationale if it applies
- If the health plan denies an enrollee's request or approves it for an amount that is less than the health plan asked for, the health plan will send the health plan a notice called an "appeal decision notice."
- If the health plan says no to enrollee's level 1 appeal, the health plan is required to automatically send the enrollee's level 1 case file on to the next level of the appeals process (level 2)

Standard appeal timeframes

- A pre-service authorization appeal request will be decided **within 30 calendar days after** the health plan has received the enrollee's appeal. The health plan will render the decision sooner if the enrollee's health condition requires a more expedient decision.

- Appeal extensions - If the enrollee or the health plan needs to gather more information that may benefit the enrollee, the health plan can **take up to 14 more calendar days**. If the health plan decide the health plan need to take extra days to make the decision, the health plan will notify the enrollee in writing what information is needed and why the delay is in the enrollee's best interest. The health plan will make a decision as soon as feasible upon receiving the necessary information, but no later than 14 days from the day the health plan asked for more information. If the enrollee believes the health plan should not take extra days, the enrollee can file a "fast complaint" about our decision to take extra days. When the enrollee files a fast complaint, the health plan will give the enrollee an answer to enrollee's complaint **within 24 hours**.
- If the health plan does not give the enrollee an answer by the applicable deadline (or by the end of the extra days the health plan took on enrollee's request for a medical item or service), the health plan is required to send enrollee's request on to level 2 of the appeals process where an independent outside organization will review it

If our answer is yes to part or all of what the health plan asked for,

the health plan must authorize or provide the coverage the health plan has agreed to provide within 72 hours of when the health plan made the decision about coverage for services the enrollee has not yet received.

If our answer is no to part or all of what the enrollee asked for,

to make sure the health plan followed all the rules when the health plan said no to enrollee's appeal, the health plan is required to send enrollee's appeal to the next level of appeal. When the health plan do this, it means that enrollee's appeal is going on to the next level of the appeals process, which is level 2.

Timeframes for a "fast track" appeal about coverage for services the enrollee has not yet received:

- When the health plan is using the fast timeframes, the health plan must give the enrollee our answer **within 72 hours after the health plan receives the enrollee's appeal**. The health plan will give the enrollee our answer sooner if enrollee's health requires us to do so.

- If the enrollee asks for more time or if the health plan need to gather more information that may benefit the Health Plan, the health plan **can take up to 14 more calendar days**. If the health plan decides to take extra days to make the decision, the health plan will tell the enrollee in writing what information is needed and why the delay is in the enrollee's best interest. The health plan will decide as soon as feasible once the health plan receives the necessary information, but no later than 14 days from the day the health plan asked for more information.
- If the health plan does not give the enrollee an answer within 72 hours (or by the end of the extra days the health plan took) on appeals where coverage for services the enrollee has not received yet, the health plan is required to automatically send the enrollee's request on to level 2 of the appeals process

If our answer is yes to part or all of what the health plan asked for. The health plan must authorize or provide the coverage the health plan has agreed to provide within 72 hours after the health plan receives the enrollee's appeal.

If our answer is no to part or all of what the health plan asked for. The health plan will automatically send enrollee's appeal to an independent review organization for a level 2 appeal.

- The enrollee or someone the enrollee trusts can also file a complaint with the plan if the enrollee doesn't agree with our decision to take more time to review the enrollee's action appeal
- During the level 2 appeal, an independent review organization, called the **"Administrative Hearing Office (AHO)" or "Hearing Office,"** reviews our decision on enrollee's level 1 integrated appeal. This organization decides whether the decision the health plan made should be changed.
- The health plan tells the enrollee about this organization and explains what happens at level 2 of the appeals process

At any time in the process, the health plan or someone the health plan trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Level 2 appeals process (administrative hearing office review)

Information in this section applies to all of the enrollee's Medicare and most of the enrollee's Medicaid benefits covered by UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP).

This information does not apply to the enrollee's Medicare Part D prescription drug benefits.

If the health plan says no to enrollee's level 1 appeal, the enrollee's case will **automatically** be sent on to the next level of the appeals process, the level 2 appeal. During the level 2 appeal, the **Hearing Office** reviews our decision for enrollee's level 1 appeal. This organization decides whether the decision the health plan made should be changed.

The Hearing Office is an independent New York State agency. It is not connected with the health plan. Medicare and Medicaid oversee its work.

- The health plan will send the information about the enrollee's appeal to this organization. This information is called the enrollee's "case file." The enrollee also has a right to ask for a free copy of their level 1 appeal case file.
- The enrollee has a right to give the Hearing Office additional information to support the enrollee's appeal
- Reviewers at the Hearing Office will take a careful look at all the information related to the enrollee's appeal. The Hearing Office will contact the enrollee to schedule a hearing.
- If the enrollee had a fast appeal to our health plan at Level 1 because the enrollee's health could be seriously harmed by waiting for a decision under a standard timeframe, the enrollee will automatically get a fast appeal at level 2. The review organization must give the enrollee an answer to the enrollee's level 2 appeal **within 72 hours** of when it receives the enrollee's appeal.
- If the Hearing Office needs to gather more information that may benefit the enrollee, it can **take up to 14 more calendar days**
- If the enrollee had a "standard" appeal at level 1, the enrollee would also have a "standard" appeal at level 2
- If the enrollee had a standard appeal to our plan at level 1, the enrollee would automatically get a standard appeal at level 2
- The review organization must give the enrollee an answer to the enrollee's level 2 appeal **within 90 calendar days** of when it gets the enrollee's appeal
- If the Hearing Office needs to gather more information that may benefit the health plan, it **can take up to 14 more calendar days**
- If the enrollee qualified for continuation of benefits when the enrollee filed their level 1 appeal, the enrollee's benefits for the service, item or drug under appeal will also continue during level 2
- The Hearing Office will tell the enrollee its decision in writing and explain the reasons for it

