2026 UnitedHealthcare Community Plan of Virginia Provider Manual

Physician, Care Provider, Facility, and Ancillary

Includes: Virginia Medicaid

Doc#: PMG 20260225-092545

UnitedHealthcare® Community Plan

Welcome

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

Click to access different care provider manuals

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

A different Community Plan care provider manual – **UHCprovider.com/guides**

- Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on "Find your State" **Virginia**.

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

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services.**

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 care provider manual, unless your Agreement states you should utilize the Agreement instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation agreement

This manual will be amended as policies change.

- Terms and definitions as used in this care provider 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 care provider manual
- 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 of Virginia provides benefits to:

- **Virginia Medicaid members**, which include low-income children and adults and individuals who are aged, blind and/or disabled
- **FAMIS** – Family Access to Medical Insurance Security, which includes:
  - **LIFC:** Low Income Families with Children
  - **CHIP:** Children's Health Insurance Program

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at: **1-844-284-0146**.

How to join our network

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

Already in network and need to make a change?

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

Long-Term Services and Supports overview

What is UnitedHealthcare Long-Term Services and Supports?

Managed care is when health care organizations manage how members receive health care services. Managed care organizations (MCOs) work with different care providers to offer quality health care services.

The goals of UnitedHealthcare Community Plan Long-Term Services and Supports (LTSS) plan are to provide:

- Coordinated long-term care across different health care settings
- A choice of the best long-term care plan for their needs
- Long-term care plans with the ability to offer more services
- Access to cost-effective community-based long-term care services

Members in the LTSS plan have their services/care managed through the managed care health plan. We work with you to offer quality health care services and to help ensure members have access to covered services.

Enrollment in the LTSS plan will not change a member's Medicare benefits.

These benefits allow at-risk individuals to remain at home and improve their quality of life.

How the Long-Term Services and Supports plan works

We have a contract with the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS).

We support and coordinate all LTSS-covered benefits for members. Our goal is to assist members with services that provide them opportunities to live in the community, when possible.

The managed care plan also helps to provide the member with every opportunity to improve quality of life and, when or if possible, allow for a successful transition back into the community from a facility.

The plan uses covered benefits, enhanced benefits, community resources, caregiver/family support systems and primary care providers (PCPs) to meet the member's overall care needs. We are required to comply with any new Medicaid coverage decisions.

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Long-Term Services and Supports plan care provider relationship

The success of our plan depends on strong relationships with you. Each member has an assigned care manager, and we encourage members to work with their care manager to coordinate care and help them access covered benefits. If the member uses a non-contracted care provider, **the services may not be covered** unless authorized by the care manager.

The member and UnitedHealthcare Community Plan

Only LTSS plan members who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to be in the LTSS Plan. Each member has a choice of Managed Care Plans.

They may select any authorized Managed Care Plan unless the Managed Care Plan is restricted to a specific population that does not include the member.

The Department of Medical Assistance Services, or its agent, is responsible for enrollment, including enrollment into the LTSS Plan, disenrollment and outreach and education.

We accept Medicaid recipients without restriction in the order they enroll. We do not discriminate on the basis of religion, gender, race, color, age, national origin, health status, pre-existing condition or need for health care services.

Care coordinator provisions

Each member will have access to care management and care coordination. They work with the care providers, and authorized representatives, to develop and coordinate the care plan. **A Medicare beneficiary can access any Medicare-approved care provider without authorization.**

Home and Community-Based Services program

Home and Community-Based Services (HCBS) program combines traditional physical health, behavioral health and nursing facility-based services. All HCBS require prior authorization through the plan of care (POC) process.

Goals of this program include:

- Having integrated, whole-person care
- Preserving paths to independence
- Creating access models with emphasizing home- and community-based services

Electronic visit verification

More information on HCBS services, including benefit limitations, unit definitions and billing codes is available on the DMAS web portal at dmas.virginia.gov > Providers. In accordance with federally mandated electronic visit verification (EVV) requirements, DMAS has implemented EVV for home health service providers, Agency and Consumer for Agency and Consumer Directed personal care, respite care and companion services that begin or end in the member's home. Find more information on the DMAS provider portal at Cardinal Care Virginia's Medicaid Program > Providers > Long Term Care > Programs and Initiatives > Electronic Visit Verification.

Virginia Medicaid overview

The Virginia Medicaid plan serves Medicaid and FAMIS members throughout Virginia. The program goals are to increase member and provider engagement, support integration and innovation, and improve health care quality and outcomes.

Who is eligible?

Virginia Medicaid adds new populations and services:

- Pregnant women
- Infants
- Children/teens
- Children in foster care or adoption assistance
- Early intervention services
- Mental Health Services (MHS)
- Third-party liability
- Adults between 19 and 64 years old

Go to virginiamanagedcare.com for more information on eligible populations.

Virginia Medicaid covered benefits for eligible individuals include comprehensive health care and prevention services, including:

- Prenatal, delivery and postpartum care

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- Newborn, pediatric (through age 19), preventive and acute treatment, including immunizations, health screening and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) through age 21
- Foster care and adoption assistance
- Addiction and Recovery Treatment Services (ARTS)
- Telemedicine
- Care Management
- Mental Health and Rehabilitation Services

Our approach to health care

Care Model

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

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, health care, 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:

- 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
- Online tools that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Help scheduling and coordinating appointments with PCP and other appointments. The Care Model program refers members to an RN, behavioral health advocate or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The goals of the Care Model program are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, as measured 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 needs, measured by number of behavioral health care provider visits within identified time frames
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Health Plan Employer 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

Referring your patient

To refer your patient who is a UnitedHealthcare Community Plan member to Care Model, call **Provider Services** at **1-844-284-0146.**

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**.

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UnitedHealthcare Community Plan offers the following support services:

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

  Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

- **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**.

Enrollment Broker

DMAS contracts with an enrollment broker to help members with enrollment using a toll free member service helpline and website.

An enrollment broker is an independent broker (third-party vendor) who enrolls members in the health plan and who is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to, member education and enrollment, assistance with and tracking of member's grievance resolution, and may include member marketing and outreach.

Members may call the Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday–Friday, 8:30 a.m.–6 p.m. ET or go to the Cover Virginia website at virginiamanagedcare.com to apply or make changes to Medicaid enrollment. If members do not have coverage, they click on "Enroll."

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

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

Learn the differences by viewing the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient – and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

Application programming interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

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

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The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging in to 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** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi.**

Getting started

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

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

TrackIt Tool

TrackIt is an innovative tool on the portal that serves as your daily to-do list, your personal assistant and an automatic reminder of many of your UnitedHealthcare tasks. For more information, go to **UHCprovider.com/TrackIt**.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist™ integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs.

This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca.**

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal.**

You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling, submitting appeal requests, and finding copies of PRAs and letters in Document Library. All at no cost to you.