- If the Hearing Office says yes to part or all enrollee's request, the health plan must authorize the service or give the enrollee the item within 1 business day of when the health plan gets **the Hearing Office's decision**
- If the Hearing Office says no to part or all of enrollee's appeal, it means they agree with our decision that the enrollee's request (or part of enrollee's request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down enrollee's appeal.")
- If the Hearing Office says no to part or all of enrollee's appeal, the enrollee can choose whether the health plan want to take enrollee's appeal further
- There are 2 additional levels in the appeals process after level 2 (for a total of 4 levels of appeal)
- If the enrollee's level 2 appeal is turned down, the enrollee must decide whether the health plan want to go on to level 3 and make a third appeal. The written notice the enrollee got after enrollee's level 2 appeal has the details on how to do this.
- The Medicare Appeals Council handles the level 3 appeal. After that, the health plan may have the right to ask a federal court to look at the enrollee's appeal.

At any time in the process, the health plan or someone the health plan trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

External appeals for Medicaid only

The enrollee or enrollee's doctor can ask for an external appeal for **Medicaid covered benefits only**.

The enrollee can ask New York State for an independent **external appeal** if the health plan decides to deny coverage for a medical service the enrollee and enrollee's doctor asked for because it is:

- Not medically necessary
- Experimental or investigational
- Not different from care the enrollee can get in the plan's network
- Available from a participating care provider who has correct training and experience to meet enrollee's needs

This is called an external appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State.

The service must be in the plan's benefit package or be an experimental treatment. The enrollee does not have to pay for an external appeal.

Before the enrollee appeals to the state:

- The enrollee must file a level 1 appeal with the plan and get the plan's final adverse determination **or**
- The enrollee may ask for an expedited external appeal at the same time if the enrollee has not gotten the service and the enrollee asks for a fast appeal. (The enrollee's doctor will have to say an expedited appeal is necessary) **or**
- The enrollee and the health plan may agree to skip the plan's appeals process and go directly to external appeal **or**
- The enrollee can prove the health plan did not follow the rules correctly when processing the enrollee's level 1 appeal

The enrollee has **4 months** after the enrollee gets the health plan's final adverse determination to ask for an external appeal. If the enrollee and the health plan agreed to skip the Health Plan's appeals process, then the enrollee must ask for the external appeal within 4 months of when the enrollee made that Agreement.

To ask for an external appeal, fill out an application and send it to the Department of Financial Services.

- The enrollee can call Enrollee Services at **1-866-547-0772**, TTY **711** if the enrollee needs help filing an external appeal
- The enrollee and enrollee's doctors will have to give information about the enrollee's medical problem
- The External Appeal application says what information will be needed

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at dfs.ny.gov
- Contact the health plan at **1-866-547-0772**, TTY **711**
- The reviewer will decide enrollee's external appeal in **30 days**. If the external appeal reviewer asks for more information, more time (**up to 5 workdays**) may be needed. The reviewer will tell the enrollee and the health plan the final decision **within 2 days after making the decision**.

The enrollee can get a faster decision if the enrollee's doctor says that a delay will cause serious harm to the enrollee's health. This is called an **expedited external appeal**.

The external appeal reviewer will decide an expedited appeal **in 72 hours or less**. The reviewer will tell the enrollee and the health plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells the enrollee the decision.

At any time in the process, the health plan or someone the health plan trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Level 3 Medicare Appeals Council

- The enrollee may appeal an adverse AHO decisions to the Medicare Appeals Council (MAC)
- Cases appealed to the MAC will be reviewed on the basis of the record compiled by the AHO, and, upon request by the MAC, any supplemental record or argument submitted by the parties to the appeal
- The Medicare Appeals Council will apply all Medicare and Medicaid coverage rules as specified in the MAP health plan's enrollee handbook and the model contract between the health plan and DOH, as well as the Evidence of Coverage (EOC) of the exclusively aligned MAP-participating D-SNP
- Medicare Appeals Council Appeal Process
 - An enrollee must appeal an adverse AHO decision within 60 calendar days of the date of said decision
 - The enrollee will submit his/her request for Medicare Appeals Council review to the AHO. The AHO will forward the appeal and the record to the Medicare Appeals Council.
- The Medicare Appeals Council will complete a paper review and issue a decision within 90 calendar days from the receipt of the appeal request
- Benefits will continue pending an appeal
- The health plan may not appeal AHO decisions to the Medicare Appeals Council
- If the Medicare Appeals Council overturns any portion of the AHO decision, DOH, either directly or through its agent, shall issue a new final state agency determination in conformance with the Medicare Appeals Council decision

Level 4 - federal and state court reviews

- Adverse Medicare Appeals Council (MAC) decisions may be appealed to Federal District Court consistent with procedures described in 42 C.F.R. § 422.612

- A final state agency decision pertains to a **Medicaid** benefit determination which may be appealed to New York State Supreme Court
- Adverse AHO decisions pertaining to Medicaid benefit determinations that are not timely appealed to the Medicare Appeals Council may be appealed to New York State Supreme Court
- New York State Supreme Court procedures:
 - Appeals to State Supreme Court must be filed within 4 months of final agency decisions
 - State Supreme Court may only hear appeals regarding **Medicaid** benefit determinations
 - Validation of Medicare Appeals Council (MAC) and Administrative Hearing Office AHO decisions
 - CMS and NYSDOH, through the oversight team, will conduct a quality oversight process for the integrated appeal system

Member complaint process:

Information in this section applies to all enrollee's Medicare and Medicaid benefits covered by UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP). This information does not apply to enrollee's Medicare Part D prescription drug benefits.

The health plan hopes our plan serves the enrollee well. If the enrollee has a problem with the care or treatment received from our staff or care providers, or if the enrollee does not like the quality of care or services the enrollee receives from us, call Enrollee Services at **1-866-547-0772**, TTY **711** or write to Enrollee Services. The formal name for making a complaint is "filing a grievance."

The enrollee can ask someone the enrollee trusts to file the complaint on their behalf. If the enrollee needs our help because of a hearing or vision impairment, or if the enrollee needs translation services, the health plan can help the enrollee. The health plan will not make things hard for the enrollee or take any action against the enrollee for filing a complaint.

Only someone the enrollee names in writing can represent the enrollee during the enrollee's complaint/complaint appeal. If the enrollee wants a friend, relative or other person to be the enrollee's representative during the complaint/complaint appeal, the enrollee can complete an "appointment of representative" form or write and sign a letter naming enrollee's representative.

- To get an "appointment of representative" form, call Enrollee Services and ask for the form

- The health plan can also get the appointment of representative form on the Medicare website at [cms.gov](https://www.cms.gov). The form gives the person permission to act for the enrollee. The enrollee must give the health plan a copy of the signed form, or
- The enrollee can also write a letter and send it to us. (The enrollee or the person named in the letter as enrollee's representative can send the letter.)

Filing a member complaint:

- **Calling:** The first step is to contact Enrollee Services. If there is anything else the enrollee needs to do, Enrollee Services will let the health plan know. **1-866-547-0772, TTY 711**, Monday-Friday, 8 a.m.-8 p.m. ET.
- If the enrollee does not wish to call (or the enrollee called and was not satisfied), the enrollee can put the complaint in writing and send it to the Health Plan. If the enrollee puts the complaint in writing, the health plan will respond to enrollee's complaint in writing. The health plan can write us with enrollee's complaint. It should be mailed to:
UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP)
P.O. Box 6103
Mail Stop CA124-0187
Cypress, CA 90630-0016
- Whether the enrollee calls or writes, the health plan should contact Enrollee Services right away. The enrollee can make the complaint at any time after the enrollee had the problem in question.

What happens next:

- If possible, the health plan will answer the enrollee right away. If the enrollee called us with a complaint, the health plan may be able to give the enrollee an answer on the same phone call. If the enrollee's health condition requires us to answer quickly, the health plan will do that.
- The health plan answers most complaints in 30 calendar days
- If the enrollee is making a complaint because the health plan denied the enrollee's request for a "fast service authorization" or a "fast appeal," the health plan will automatically give the health plan a "fast" complaint. If the enrollee has a "fast" complaint, it means the health plan will give the health plan **an answer within 24 hours**.

- If the health plan needs more information, and the delay is in enrollee's best interest or if the enrollee asks for more time, the health plan can take up to 14 more calendar days (44 calendar days total) to answer enrollee's complaint. If the health plan decide to take extra days, the health plan will tell the enrollee in writing. However, if the enrollee has already asked the health plan for a service authorization or made an appeal, and the enrollee thinks that the health plan is not responding quickly enough, the enrollee can also make a complaint about our slowness. Here are examples of when the enrollee can make a complaint:
 - If the enrollee asked the health plan to give the enrollee a "fast service authorization" or a "fast appeal" and the health plan said the health plan will not
 - If the enrollee believes the health plan is not meeting the deadlines for giving the enrollee a service authorization or an answer to an appeal the enrollee made
 - When a service authorization the health plan made is reviewed and the health plan is told that the health plan must cover or reimburse the enrollee for certain medical services or drugs within certain deadlines and the enrollee thinks the health plan is not meeting the deadlines
 - When the health plan does not give the enrollee an appeal decision on time and the health plan does not forward the enrollee's case to the Hearing Office by the required deadline
- If the health plan does not agree with some or all of the enrollee's complaint or does not take responsibility for the problem the enrollee is complaining about, the health plan will let the enrollee know. Our response will include our reasons for the decision. The health plan must respond whether the health plan agrees with the complaint or not.

Complaint appeals

If the enrollee disagrees with a decision the health plan made about enrollee's complaint about the enrollee's Medicaid benefits, the enrollee or someone the health plan trusts can file a complaint appeal with the plan.

How to make a complaint appeal:

- If the enrollee is not satisfied with what the health plan decides, the enrollee has **at least 60 workdays** after hearing from us to file a complaint appeal

- The enrollee does this themselves or asks someone the enrollee trusts to file the complaint appeal for the Health Plan
- The enrollee must make the complaint appeal in writing
 - If the enrollee makes an appeal by phone, the enrollee must follow it up in writing
 - After enrollee's call, the health plan will send the enrollee a form that summarizes the enrollee's phone appeal
 - If the enrollee agrees with our summary, the enrollee must sign and return the form to us. The enrollee can make any needed changes before sending the form back to us.

Health plan response to a complaint appeal:

After the health plan gets the enrollee's complaint appeal, the health plan will send the enrollee a letter within 15 workdays. The letter will tell the enrollee:

- Who is working on enrollee's complaint appeal
- How to contact this person
- If the health plan need more information

1 or more qualified people will review the enrollee's complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about the enrollee's complaint.

If the enrollee's complaint appeal involves clinical matters, 1 or more qualified health professionals will review the case. At least 1 of those professionals will be a clinical peer reviewer who was not involved in making the first decision about the enrollee's complaint.

The health plan will let the enrollee know our decision within **30 business days** from the time the health plan has all information needed. If a delay would risk the enrollee's health, the enrollee will get our decision in **2 business days** of when the health plan has all the information the health plan needs to decide the appeal. The health plan will give the enrollee the reasons for our decision and our clinical rationale if it applies.