Provider Services

Provider Services at **1-844-284-0146** 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 decisions, 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 and/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**.

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

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

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **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**.

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

- Manage overpayments in a controlled process
- Create a transparent view between you and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Run 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 members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable network facilities or arrangements with a network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

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How to contact us

*We no longer use fax numbers.

Topic	Contact	Information
Behavioral health / Provider Express	**providerexpress.com** **1-877-614-0484**	
Benefits	**UHCprovider.com/benefits** **1-844-284-0146**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization/EviCore	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Phone line is available Monday-Friday, 7 a.m.–7 p.m. ET. Prior authorization numbers represent the specific procedure requested and are valid for 45 calendar days from the date they are issued.
Care provider education	**UHCprovider.com/news** **1-844-284-0146**	
Care provider manuals	**UHCprovider.com/guides** **1-844-284-0146**	
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-844-284-0146**	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the UnitedHealthcare Provider Portal at **UHCprovider.com/claims** **1-844-284-0146** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402 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.

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Topic	Contact	Information
Claim overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal, then select the UnitedHealthcare Online app. **1-844-284-0146** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Credentialing	Medical: Network Management Support Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Chiropractic: **myoptumhealthphysicalhealth.com**	
Dental services	CardinalCare Smiles Adult Dental Benefit FAQs or CardinalCare Smiles Fact Sheet Locate a CardinalCare Smiles Dental Provider at DentaQuest.com 1-888-912-3456	Dental services are provided by CardinalCare Smiles and DentaQuest. Available Monday–Friday, 8 a.m.–6 p.m. ET.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	epsdt@dmas.virginia.gov 1-800-234-1448	
Early Intervention Services for children with disabilities ages 0–3	itcva.online 1-800-234-1448	
Electronic Data Intake (EDI) issues EDI Transaction Support Form	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues.
Eligibility	**UHCprovider.com/eligibility** **1-844-284-0146** DMAS Provider Portal	Confirm member eligibility.

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Topic	Contact	Information
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.
Ethics and compliance help center	**1-844-359-7736**	Report unethical, unlawful or inappropriate behavior by a UnitedHealthcare Community Plan employee.
Fraud, waste, and abuse (payment integrity)	mfcu_mail@oag.state.va.us **Payment integrity information: UHCprovider.com/vacommunityplan** > Integrity of Claim, Reports, and Representations to the Government **Reporting: uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430**	Learn more about our payment integrity policies. Notify us anonymously of suspected fraud or abuse on the part of a provider or member. The Medicaid Fraud and Abuse Complaint Form is available online at: oag.state.va.us > Programs & Outreach > Medicaid Fraud.
General care provider assistance	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.	
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network**	The Preferred Lab Network webpage provides a full listing of eligible labs.
Medicaid-Virginia Department of Medical Assistance Services (DMAS)	dmas.virginia.gov 1-855-242-8282	Contact VA Medicaid directly.
Virginia Department of Medical Assistance Services (DMAS)	vamedicaid.dmas.virginia.gov/provider	Medical Assistance (DMAS) for Medicaid provider manuals and Medicaid guidance memos.
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** for more information. **1-844-752-9434** Most care providers in your state must submit reconsideration/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. Once final adjudication of a claim is complete, providers can appeal within 30 days.
Member handbook	**UHCCommunityPlan.com/va** > Community Plan > Member benefits	

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Topic	Contact	Information
Member Services	**myuhc.com®** **1-844-752-9434**	Assist members with issues or concerns. Available Monday-Friday, 8 a.m.–8 p.m. CT.
Mental health and substance abuse (including mental health services and addiction recovery treatment services)	**providerexpress.com** **1-844-284-0146**	
Multilingual/ telecommunication device for the deaf (TDD) services		Available Monday-Friday, 9 a.m.–6 p.m. ET, except state-designated holidays.
National plan and provider enumeration system (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management support	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.	Self-service functionality to update or check credentialing information.
News and bulletins	**UHCprovider.com/news** **1-844-284-0146**	
NurseLine	**1-800-842-3014**	Available 24 hours a day, 7 days a week.
Obstetrics and baby care	Healthy First Steps ® **uhchealthyfirststeps.com** **1-800-599-5985** Pregnancy notification form at **UHCprovider.com**. Go to the UnitedHealthcare Provider Portal.	For pregnant members, contact Healthy First Steps by calling or filling out the Pregnancy Notification Form.
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**. **1-855-819-5909**	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.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications that go through the pharmacy benefit and require a prior authorization per the Virginia Preferred Drug List (PDL).

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Topic	Contact	Information
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** (Optum Rx®)	Optum Rx oversees and manages our network pharmacies.
Prior authorization requests and advance admission notification of health services	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/priorauth** • Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call **1-844-284-0146**	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/vacommunityplan > Prior Authorization and Notification** Do not use this prior authorization information for prescriptions.
Provider advocate	Hospital/Medical Providers: Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Skilled Nursing Facilities: virginia_snf_pra@optum.com Home- and Community-Based Services: va_hcbs_pr@uhc.com	
Provider directory	**UHCprovider.com/findprovider** **1-844-284-0146**	
Provider grievance	1-804-371-8488 After exhausting appeals/grievances to the Virginia Health Plan, submit appeal/ grievance to DMAS at: Office of Appeals Hearings, Department of Medical Assistance Services (DMAS) Appeals Division - 600 E Broad Street Richmond, VA 23219	Ask for an appeal hearing in writing at this address. You must exhaust appeals with us before appealing to DMAS.
Provider Services	**UHCprovider.com/vacommunityplan** **1-844-284-0146**	Available Monday-Friday, 7 a.m.–5 p.m. CT.
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.

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Topic	Contact	Information
Referrals	**UHCprovider.com/referrals** **1-844-284-0146**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/vacommunityplan** > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Resource library	**UHCprovider.com/resourcelibrary**	
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus**. **1-866-209-9320** for Optum support	Technical support
Training	**UHCprovider.com/training** **1-844-284-0146**	
Transportation (SafeRide)	SafeRide Provider Portal **1-888-462-6049** (Reservations) **1-888-462-6049** (Ride Status/Will-Call) TTY **711**	Call to schedule transportation. To arrange non-urgent transportation, please call 5 business days in advance.
UnitedHealthcare Dual Complete	**UHCprovider.com/VA** > Medicare > **Virginia Dual Complete® Special Needs Plans** **1-844-284-0146**	
UnitedHealthcare CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
UnitedHealthcare Provider Portal	For chat options and contact information, visit **UHCprovider.com/contactus**. New users: **UHCprovider.com/access** **1-844-284-0146**	
UnitedHealthcare Provider Portal support	For chat options and contact information, visit **UHCprovider.com/contactus**.	

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Chapter 2: Care provider standards and policies

General care provider responsibilities

Non-discrimination

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

Communication between care providers and members

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

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care.