If the enrollee is still not satisfied, the enrollee or someone on the enrollee's behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.

Participant Ombudsman:

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long-term care recipients in the state of New York. The enrollee can get free independent advice about enrollee's coverage, complaints and appeal options.

They can help the enrollee manage the appeal process. If the Participant Ombudsman is helping the enrollee file an appeal, the Participant Ombudsman must notify the health plan the enrollee has requested an appeal.

The Participant Ombudsman can also provide support before the enrollee enrolls in a MAP plan like UnitedHealthcare Dual Complete NY-Y001 (HMO D-SNP). This support includes unbiased health plan choice counseling and general program related information. ICAN can be contacted per below to learn more about their services:

Phone: 1-844-614-8800, TTY 711

Web: icannys.org | Email: ican@cssny.org

Chapter 17: Applied behavioral analysis services

Applied behavioral analysis services

Medicaid covers applied behavioral analysis (ABA) services for individuals under 21 years old (an EPSD benefit) who have a diagnosis of Autism Spectrum Disorder (ASD) or Rett Syndrome as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V). The enrollee must be referred by a NYS licensed and NYS Medicaid-enrolled physician (including psychiatrists and developmental/behavioral pediatricians), psychologist, PA or psychiatric/pediatric nurse practitioner.

ABA services can be provided by Licensed Behavior Analysts (LBAs) or Certified Behavior Analysts Assistants (CBAAs) working under the LBAs supervision. NYSED licensure/certification is a requirement for enrollment in the NYS Medicaid program. Settings will include anywhere LBA/CBAAs may legally provide ABA services:

- Private/group practice settings where patients/clients reside full time or part time, clinics, hospitals, residences and community settings
- ABA services are not considered primary care services and, thus, will not be provided in a school-based health center
- Medicaid does not cover ABA services that are part of an Individual Education Plan (IEP) that are already covered by the Board of Education



Prior authorization requests can be made online by visiting **providerexpress.com** > ABA Information.



The Quick Reference Guide for New York Medicaid can be found **here**.

Appendices

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Appendix A: Additional health links

TOPIC	URL
Diabetes	care.diabetesjournals.org/content/44/Supplement_1
HTN JNC7 prevention, detection, evaluation and treatment of HBP	nhlbi.nih.gov/guidelines
High blood cholesterol ATP III guidelines at-a-glance quick desk reference	nhlbi.nih.gov/health-topics/blood-cholesterol
Asthma	nhlbi.nih.gov/health-topics/asthma
CHF	nhlbi.nih.gov/health/heart-failure
COPD	goldcopd.org/GuidelineItem.asp?intId=1116
Section 85.40 – Prenatal care assistance program	health.ny.gov/community/pregnancy/health_care/prenatal/helpful_links.htm
Major depression / major depressive disorder	nimh.nih.gov/health/topics/depression/index.shtml
Childhood immunization	cdc.gov/vaccines/index.html
Vaccines for children program (VFC)	nyc.gov/site/doh/providers/nyc-med-cir/vaccines-for-children-program.page health.ny.gov/prevention/immunization/vaccines_for_children/resources.htm
Adult immunization	cdc.gov/vaccines
ADHD	cdc.gov/ncbddd/adhd/
Smoking cessation	surgeongeneral.gov/tobacco/treating_tobacco_use.pdf
Acute myocardial infarction	acc.org/clinical/guidelines/stemi/Guideline1/index.html
Sickle cell	nhlbi.nih.gov/health-topics/sickle-cell-disease

Public Health Websites		
County Health Department	Phone number	County LHD Website/CHA Report
Albany	1-518-447-2089	Albany County Department of Health
Broome	1-607-777-2622	Broome County Health Department
Cayuga	1-315-253-1451	Cayuga County Health Department

Public Health Websites		
County Health Department	Phone number	County LHD Website/CHA Report
Chautauqua	1-716-753-4000	Chautauqua County Health Department
Chemung	1-607-737-2028	Chemung County Health Department
Chenango	1-607-337-1650	Chenango County Department Health
Clinton	1-518-565-4840	Clinton County Health Department
Columbia	1-518-828-3358 ext. 1326	Columbia County Department of Health
Erie	1-716-858-7690	Erie County Department of Health
Essex	1-518-873-3500	Essex County Public Health Department
Fulton	1-518-736-5720	Fulton County Public Health Department
Genesee	1-585-344-2580 ext. 5497	Genesee County Health Department
Herkimer	1-315-867-1176	Herkimer County Public Health Nursing
Jefferson	1-315-786-3710	Jefferson County Public Health Service
Lewis	1-315-376-5453	Lewis County Public Health Agency
Madison	1-315-366-2361	Madison County Department of Health
Monroe	1-585-753-5332	Monroe County Department of Public Health
Nassau	1-516-227-9408	Nassau County Department of Health
New York City	1-347-396-7964	New York City Department of Health and Mental Hygiene
Niagara	1-716-439-7435	Niagara County Department of Health
Oneida	1-315-798-5508	Oneida County Health Department
Onondaga	1-315-435-3648	Onondaga County Health Department
Ontario	1-585-396-4343	Ontario County Public Health
Orange	1-845-291-2334	Orange County Department of Health
Oswego	1-315-349-3587	Oswego County Health Department
Rensselaer	1-518-270-2626	Rensselaer County Health Department
Rockland	1-845-364-2956	Rockland County Department of Health

Public Health Websites		
County Health Department	Phone number	County LHD Website/CHA Report
Saint Lawrence	1-315-386-2325	St. Lawrence County Public Health Department
Seneca	1-315-539-1925	Seneca County Health Department
Suffolk	1-631-854-0088	Suffolk County Department of Health Services
Tioga	1-607-687-8607	Tioga County Health Department
Ulster	1-845-334-5527	Ulster County Health Department
Warren	1-518-761-6580	Warren County Public Health
Wayne	1-315-946-5749	Wayne County Public Health Department
Westchester	1-914-955-7522	Westchester County Department of Health

New York State Department of Health	
Description	Web Address
Asthma – provides asthma action plans, materials	health.state.ny.us/diseases/asthma
Cardiovascular disease – discusses statewide programs and data and statistics	health.state.ny.us/nysdoh/heart/heart_disease.htm
Diabetes – discusses prevention, statistics and professional education	health.state.ny.us/diseases/conditions/diabetes
Early Intervention – discusses regulations and laws, training	health.ny.gov/community/infants_children/early_intervention
Immunizations – discusses vaccine safety, supply and locating immunization records	health.state.ny.us/prevention/immunization
Lead – provides data and statistics as well as information for healthcare physicians	health.state.ny.us/environmental/lead
Tobacco use – provides NY state Quitline, reports on tobaccos use, its effects on health and economics	health.state.ny.us/prevention/tobacco_control/
TB – provides FAQs, data and statistics	health.ny.gov/diseases/communicable/tuberculosis/fact_sheet.htm
Health insurance programs – Discusses all of the health insurance programs for NY state.	health.state.ny.us/health_care

New York State Department of Health

Postpartum care - discusses the new length of the postpartum period as 12 months. With the 12-month postpartum period beginning on the last day of the last day of the pregnancy and ending on the last day of the 12th month.

health.ny.gov/health_care/medicaid/program/update/2023/docs/mu_no6_mar23_pr.pdf

New York State Department of Health and Mental Hygiene

Description	Web Address
Alcohol and substance abuse services – addiction, treatment services, screening, publications	oasas.ny.gov
Asthma – provides asthma action plans, materials	health.state.ny.us/diseases/asthma
Cardiovascular disease - discusses stroke, HTN prevention	health.ny.gov/diseases/asthma
Cholesterol	health.ny.gov/diseases/cardiovascular/heart_disease/risk_factors.htm
Depression	nyc.gov/site/doh/providers/resources/public-health-action-kits-depression.page
Discusses numerous communicable diseases, their treatment and prevention	health.ny.gov/professionals/diseases/reporting/communicable
Crisis intervention – provides contacts and services	health.ny.gov/environmental/emergency/
Early intervention – provides information on eligibility and services, physician directories	health.ny.gov/community/infants_children/early_intervention/index
Hypertension – discusses controlling HTN, provides publications and resources	nyc.gov/site/doh/health/health-topics/heart-disease-blood-pressure.page
Immunization – discusses clinics, programs and services	health.ny.gov/prevention/immunization
Lead – this is specific for healthcare physicians for information on lead	health.ny.gov/environmental/lead/health_care_providers
Managed Medicaid compendium	hca-nys.org/about/about-home-care

New York State Department of Health and Mental Hygiene	
Smoking cessation/tobacco control - discusses reporting violations, controlling the epidemic	health.ny.gov/prevention/tobacco_control/program_components.htm
Take care New York	nyc.gov/site/doh/about/about-doh/take-care-new-york.page
Tuberculosis	nyc.gov/site/doh/providers/health-topics/tuberculosis.page

Appendix B: Cardiology prior authorization phone prompt selections

Cardiology prior authorization phone options

Please call **1-866-889-8054** and use the following options:

Request prior authorization:

- Select option #1 and provide the ordering physician's 10-digit NPI number. **After providing the NPI number, the options are:**
 - Select option #3 for UnitedHealthcare Community Plan members and provide the requested information. Then select:
 - Option #2 for Cardiac Procedures including stress echocardiograms, diagnostic catheterizations and procedures for implantable devices
 - When you call, have the study type information available
- **New procedure:** If there is another procedure request for this member, press option #2
- **New patient under the same care provider:** If you have additional member requests for this care provider, press option #3
- **New care provider:** If you are requesting prior authorization for additional care providers, press option #4

Verify or check prior authorization status:

- Select option #2
- Please provide the 10-digit case number
 - If you don't have a case number or it is invalid, press *

Initiate physician-to-physician discussion

- Select option #3
- Please provide the 10-digit case number
 - If you don't have a case number or it is invalid, press *

To speak to a Provider Services representative

- Select option #4
- Please provide the 10-digit case number
 - If you don't have a case number or it is invalid, press *

If you have questions after selecting option #4, use these options:

- For questions about claims, payments, appeals or all eligibility issues, select option #1
- For general questions about UnitedHealthcare Community Plan members, select option #3
- For all other inquiries, select option #5
- To return to the main menu, select option #6
- To repeat these options, select option #9

Helpful phone hints

- The phone system will always repeat the information entered. To bypass this function, simply enter the next required data element.
- If a typing error is made, press # to end that entry and try again
- If the member's ID number has alpha characters, use the corresponding numeric number on the telephone key pad to enter them. Verification of the identification will be returned in the numeric format only.
- You can initiate multiple requests per call for the same member

Appendix C: Radiology prior authorization phone prompt selections

Radiology prior authorization phone options

Please call **1-866-889-8054** and use the following options:

Request prior authorization:

- Select option #1 and provide the ordering physician's 10-digit NPI number. After providing the NPI number, the options are:
 - Select option #3 for UnitedHealthcare Community Plan members and provide the requested information. Then select:
 - Option #1 for advanced outpatient imaging, which includes nuclear stress tests and PET scans
 - When you call, have the study type information available
- **New procedure:** If there is another procedure request for this member, press option #2
- **New patient under the same care provider:** If you have additional member requests for this care provider, press option #3
- **New care provider:** If you are requesting prior authorization for additional care providers, press option #4