To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

Educate members, and/or their representative(s) about their health needs.

1. Share findings of history and physical exams.
2. 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.
3. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
4. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

Coordination of care tips

At the initial session, discuss what coordination of care is and invite your patient to ask any questions they may have about the process.

Engage and inform your patient about the importance and benefits of coordinating their care with other health care professionals.

Complete a coordination of care (COC) form with the member within a week of your initial assessment and **annually** thereafter.

Provide the appropriate assessment information to other treatment professionals, with the appropriate permissions and releases on file.

Request that the other treating professional provide you with relevant clinical information, including medical, mental health or substance use treatment they are providing. Document all actions in the patient progress notes, including if the patient declined to allow coordination of care.

Important concepts in integration: Coordination of care

Provide official notice

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

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

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

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care.

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This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

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

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 us to reactivate a TIN.

Changing an existing TIN or adding a care provider

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

Enrollment with Medicaid agency

Care providers must be screened, enrolled and periodically revalidated in the department's Medicaid Enterprise System (MES) Provider Services Solution (PRSS) in accordance with the following:

42 CFR §438.602(b)

42 CFR §438.608(b)

42 CFR §455.100-106

CFR :: 42 CFR Part 455 Subpart B -- Disclosure of Information by Providers and Fiscal Agents

42 CFR §455.400-470

CFR :: 42 CFR Part 455 Subpart E -- Provider Screening and Enrollment], and Section 5005(b)(2) of the 21st Century Cures Act

PUBL255.PS (govinfo.gov)

Medicaid Provider Enrollment Compendium (MPEC)

This rule applies to all care provider types and specialties, including:

- Billing
- Rendering
- Ordering
- Prescribing
- Referring
- Sponsoring and attending care providers

Enrollment with the state Medicaid agency is mandatory for continued contract participation and prior to finalization of new contracts.

Updating your practice or facility information

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

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

After-hours care

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

If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center. Members can find a list of participating urgent care centers in our care provider and pharmacy directories on **myuhc.com/communityplan**.

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.
You must provide timely responses to queries and/or completion of improvement action plans during quality-of-care investigations. UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions.

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This is determined by United States government agencies and professional specialty societies.

Provide access to your records

You must provide access to any medical, financial or administrative records related to 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 10 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.

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 9** for Medical Record Standards.

Inform members of advance directives

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

Dispute resolution

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if 1 of us remains dissatisfied, you may file for arbitration. If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

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If a member asks you to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the member handbook at **UHCCommunityPlan.com/VA**. Also, reference **Chapter 12** of this manual for information on Provider claim disputes, 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
- 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 (VA DMAS access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number – anytime
- Emergency care – immediately or referred to an emergency facility
- Urgent care appointment – within 24 hours
- Routine care appointment – within 30 calendar days
- 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

Long-term services and supports

LTSS must be made available as soon as the member's condition requires and within no more than 5 days from the contractor's determination that coverage criteria is met.

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Behavioral health services

Behavioral health appointments must be made available as expeditiously as the member's condition requires and within no more than 5 days from the Contractor's determination that coverage criteria is met.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

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

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

Provider directory

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

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

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

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

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

To help ensure we have your most current information:

- **For delegated providers** – submit changes to your designated submission pathway
- **For non-delegated 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 provider data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services**. If you have received the upgraded My Practice Profile and have editing rights, access the My Practice Profile in the **UnitedHealthcare Provider Portal** to make many of the updates required in this section.

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

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services and/or medication. Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

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

- Verify eligibility using the UnitedHealthcare Provider Portal at **UHCprovider.com/eligibility** or by calling **Provider Services**. 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.

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

Decision time frames

Standard – As soon as the member's health condition requires, not to exceed 7 calendar days following the request for service, with a possible extension of up to 14 additional calendar days if the member or the provider requests extension.

Expedited – As soon as the member's health condition requires and no later than 72 hours (3 calendar days) after the request for service, with a possible extension of up to 14 additional calendar days if the member requests extension.

If you have questions or problems connecting to the UnitedHealthcare Provider Portal, please call the UnitedHealthcare Web Support chat options and contact information, visit **UHCprovider.com/contactus**. Monday-Friday, 8 a.m.–10 p.m. ET.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Sentinel event requirements

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

Report sentinel events to the health plan immediately upon identification.

Critical Incident Reporting Form

critical_incidents@uhc.com

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

Specialists include internal medicine, pediatrics, or obstetrics/gynecology

PCPs are an important partner in the delivery of care, and VA Department of Medical Assistance Services (DMAS) members may seek services from any participating care provider. The VA DMAS 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 anytime 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 must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer Service is available Monday-Friday, 8 a.m.–8 p.m.

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We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process. Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. The coverage will include anytime availability. During non-office hours, access by phone 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. A recorded message directing the member to go to an emergency department for potentially emergent conditions is acceptable.

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service (FFS) if provider serves only Medicaid beneficiaries. Care provider will make covered services available 24/7 when medically necessary.
- Be available to members by telephone anytime
- 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

Specialists 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
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services or our clinical or pharmacy departments, as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards

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- Comply with the VA DMAS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual.

Primary care provider checklist

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

Risk arrangements

We are required to disclose care provider incentive arrangements when requested. The purpose of this is to allow the Commonwealth of VA to monitor us since we hold care providers at "substantial financial risk." In addition, we are required to give this information to current and potential members, if requested.

The information we give describes the plan's general arrangement, not specific to any care provider. Please respond promptly to our requests for information.

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 and/or social worker
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the VA DMAS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. Or PCPs 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.

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

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

Ancillary care provider responsibilities

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

UnitedHealthcare Community Plan participating ancillary 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.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
- Identify and bill other insurance carriers when appropriate

Prenatal care responsibilities for Virginia Medicaid members

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

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. Advise and test pregnant members for HIV unless the member refuses.

Include refusal documentation in the member's medical record. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.

Resources for care providers:

Behavioral Health Toolkit for Medical Providers Toolkit includes:

HEDIS® Best Practices for Primary Care and Screening Tools for behavioral health disorders

Clinical and Quality Measures Toolkit for Behavioral Providers

The 2025 PATH Reference Guide for all HEDIS Measures (including BH)

Interacting with capitated/ delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare ("capitated organization"). If your patient is assigned to 1 of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

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

What is delegation?

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

We may delegate:

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

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

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

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

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

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

Key principles:

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

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Chapter 3: Care provider office procedures and member benefits

Member benefits

UHCCommunityPlan.com/va > View Medicaid Plans or **UHCprovider.com/eligibility** for more information.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically by signing into the UnitedHealthcare Provider Portal at UHCprovider.com.

Each month, we monitor PCP panel sizes via PCP-to-member ratio reports. When a PCP's panel nears the max limit, we remove it from auto-assignment. PCPs must notify the state at 85% capacity. To update 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 Community Care Roster has member contact information, clinical information to include HEDIS® measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use **Report Center** for member contact information in a PDF at the individual practitioner level.