Verify or check prior authorization status

- Select option #2
- Please provide the 10-digit case number
 - If there is no case number or it is invalid, press *

Initiate physician-to-physician discussion

- Select option #3
- Please provide the 10-digit case number
 - If there is no case number or it is invalid, press * To speak to a Provider Services representative
- Select option #4
- Please provide the 10-digit case number.
 - If there is no case number or it is invalid, press *

If you have questions after selecting option #4, use these options:

- For questions about claims, payments, appeals or eligibility issues, select option #1
- For general questions regarding UnitedHealthcare Community Plan members, select option #3
- For all other inquiries, select option #5
- To return to the main menu, select option #6
- To repeat these options, select option #9

Helpful phone hints

- The phone system will always repeat the information entered. To bypass this function, simply enter the next required data element.
- If a typing error is made, press # to end that entry
- If the member's ID number has alpha characters, use the corresponding numeric number on the telephone key pad to enter them. Verification of the identification will be returned in the numeric format only.
- You can initiate multiple requests per call for the same member

Appendix D: ADHD appraisal

All children have problems paying attention and controlling their behavior, but for some children, these problems negatively affect some areas of their life, like their performance at school or interaction with friends. A child with ADHD may have problems in either one or both of these areas.

- Paying attention
- Controlling either hyperactive or impulsive behavior

Use the information at [healthychildren.org](https://www.healthychildren.org) > Health Issues > Conditions > ADHD > Diagnosing ADHD in Children: Guidelines & Information for Parents to help you decide if your child needs further evaluation.

If you would like us to arrange for a behavioral health consultation with one of our network clinicians, please call the 1-800 number on your health insurance card that is listed for mental health and substance abuse benefits and we will be happy to help you.

When you contact us you will be asked a few questions that allow us to verify your insurance coverage. If you are experiencing an urgent problem you will be immediately connected with one of our professional care managers who will help you get to the care you need.

You may also call us if you have any questions about our prevention program or our services. Again, simply call the number on your card and we will be happy to answer your questions or arrange for you to see a clinician.

Appendix E: Screening/assessment tool links

Category	Topic	URL
Cultural factors	Cultural Formulation Interview	psychiatry.org/File Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf
General mental health	Modified Mini Screen (MMS) (Clinician or Self Administered)	Adult Screening Instruments (ny.gov)
General mental health	Kessler Psychological Distress Scale (K10) (self)	Adult Screening Instruments (ny.gov)
General mental health	Kessler Psychological Distress Scale (K6) (self)	Adult Screening Instruments (ny.gov)
General mental health	Mental Health Screening Form -III (MHSF-III)	Adult Screening Instruments (ny.gov)
Substance use	Car, Relax, Alone, Forget, Friends Trouble Screening (CRAFT)	craftt.org/
Substance use	Level of Care Determination -Adolescent (LOCADTRA-A)	Level of Care Determination (LOCADTR) Office of Addiction Services and Supports (ny.gov)
Substance use	Global Appraisal of Individual Needs (GAIN)	Gain Instruments - GAIN Coordinating Center (gaincc.org)
Substance use	Alcohol Use Disorder Identification Test (AUDIT)	Alcohol self-test (auditscreen.org)
Substance use	Drug Abuse Screening Test (DAST-10)	oasas.ny.gov/system/files/documents/2019/11/drugabusescreeningtest-10_4-24-18.pdf
State resource	OASAS approved Adult and Adolescent Screening Instruments for Co-Occurring Mental Health Problems:	Adult Screening Instruments (ny.gov) Adolescent Screening Instruments (ny.gov)
General mental health	Pediatric Symptom Checklist 17 Youth (PSC-17 -Y) (Self Administered)	Adolescent Screening Instruments (ny.gov)
General mental health	Pediatric Symptom Checklist 17 Youth (PSC-17 -Y) (Parent/Guardian)	Adolescent Screening Instruments (ny.gov)
Patient/client safety	Columbia-Suicide Severity Rating Scale (C-SSRS)	Adult Screening Instruments (ny.gov)

Category	Topic	URL
Patient/client safety	Columbia-Suicide Severity Rating Scale (C-SSRS) Screen with Triage Points for Emergency Department	Adult Screening Instruments (ny.gov)
Patient/client safety	Ask Suicide Screening Questions (asQ) (Clinician Administered)	Adolescent Screening Instruments (ny.gov)
General mental health	Strengths and Difficulties Questionnaire (S17+) (SDQ) (Self Administered)	Adolescent Screening Instruments (ny.gov)
General mental health	SDQ Scoring	Adolescent Screening Instruments (ny.gov)
Depression	Patient Health Questionnaire 9: Modified for Teens (PHQ -9 Modified for Teens) (self)	Adolescent Screening Instruments (ny.gov)
Depression	Patient Health Questionnaire 2: Modified for Teens	Adolescent Screening Instruments (ny.gov)
Depression	Center for Epidemiologic Studies Depression Scale for Children (CES-DC)	Adolescent Screening Instruments (ny.gov)
Perinatal Depression	Edinburgh Postnatal Depression Scale (EPDS)	Adult Screening Instruments (ny.gov)
Anxiety	Generalized Anxiety Disorder 7 (GAD-7)	Adult Screening Instruments (ny.gov)
Anxiety	Generalized Anxiety Disorder 2 (GAD-2) (Self)	Adult Screening Instruments (ny.gov)
Trauma /PTSD	Adverse Childhood Experiences (ACEs)	acesaware.org/learn-about-screening/screening-tools/ traumainformedcare.chcs.org/wp-content/uploads/TA-Tool-Screening-for-ACEs-and-Trauma_020619.pdf
Trauma /PTSD	Child PTSD Symptoms Scale (CPSS) (Self)	Adolescent Screening Instruments (ny.gov)
Trauma /PTSD	Child and Adolescent Trauma Screen (CATS) Youth Report (Self)	Adolescent Screening Instruments (ny.gov)
Anxiety	Screen for Child Anxiety Related Disorders (SCARED) Self	Adolescent Screening Instruments (ny.gov)
ADHD	Adult ADHD Self-Report screening Scale for DSM 5 (ASRS-5)	Adult Screening Instruments (ny.gov)