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

Choosing a primary care provider

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

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

If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Deductibles/copayments

The General Assembly ended FAMIS copays on July 1, 2022. There are no Medicaid or FAMIS copays except for LTSS members with a patient pay amount and FAMIS members who opt for a brand-name drug instead of a generic. Go to the **Balance Billing** section of the provider manual for more information

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. Medically necessary health care services or supplies are medically appropriate and:

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

Member assignment

Assignment to UnitedHealthcare Community Plan

VA DMAS 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. VA DMAS 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 information on how to access the **Community Plan Member Handbook.**

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The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the member handbook online by contacting **UHCCommunityPlanVA**. Go to Member Resources > Member Handbook.

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 **Provider Services** at **1-844-284-0146**.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with VA DMAS Cardinal Care Medicaid program. The VA DMAS determines program eligibility. An individual who becomes eligible for the VA DMAS Cardinal Care program either chooses or is assigned to 1 of the VA DMAS-contracted health plans

Member ID card

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

If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the Fraud, waste, and abuse hotline.

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

Sample health member ID card

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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 VA DMAS Medicaid Number is also on the member ID card.

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**
- **Provider Services** is available Monday-Friday, 8 a.m.–6 p.m. ET
- Virginia Medicaid Enterprise System

Pregnant women using Medicaid

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

Please advise members to enroll the newborn as soon as possible using the enrollment website at virginiamanagedcare.com or by calling the helpline at 1-800-643-2273.

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 for pregnant women using Medicaid

Ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

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

UnitedHealthcare Dual Complete

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

For information about D-SNP, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. For state-specific information, go to **UHCprovider.com/VA** > Medicare > **Virginia Dual Complete® Special Needs Plans**.

Covered benefits

Covered benefits are services provided by UnitedHealthcare Community Plan, the Department, or its contractor. Generally, covered benefits should be rendered by a contracted (or in-network) care provider. If the member receives services from a non-contracted provider, we provide an opportunity for the non-contracted provider to become contracted with UnitedHealthcare. If the care provider chooses to remain non-contracted, the care manager works with the member and our participating care providers to transition services. All services rendered by a non-contracted provider require case management authorization. Medicare members may access any Medicare-approved care provider without authorization.

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Chapter 4: Medical management

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

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. Coverage for hospice services is based on medical necessity. A service authorization is not required for hospice services; however, the Health Plan must establish the level of care needed in order for hospice services to begin.

The Health Plan will enter the hospice admissions and discharges into the Virginia Medicaid Web Portal no later than 2 business days of notification of the admission/discharge from the provider.

Home hospice

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

Respite hospice

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

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting.

Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

VA DMAS covers residential inpatient hospice services. VA DMAS will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Members who elect hospice benefits while enrolled in fee-for-service will not be enrolled into managed care. However, a managed care-enrolled individual who subsequently enters a hospice program will remain enrolled in managed care.

LTSS: If a member enters a hospice program while enrolled in the LTSS program, the member will remain enrolled in LTSS for those services.

Family planning

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

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

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

Non-covered items include:

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

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

Parenting/childbirth education programs

- Childbirth education is covered
- Parenting education is not covered, however, HFS staff can assist in linking parents/family with a Community Based Organization that provides these services

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 VA DMAS Regulations for more information on sterilization.

Sterilization and hysterectomy procedures for Virginia Medicaid members

Reimbursement for sterilization procedures is based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the VA DMAS must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date.

If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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

You may also find the form on the VA Department of Social Services website dmas.virginia.gov.

Have 3 copies of the consent form:

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

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Maternity/pregnancy/well-child care

Doula services

The Department of Medical Assistance Services (DMAS) now offers a community doula services benefit for Medicaid members. A recommendation by a licensed practitioner is required for your patient to access these benefits.

UnitedHealthcare Community Plan of Virginia has expanded maternity benefits for members. Coverage includes the cost of doula services for birth parents in community-based, prenatal, labor and birth and postpartum settings. To initiate the benefits, a licensed health care professional (obstetrician, primary care physician or specialist) must recommend doula services by submitting a referral form (at no charge to the member) to the Virginia Department of Health.

To learn more, go to Community Doula Program.

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 (HFS) program.

Care providers should complete a Virginia Obstetrical Risk Assessment Form (OBRAF) for their pregnant United Healthcare Community Plan of Virginia patients.

Complete the OBRAF on-line by signing in to the **UnitedHealthcare Provider Portal**

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
- Provide 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 health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit For Life tobacco program
- Help identify and build the mother's support system, including referrals to community resources and pregnancy support programs
- Program staff act as a liaison between members, care providers and UnitedHealthcare for care coordination

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the 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 3 obstetrical ultrasounds per pregnancy. The member is only allowed the fourth and later obstetrical ultrasound procedures if identified as high-risk member.

High-risk member claims must include the corresponding diagnosis code.

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

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

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

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

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for cesarean 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.**

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

Hospitals are encouraged to facilitate newborn enrollment Newborn Eligibility Notification Form or the Medicaid provider web portal at dmas.virginia.gov.

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 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.

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

Post-discharge/partum care for Medicaid/ Family Access to Medical Insurance Security members

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. 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 post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule. We also cover lactation consultation and breast pumps as part of post-discharge care.

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members. UnitedHealthcare Community Plan will provide coverage for newborns for the entire birth month plus 2 additional consecutive months, regardless of whether the newborn receives a Medicaid ID number. If the member changes the newborn's enrollment during the "birth month plus 2" period, the new MCO will provide coverage for the newborn. In such cases, the former MCO is not responsible once the newborn is enrolled into another MCO.

Coverage for the newborn during the "birth month plus 2" period is not contingent on the parent's continued enrollment with UnitedHealthcare Community Plan.

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We will cover the newborn even if the parent does not remain enrolled after the MCO newborn's date of birth.

The hospital provides significant support to the enrollment process by providing required birth data at the time of admission. Please advise members to enroll the newborn as soon as possible using virginiamanagedcare.com or by calling the helpline at 1-800-643-2273.

Home care and all prior authorization services

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

Hysterectomies

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

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility. Find the form on the VA Department of Social Services at dmas.virginia.gov.

See "Sterilization consent form" section on next page for more information. Exception: VA DMAS does not require informed consent if:

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

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

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member's primary care provider. Members must use the UnitedHealthcare Community Plan care provider network. No funds shall be used to perform, assist, encourage or make direct referrals for abortions.

Neonatal intensive care unit case management

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

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

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

Inhaled nitric oxide

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

Oncology

Prior authorization

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

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Virginia Medicaid members ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

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

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

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

Non-emergency medical transportation

Non-emergency medical transportation services (NEMT) are available for eligible members through the transportation broker SafeRide. Transportation is provided by taxi, van, stretcher van, sedan, mass transit, wheelchair-equipped vehicle, non-emergency ambulance or transportation network company (TNC).

For non-urgent appointments, members must call for transportation at least 5 business days before their appointment. Online requests can be made online anytime at **uhc.member.saferidehealth.com** or by phone at

- SafeRide: **1-888-462-6049**
- UnitedHealthcare Virginia Medicaid Reservations – **1-888-462-6049**
- UnitedHealthcare Virginia Medicaid Ride Status/Will Call – **1-888-462-6049**

Rides may be scheduled up to 30 days in advance.

Members using SafeRide must call Monday-Friday, 7 a.m–7 p.m. ET to schedule transportation. If they have questions about their order, they may call SafeRide.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Stress echocardiograms

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

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

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

Request prior authorization:

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

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

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Care management program

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

The program goals are to:

- Assess and address social determinants of health by linking to services/supports
- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care management by collaborating with providers to improve member outcomes
- Supportive chronic disease education and self management
- Support member empowerment and informed decision-making
- Effectively manage their condition and comorbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

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

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

Long-Term Services and Supports waiver

The LTSS waiver covers a range of community support services offered to:

- Older adults
- Disabled individuals
- Chronically ill or severely impaired individuals who have lost a vital body function and who need substantial and ongoing skilled nursing care

The individuals may require admission to a nursing facility, prolonged stay in a hospital or specialized care nursing facility. Individuals in this waiver are eligible to participate in the LTSS program.

The waiver covers the following services for qualifying members:

- Adult day health care
- Assistive technology
- Environmental modifications
- Personal Care Support Services
- Personal emergency response system and medication monitoring
- Respite care
- Services facilitation
- Private duty nursing
- Transition services

Dental services

Covered

Visit CardinalCare Smiles for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. The Virginia DMAS offers comprehensive dental services for adult Medicaid members. Visit Cardinal Care Virginia's Medicaid Program > Members > Benefits and Services > Dental to learn more.

Facility services require a prior authorization.

The following services are covered for children younger than 21 years, pregnant women and members in FAMIS until age 19:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)

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- Restorative
- Oral and maxillofacial surgery
- Endodontics

For more details, go to dentaquest.com/state-plans/regions/virginia.

CardinalCare Smiles for Children program

The CardinalCare Smiles for Children program provides dental services for children younger than 21 and pregnant women. Services for children include diagnostic, preventive, restorative/surgical procedures and orthodontia.

For pregnant women, coverage includes:

- X-rays
- Examinations
- Cleanings
- Fillings
- Root canals
- Gum-related treatment
- Crowns, bridges, partials and dentures
- Tooth extractions and other oral surgeries
- Other appropriate general services

Orthodontic treatment is not included for pregnant women. The dental coverage ends 60 days after the baby is born.

Durable medical equipment

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

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

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

Emergency care resulting in admissions

Emergency services do not require prior authorization.

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

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

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, etc.). The criteria are available in writing upon request or by calling Provider Services.

For policies and protocols, go to **UHCprovider.com/resources** > Health Plans, Policies, Protocols and Guides > For Community Plans.

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

Emergency/urgent care services

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

Covered services include:

- Hospital emergency department room, ancillary and other care by in- and out-of-network care providers
- Medical examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services
- Emergency ground and air transportation

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- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage and cyst removal

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

Prior notification is not required for emergency 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.

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

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

The treating care provider may continue with care until the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

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

This applies whether the member receives emergency services in or outside their service area.

Urgent care (non-emergent)

Urgent care services are covered. For a list of urgent care centers, contact **Provider Services**

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

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.

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

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

Prescription drug coverage

We have an extensive pharmacy program, including a Prescription Drug List (PDL) and pharmaceutical management procedures. This list applies to all UnitedHealthcare Community Plan of Virginia members.

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

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

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Prescriptions requiring prior authorization

To request a pharmacy prior authorization, including injectable drugs, call **1-800-310-6826.** Prior authorization forms are located on our website at **UHCprovider.com/priorauth** > Clinical and specialty pharmacy > Community Plan Prior Authorization Forms > **Virginia Community Plan Prior Authorization Forms.**

Review the UnitedHealthcare Community Plan Prescription Drug Lists, go to **UHCprovider.com/vacommunityplan** > Pharmacy Resources and Physician Administered Drugs to verify if prior authorization is necessary. You should request a prior authorization before giving our member a prescription that requires prior authorization. We make prior authorization determinations within 24 hours of receiving all the necessary information.

Generic drugs

Generic drugs are given, when available, as required by state mandatory generic substitution regulations. Generic drugs are approved by the Food and Drug Administration (FDA) as equivalent to their brand name counterparts. If a generic drug is available, a brand-name drug will not be provided to the member. In some cases, the brand-name drug may be preferred over its generic equivalent.

Brand-name drugs

If a brand name is needed based on medical necessity, prior authorization is required.

Pharmacy benefit exclusion

Certain drugs are not covered by the pharmacy benefit.

Existing UnitedHealthcare Community Plan members may continue taking a medication not on the formulary if:

- Member is enrolled in UnitedHealthcare Community Plan (unless the medication has been deemed unsafe)
- You provide medical rationale to support continued use
- You have consulted with and received approval from the member

A member may change to a medication on the UnitedHealthcare Community Plan formulary only if you and the member agree on the change.

Members new to therapy are required to use a medication on the formulary, unless otherwise authorized.

Day supply dispensing limitations

Members may receive up to a one-month supply (34 days) of medication per prescription order or refill. Members may reorder or refill a medication after using 90% of controlled substance medications or 85% of all other medications. If submitting a refill before then, the claim will reject with a “refill too soon” message.

Quantity limitations

We have quantity limitations on medications indicated with “QL” next to the medication name on the PDL. Per state and Plan regulations, certain quantity limits may apply. These include prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.

We recognize a number of patient-specific variables must be taken into consideration when drug therapy is prescribed. Overrides are available through the medical exception (prior authorization) process.

Emergency prescriptions

We allow for a 3-day emergency medication supply when a medication is needed without delay and prior authorization (PA) cannot be resolved within 24 hours. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the PDL or because they are subject to clinical edits.

A pharmacy may dispense a product packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

If you cannot be reached, or are unable to request a PA, the pharmacy may submit an emergency 72-hour prescription.

Specialty pharmacy medications

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

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

Drugs on the PDL that are part of this program are identified by a "SP" in superscript next to the drug name on the PDL.

Specialty pharmacy medications are available through our preferred specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth** > **Clinical Pharmacy and Specialty Drugs**.