Category	Topic	URL
Bi-Polar Disorder	Composite International Diagnostic Interview based Bipolar Disorder Screening Scale (CIDI) (Clinician)	Adult Screening Instruments (ny.gov)
Bi-Polar Disorder	Altman Self Rating Mania Scale (ASRM) Self	Adult Screening Instruments (ny.gov)
Eating Disorders	Eating Disorders Examination Questionnaire (EDE-Q (Self)	Adult Screening Instruments (ny.gov)
Eating Disorders	Eating Disorders Diagnostic Scale (EDDS) (Self)	Adult Screening Instruments (ny.gov)
Anxiety	Social Interaction Anxiety Scale (SIAS)	Adult Screening Instruments (ny.gov)
Trauma /PTSD	PTSD Checklist for DSM-5 (PCL-5) (Self)	ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.pdf
Trauma /PTSD	The Primary Care PTSD Screen - DSM-5 (PC-PTSD-5_ (Self)	ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf
Eating Disorders	Eating Disorders Diagnostic Scale Scoring (EDDS) (Self)	phenxtoolkit.org/toolkit_content/PDF/PX120602.pdf
Depression	Beck Depression Inventory	beckinstitute.org/cbt-resources/resources-for-professionals-and-students/assesment-tools/
Comprehensive Assessment	Child and Adolescent Needs and Strengths (CANS)	omh.ny.gov/omhweb/resources/publications/cans/cans_manual.pdf
Co-Occurring Disorders	Screening, Brief Intervention, Referral & Treatment (SBIRT)	oasas.ny.gov/AdMed/sbirt/index.cfm
Tobacco Use	Fagerstrom Test for Nicotine Dependence (FTND) and Heaviness of Smoking (HIS)	iarc.fr/en/publications/pdfs-online/prev/handbook12/Tobacco_vol12_appendices.pdf
Patient/Client Safety	CASE Approach	suicideassessment.com/the-case-approach/
General Mental Health	Patient Stress Questionnaire	thenationalcouncil.org/resources/patient-stress-questionnaire/
Substance Use	Drug Abuse Screen Test (DAST-10)	projectteachny.org/app/uploads/2017/10/DAST_10_with_scoring.pdf
Substance Use	Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	who.int/publications/i/item/978924159938-2

Category	Topic	URL
Substance use	CAGE-AID Substance Abuse Screening Tool	pedagogyeducation.com/Main-Campus/Resource-Library/Correctional-Nursing/CAGE-AID-Substance-Abuse-Screening-Tool.aspx
Screening summaries	Mental Health Screening and Assessment Tools for Primary Care	heardalliance.org/wp-content/uploads/2011/04/Mental-Health-Assessment.pdf
Psychosis	Brief Psychiatric Rating Scale (BPRS) (Clinician Administered)	Adult Screening Instruments (ny.gov)
Functional impairment	World Health Organization Disability Assessment Schedule	Adult Screening Instruments (ny.gov)
Autism	Clinical Practice Guideline on Assessment and Intervention Services for Youth Children with Autism Spectrum Disorder	health.ny.gov/publications/20152.pdf
Autism	Modified Checklist for Autism in Toddlers (M-CHAT)	projectteachny.org/app/uploads/2019/08/M-CHAT.pdf
State resource	OASAS Approved Gambling Screening/Assessment Tools	approved-gambling-screening-and-assessment-tools.pdf
Gambling	Lie-Bet Tool to Rule Out Problem Gambling	approved-gambling-screening-and-assessment-tools.pdf
Gambling	National Opinion Research Center Diagnostic Screen for Gambling Disorders, Loss of Control, Lying and Pre-occupation, Escape, Risked Relationships and Chasing Screen (NODS-PERC)	approved-gambling-screening-and-assessment-tools.pdf
Gambling	Brief Bio-Social Gambling Screen (BBGS)	approved-gambling-screening-and-assessment-tools.pdf
Gambling	Brief Adolescent Gambling Screen (BAGS)	approved-gambling-screening-and-assessment-tools.pdf
Gambling	South Oaks Gambling Screen	approved-gambling-screening-and-assessment-tools.pdf
Gambling	South Oaks Gambling Screen-Adolescents	approved-gambling-screening-and-assessment-tools.pdf

Category	Topic	URL
Gambling	National Opinion Research Center Diagnostic Screen for Gambling Disorders, Loss of Control, Lying and Pre-occupation Screen (NODS-CLiP)	oasas.ny.gov/system/files/documents/2022/06/nods_clip.pdf
Gambling	DSM-V Screen for Pathological Gambling	oasas.ny.gov/system/files/documents/2020/02/dsmvgamblingdiagnosticform.pdf
Gambling	South Oaks Gambling Screen -Spanish	evergreencpg.org/wp-content/uploads/2021/03/12-SOGS-in-Spanish.pdf
Gambling	Problem Gambling Severity Index	portal.ct.gov/-/media/dmhas/pgs/severityindexprintablepdf.pdf