To request pharmacy prior authorization, call the Optum Rx Pharmacy Help Desk at **1-800-310-6826**. We provide notification for prior authorization requests within 24 hours of request receipt

Prescription monitoring program

The Prescription Monitoring Program (PMP) is an electronic system to monitor the dispensing of Schedule II, III, IV and V controlled substance prescription drugs. It is established, maintained and administered by the Department of Health Professions. More information on the Virginia PMP is available on the Department of Health Professions website at dhp.virginia.gov.

Use information from the PMP about specific members to determine eligibility when completing prior authorization forms and to manage the care of the specific member participating in the Patient Utilization Management and Safety (PUMS) program.

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 approval 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** – **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 crosswalk table and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Sign In > Specific Radiology Programs.

Tuberculosis screening and treatment; direct observation therapy

Guidelines for tuberculosis screening and treatment (TB)and direct observation therapy (DOT) 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.

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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 contact UnitedHealthcare Community Plan.

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

Urgency	Type	Time frame	Extension
Urgent	Concurrent	72 hours (3 calendar days)	14 calendar days
	Pre-service	72 hours	14 calendar days
Non-urgent	Pre-service	7 calendar days	14 calendar days
Post-service	N/A	30 calendar days	14 calendar days

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Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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

Determination of medical necessity

Medically necessary services or supplies are those that are not considered experimental and are necessary to:

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

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

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Referral guidelines

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

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-844-284-0146**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services requiring prior authorization

For a list of services that require prior authorization, go to the Prior Authorization and Notification section at **UHCprovider.com/vacommunityplan**.

Direct access services – Native Americans

Services provided through tribal clinic provider types are carved out of this contract and reimbursed through FFS per the provider's agreement with the department.

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission –** 1 business day
- **Inpatient admissions; after ambulatory surgery –** 1 business day
- **Non-emergency admissions and/or outpatient services (except maternity)** – At least 14 business days if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time suited for the needed services.
  Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

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Utilization management guidelines

Call **1-844-284-0146** to discuss the guidelines and utilization management.

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

Utilization management appeals

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decision may file a UM appeal. See Appeals in **Chapter 12** for more details.

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid. FAMIS Children enrolled in the FAMIS program are not eligible for all EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO) in most parts of the state. Although FAMIS enrollees receive well-child visits, they are not eligible for the full EPSDT treatment benefit. The EPSDT diagnostic and treatment benefit is available to FAMIS Fee-for-Service enrollees.

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

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

Early Intervention Services

Early Intervention Services provide early intervention services to infants and toddlers with disabilities and their families.

Referral

Refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. Provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, contact the local lead agency for evaluation and early intervention services. After contacting the local lead agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Continuity of care

Support the development of the Individualized Family Service Plan (IFSP) developed by the local lead agency and its providers. The assigned coordinator will help the local lead agency and you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP. UnitedHealthcare Community Plan provides member case management and care management to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Intervention Program, with your participation. Contact your local lead agency at infantva.org or Infant and Toddler Connection of Virginia at 1-800-234-1448

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

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

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

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Lead screening/treatment

Lab directors must report all detectable lead blood levels for Virginia Medicaid enrollees under 21 years old to the local health department within 3 days. Lead reportable levels, consistent with 12VAC 5-90-10, means any detectable blood level in children 15 years old and younger, and levels greater than or equal to 5 µg/dL in a person older than 15 years of age. Providers are required to report children's blood levels that are equal to or exceed 5 µg/dL using the EP-1 form located on the VDH website. In addition to required health department reporting, children with elevated blood lead levels will be offered enrollment in a UnitedHealthcare Care Coordination Program. Please call Member Services at **1-844-752-9434** to refer a member to our Care Coordination Program whenever you discover a patient under 21 years old with an elevated blood level.

Case management

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

Case Management is a voluntary program and members may choose to opt out. Your support of the member and care manager during the process is valued and necessary for successful outcomes. Current focused programs under our Case Management include:

- Complex Case Management for members with emerging risk, high utilization or catastrophic event Chronic Condition Management
- Asthma
- Diabetes
- CHF/CAD
- COPD
- Cancer
- Childhood obesity
- Maternity case management
- NICU
- Children and youth with special health care needs, including children in foster care
- Behavioral health case management

You, on behalf of a member, may request participation in any of the programs. The care manager will work with you, the member and/or the hospital to identify the necessary:

- Intensity level of care management services and education needed
- Health care services required, including equipment and/or supplies
- Community-based services available
- Communication required between member and PCP/specialist

Virginia Medicaid: If you have identified a member who could benefit from any of our case management programs, refer members for case management by calling Member Services at **1-844-752-9434**.

All of our case management programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with high-risk or complex- health coordination needs. The program includes a holistic, member-centric care management approach that allows care managers to focus on multiple needs of member.

Program features:

- Proactive population identification processes and risk stratification
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, and compliance/surveillance
- Community or home visits and case/care management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status as needed

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Vaccines for Children program

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

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

Contact VFC if you have questions.
Phone: 1-800-219-3224
Fax: 1-573-526-5220

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; FAMIS excluded
- 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 an FQHC or RHC; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

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Adult vision enhanced benefit

We provide members with vision services that include:

- Exams for members 21 and older every 2 years
- Glasses (or medically necessary contact lenses) – 1 pair every 24 months; Replacement of glasses once per 2 years

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.

We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

1. Go to **myoptumhealthphysicalhealth.com**.
2. Enter your provider ID and password.
3. Click "Tools & Resources."
4. Click "Plan Summaries" or "Fee Schedules."

For more information on chiropractic care, go to **myoptumhealthphysicalhealth.com**.

Assistance for asthmatics

We offer hypoallergenic mattress covers and pillowcases that help reduce or eliminate dust mites. This benefit has a maximum value of $150 per calendar year. It requires a diagnosis of asthma and authorization of benefit qualification.

Please have the member call our Member Services number to begin the process **1-844-752-9434**.

Association for Training on Trauma and Attachment in Children ATTACh

Association for Training on Trauma and Attachment in Children (ATTACh) provides families and professionals with the necessary tools to improve the developmental, emotional and wellness outcomes in children and teens. This empowers them to do the work required to make a positive difference. Through continuing education credits, community resources, training and support, users can learn and enhance your ability to address and heal trauma and attachment issues. We offer parent and caregiver support as well as a virtual book club. For more information on the book club, visit ATTACh.org > portfolio-items > book-club.

Boys & Girls Club registration

Annual registration fee is covered by the Health Plan for the After School program. Excludes summer camps. The health plan will pay for multiple family members up to age 18.

Calm Health

Introducing Calm Health, a no-cost app that can help UnitedHealthcare Community Plan members boost mental health. Calm Health allows members to tap into a library of support – including meditation practices, mental health programs, exercises to improve focus, stress management content and more.

To access Calm Health, members should download the UHC app on the Apple App Store or Google Play Store. Sign in using their HSID and go to the "Benefits/ Coverage & Benefits" screen. Under "Additional Benefits," select the Calm Health tile to complete the free registration and get started.

Diaper Rewards

NEW Eligible new moms can receive up to 20 free packs of diapers (approximately 500 diapers) for the completion of prenatal and postpartum care visits. All eligible pregnant moms must complete their prenatal and postpartum care visits to qualify. Members can choose their preferred diaper size(s) via customized online portal. All diapers are shipped at 1 time to the member's home. Members should contact member services or work directly with their care managers to access the benefit.

Extracurricular sports physical

Healthy activities contribute to higher self-esteem, improved health and lower likelihood of childhood obesity. UnitedHealthcare Community Plan covers sports physicals for school-aged children up to 19 years of age.

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Extracurricular sports physical value add includes Athletic Training Evaluation, Athletic Training Reevaluation and examination for participation in sports.

Fotonovelas

Fotonovelas are an engaging, culturally competent way to educate the Latino population about subjects such as asthma, depression, diabetes, immunizations and obesity. Fotonovelas are Spanish comic book-like printed booklets. They can be understood by anyone with limited health literacy. This benefit has no service limits or authorization required. Members can find these booklets at community events or request them from their care coordinator.

Low-Cost free cellphone program

UnitedHealthcare members can qualify based on federal or state-specific eligibility criteria, including household income. Contact Member Services at **1-844-752-9434**. The member can also apply at assurancewireless.com/partner/buhc.

General education development GED certificate and support

Eligible members ages 18 years and older can receive

100% support and assistance with obtaining their general education development (GED) certificate through GED Works. This benefit includes GED assessment and prep courses with advisor coaching (online and telephonic support) to help members complete their GED exam. Members should call Member Services at **1-844-752-9434** for more information or visit https://app.ged.com/gedworks/UHCCPVA.

Healthy First Steps Rewards

Healthy First Steps® (HFS) Rewards is a specialized case management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine. Members self-enroll on a smartphone or computer. They can go to **uhchealthyfirststeps.com** and click on "Register" or call **1-800-599-5985.**

How it works

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

How you can help

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

Home-delivered meals

This program is available for members who are discharged following delivery of a baby, from an acute inpatient hospital stay or from a nursing facility back into the community setting.

They can receive nutritious prepared meals chosen from menus that support the management of many chronic conditions such as diabetes. After discharge, 14 meals are delivered to the member's home, enough to provide 2 meals per day for 7 days. Requests are coordinated through the member's care manager and reviewed by the medical director.

Housing application reimbursement

We offer gift card reimbursement to eligible members 18 years and older who submit housing applications.

Each eligible member is reimbursed $40 per housing application submitted, up to $80 per year, per covered member. Members should contact member services or their care manager for more information.

Menstrual equity support

UnitedHealthcare Community Plan provides free menstrual underwear to eligible members.

Eligible members will receive a period underwear box that includes:

- 2 sustainable and environmentally friendly, high-absorbency menstrual underwear
- Care instructions

Contact Member Services or the member's care manager for more information.

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Non-Emergency Medical Transportation - Social Trips

Our enhanced benefit includes up to 6 trips per 6 months to destinations that are not otherwise covered by Medicaid. This includes round trips to places of worship, gyms, Department of Motor Vehicles, grocery stores and Medicaid eligibility offices. No limits on rides to food banks, farmer's markets or Women Infants and Children appointments.

One Pass Fitness

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 **1-844-284-0146**.

UnitedHealthcare members ages 18 and up are eligible for free gym memberships to 300+ gyms and local YMCAs, as well as 14,000 free virtual fitness options. Members should call Member Services at **1-877 -504-6830** or visit YourOnePass.com to enroll.

Vaccination incentives Sticks for Kicks Plus!

UnitedHealthcare members up to age 18 who receive any of their CDC recommended immunizations can receive up to $100 to use at Footlocker® and/or Walmart™.

Members should call Member Services at **1-844-752-9434** for more information.

UHC Doctor Chat - virtual visits

Members have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for nonemergent care.
A board-certified emergency medicine physician assesses the severity of the enrollee's situation, provides treatment (including prescriptions) and recommends additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to expand and deliver access to care. Visit **uhcdoctorchat.com** for more information and to get started.

WW

UnitedHealthcare offers free WW (formally Weight Watchers®) meeting vouchers to qualified members who are age 18 and older.

Members must reach out to their assigned care manager directly to make the request.

Additional benefits

Consumer-directed services

Consumer-directed services are available for members who are eligible under the Long-Term Care Services HCBS Waiver. Eligible personal care and respite services may be provided by a health agency (known as agency-directed or AD services) or by a personal attendant hired by the consumer (known as consumer directed or CD services). CD services allow members to act as the employer in the self-direction of their personal care or respite services. This involves hiring, training, supervision and termination of self-directed personal care assistants.

Members selecting the CD services option work with their UnitedHealthcare Community Plan Care Manager to select a Service Facilitator. The selected Service Facilitator helps ensure the development and monitoring of the CD services Plan of Care, provides employee management training, and completes ongoing review activities as required by DMAS for CD personal care and respite services. The Service Facilitator works with the member's assigned Care Manager to help ensure alignment and compliance with the member's Plan of Care.

The selected Service Facilitator works with a Financial Management Service that manages the budgeted number of service hours established for members, processes timesheets submitted by personal care/respite workers, and pays these workers on the member's behalf. Members may change their selected Service Facilitator at any time.

NurseLine

NurseLine is available at no cost to our members at any time. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-800-842-3014** to reach a nurse.

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Smoking and tobacco cessation

Through the Virginia Department of Health, Quit Now Virginia provides free phone or online information and coaching to Virginians who want to quit smoking or using tobacco. Find more information on the Virginia Department of Health portal at vdh.virginia.gov > Tobacco Free Living > Quit Now Virginia. Individual and group smoking cessation counseling received from medical professionals is covered as well.

UHC Latino

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

Women, Infants, and Children Supplemental Nutrition program

Women, Infants, and Children Supplemental Nutrition program (WIC) provides federal grants for supplemental foods, health care referrals, transportation and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age 5 who are at nutritional risk.

Eligibility

- Pregnant women – as soon as there is a positive pregnancy test
- Women who have been pregnant within the previous 6 months
- Breastfeeding women
- Children younger than 5

Referral – Make referrals as a part of the initial health assessment of a pregnant, breastfeeding, or postpartum woman and children younger than 5.

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding 6-month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months.
- For infants younger than 9 months of age, height/length and weight dated within 60 days of enrollment and with each 6-month recertification call 1-877-835-5942 or visit vdh.virginia.gov/wic

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Chapter 7: Mental health and substance use

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

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

The Federal 21st Century Cures Act requires all providers, including servicing, ordering or referring providers, who serve Medicaid members through MCO networks to enroll directly with DMAS through the Medicaid Provider Services Solution (PRSS) Enrollment Portal.