Appendix F: HIV care provider information and resources

Category	Topic	URL
New York State Department of Health resources:	For information on HIV and on HIV counseling, testing, referral, and partner notification (CTRPN) services including Perinatal HIV Prevention & Newborn Screening	HIV Testing (ny.gov)
New York State Department of Health resources:	AIDS Institute	AIDS Institute (ny.gov)
New York State Department of Health resources:	AIDS Institute	Provider Directory Home Page
New York State Department of Health resources:	Designated AIDS Center (DAC) Clinic Contact List	Designated AIDS Center Clinic Contact List
New York State Department of Health resources:	Guidelines and Training for Providers	HIV Testing Clinician's Toolkit
New York State Department of Health resources:	Guidelines and Training for Providers	HIV Testing, Reporting and Confidentiality in New York State 2023 Update: Fact Sheet & Frequently Asked Questions
New York State Department of Health resources:	Rapid HIV Testing	Developing Protocols for Limited Service Laboratories Seeking to Offer Rapid HIV Testing in New York State
New York State Department of Health resources:	Rapid HIV Testing	Rapid HIV Testing Workbook and Implementation Guidelines for Limited Testing Sites in New York State
New York State Department of Health resources:	Rapid HIV Testing	Rapid HIV Testing Guidance for Licensed Article 28 Facilities
New York State Department of Health resources:	Rapid HIV Testing	Guidance for Non-Clinical Providers

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Category	Topic	URL
New York State Department of Health resources:	Perinatal HIV Prevention & Newborn Screening	September 2018 Updated Recommendations: Treatment for Women Living with HIV During the Intrapartum Period and Newborn ARV Prophylaxis & HIV Testing of Children Under 2 Years of Age PDF
New York State Department of Health resources:	Perinatal HIV Prevention & Newborn Screening	Maternal-Pediatric HIV Prevention & Care Program Test History & Assessment (DOH-4068) PDF
New York State Department of Health resources:	Perinatal HIV Prevention & Newborn Screening	Strategic Plan for Elimination of Mother-to-Child Transmission of HIV
New York State Department of Health resources:	Perinatal HIV Prevention & Newborn Screening	Situations Where Breastfeeding is Contraindicated or Not Advisable
New York State Department of Health resources:	Perinatal HIV Prevention & Newborn Screening	Health Alert: Steps to Further Reduce Mother-To-Child HIV Transmission in NYS (2007)
New York State Department of Health resources:	Important News for New Mothers About Your Baby's HIV Test, September 2017	English PDF
New York State Department of Health resources:	Important News for New Mothers About Your Baby's HIV Test, September 2017	Spanish PDF
New York State Department of Health resources:	Key Points of Information to be Provided Before an HIV Test	Expect The Test PDF
New York State Department of Health resources:	Key Points of Information to be Provided Before an HIV Test	Posters and brochures available in 6 other languages
New York State Department of Health resources:	Key Points of Information to be Provided Before an HIV Test	Information on Non-reactive (Negative) HIV Test Results PDF

Appendix F: HIV care provider information and resources

Category	Topic	URL
New York State Department of Health resources:	Key Points of Information to be Provided Before an HIV Test	If You Have Been Diagnosed as Living with HIV PDF
New York State Department of Health resources:	Key Points of Information to be Provided Before an HIV Test	Si le han indicado que tiene el VIH (Spanish PDF)
New York State Department of Health resources:	Partner Services	What Health Care Providers Need to Know about Partner Services
New York State Department of Health resources:	Standing Orders	Non-patient Specific Standing Orders for HIV & Hepatitis C Testing
New York State Department of Health resources:	Reimbursement for HIV Counseling and Testing	DOHM: Changes to the HIV Primary Care Medicaid Program
New York State Department of Health resources:	Reimbursement for HIV Counseling and Testing	Health Care Facilities Enrolled in the HIV Primary Care Medicaid Program
New York State Department of Health resources:	Reimbursement for HIV Counseling and Testing	HIV Enhanced Fee for Physicians Program (HIV-EFP)

Appendix F: HIV care provider information and resources

Category	Topic	URL
Other resources	American Academy of HIV Medicine (AAHIVM): In collaboration with the CDC, AAHIVM has developed a new online Referral Link directory listing of individual clinicians who specialize in HIV/AIDS care. The goal is to give general practitioners a handy tool to deliver care to any of their patients who test HIV positive, be it a consult with a nearby HIV/AIDS specialist or a referral to specialty care if needed. Through Referral Link, a general practitioner can provide a quality referral by matching an HIV care provider to their newly-diagnosed patient's specific situation, taking into account the patient's location, financial situation, and medical needs. AAHIVM's Referral Link lists all Academy Members, credentialed providers, and other HIV practitioners. Qualified HIV practitioners are encouraged to add their profile to the Referral Link database, which is free and does not require membership in the Academy.	Directory of HIV/AIDS Specialists
Other resources	Centers for Disease Control and Prevention (CDC) and New York City Department of Public Health.	cdc.gov/hiv
Other resources	U.S. Department of Health and Human Services, Health Resources & Services Administration (HRSA) and the Ryan White HIV/AIDS Program: The Ryan White HIV/AIDS Program can help people living with HIV/AIDS access the medical care they need but can't afford. Ryan White care includes medical care by doctors and clinics that know how to treat HIV/AIDS. Ryan White-funded medical care providers can refer for dental care and other services like transportation as well as provide access to HIV medications. Ryan White provides HIV care to those without insurance and may be able to fill gaps in care not covered by insurance or other programs like Medicaid and Medicare. What an individual pays depends on whether they have their own health insurance and how much income and resources they have.	Directory of Ryan White HIV/AIDS Medical Care providers