UnitedHealthcare Community Plan provides mental health inpatient and residential managed care services and Addiction Recovery Treatment Services (ARTS). The ARTS program expands access to all levels of American Society of Addiction Medicine (ASAM) evidence-based addiction treatment for Medicaid enrollees in the Commonwealth of Virginia.

How to join our network: Credentialing information is available at **providerexpress.com** > **Our Network**.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians and PCPs offering behavioral health services. We provide information and tools for mental health and substance use diagnoses, symptoms, treatments, prevention and other resources in 1 place. **liveandworkwell.com**, accessed through a link on **myuhc.com**, includes mental health and well-being information plus articles on health conditions, addictions and coping. It also provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

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

Standard BH services:

- Acute inpatient hospitalization
- Electroconvulsive therapy (ECT)
- Psychological testing
- Individual and group outpatient therapy

Mental health services:

- Mental health case management
- Therapeutic day treatment for children (TDT)
- Day treatment/partial hospitalization for adults
- 23 Hour Crisis Stabilization
- Community Stabilization Services
- Assertive community treatment (ACT)
- Mental health skill building services (MHSS)
- Intensive in-home services
- Psychosocial Rehabilitation Services
- Psychotherapy for crisis
- Crisis Services: Mobile and Residential
- Applied Behavioral Analysis (ABA)
- Peer support services for adults
- Family Functional Therapy (FFT)
- Family support partners for youth
- Multisystemic Therapy (MST)
- Mental health intensive outpatient (MH-IOP)
- Mental Health Partial Hospitalization Program (MH-PHP)

Addiction recovery treatment services (ARTS):

- Peer support services
- Substance abuse case management services
- ASAM level 2.1 intensive outpatient services
- ASAM level 2.5 partial hospitalization services
- ASAM level 3.1 residential services
- ASAM level 3.3 clinically managed, population-specific, high-intensity residential services

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- ASAM level 3.5 clinically managed residential services
- ASAM level 3.7 medically managed inpatient treatment
- ASAM level 4.0 medically managed inpatient hospital treatment

Family Access to Medical Insurance Security (FAMIS):

A limited set of services are available for mental health and substance abuse for FAMIS enrollees.

Eligibility

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

Evidence-based clinical guidelines are available on **UHCprovider.com/vacommunityplan** > **Policies and Clinical Guidelines**.

Authorizations

Behavioral health authorizations

Urgency	Type	Time frame	Extension
Urgent	Concurrent	72 hours (3 calendar days.)	14 calendar days.
	Pre-service	72 hours (3 calendar days.)	14 calendar days.
Non-urgent	Pre-service	14 calendar days.	14 calendar days.
Post-service	N/A	30 calendar days.	14 calendar days.

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. All ARTS and MHS services require registration or authorization using a DMAS service-specific form. Ensure prior authorizations are in place before rendering non-emergent services.

Get prior authorization by going to **Prior Authorization and Notification for Behavioral Health** or calling **1-844-284-0146.**

Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:

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

Coordination of care among behavioral health clinicians and medical care providers improves the quality of patients' care. Individuals with mental health and substance abuse disorders frequently rely on multiple organizations and treatment professionals to provide their health care. Additionally, a significant number of people with serious medical conditions also have behavioral health conditions Effectively coordinating care between these treatment professionals can lead to improved health outcomes, result in reduced health care costs and benefit practitioners by enhancing networking with other professionals. Please talk to your patients about the benefits of sharing essential clinical information.

Coordination of care tips

At the initial session, discuss what coordination of care (COC) is and invite your patient to ask any questions they may have about the process.

Engage and inform your patient about the importance and benefits of coordinating their care with other health care professionals.

Complete a COC form with the member within a week of your initial assessment and **annually** thereafter.

Provide the appropriate assessment information to other treatment professionals, with the appropriate permissions and releases on file.

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Request that the other treating professional provide you with relevant clinical information, including medical, mental health or substance use treatment they are providing.

Document all actions in the patient progress notes, including if the patient declined to allow coordination of care.

For additional coordination of care information and resources, visit:

uhcprovider.com/en/resource-library/integration-coordination-of-care.html

public.providerexpress.com/content/ope-provexpr/us/en/about-us/coordination-of-care.html

Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools.

It's a one-stop shop for working with us more efficiently. Update your practice information, review guidelines and policies and view the national Optum Network Manual. Or call **Provider Services** at **1-844-284-0146**

Claims

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

Medication-assisted treatment

Medication assisted treatment (MAT) combines behavioral therapy and medications to treat substance use disorder including but not limited to opioid use disorder (OUD) and alcohol use disorder (AUD). The FDA-approved medications for OUD include buprenorphine, methadone and naltrexone.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT provider in Virginia:

1. Go to **UHCprovider.com/findprovider**.
2. Click on "Medical Care Directory."
3. Click on "Medicaid Plans."
4. Click on applicable state.
5. Select applicable plan.
6. Type "Medication Assisted Treatment" in the search bar and click "search."

We contract with Office Based Addiction Treatment (OBAT) Centers of Excellence (where available), which are designated as premier facilities to help ensure people with SUD stay in treatment and receive appropriate follow-up care and supports within their communities.

Optum Health Education BH 3-part training series one of which discusses MAT. **optumhealtheducation.com/primary-care-behavioral-health-2021**

If you have questions about MAT, call Provider Services at **1-844-284-0146**, enter your Tax Identification Number (TIN), then say "Representative," then "Representative" a second time, then "Something Else" to speak to a representative.

Monitoring audits

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

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

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Brief summary of framework

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

Increasing education and awareness of opioids

It is critical you are up to date on the cutting-edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on the 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 be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available through **optumhealtheducation.com**. 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** > Resources > **Drug Lists and Pharmacy.** Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns and member and care provider education is central to our strategy.

Patient Utilization Management and Safety program for members

UnitedHealthcare Community Plan of Virginia has established a Patient Utilization Management and Safety (PUMS) program to coordinate care and help ensure members are accessing and using services with all applicable rules and regulations. The PUMS program is a utilization control and case management program designed to promote proper medical management of essential health care. This program is intended to:

- Improve the quality of care for members
- Curb the abuse or misuse of controlled substance medications
- Reduce unnecessary physician utilization

Members enrolled in the PUMS program will be restricted to 1 or more of the following:

- The use of a single pharmacy
- Use of a specific PCP
- Use of a specific controlled substances prescriber
- Use of a specific hospital (for non-emergency hospital services only)
- On a case-by-case basis, other qualified provider type and the circumstances of the member

Once enrolled, members remain in the PUMS program for a period of 12 months. At the end of the 12-month period, the member is re-evaluated to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS program.

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Placement into the PUMS program may occur with any of the following trigger events:

- The specific utilization review of the member's past 12 months of medical and/or billing histories indicates the member may be accessing or using health care services inappropriately, or in excess of what is normally medically necessary
- Members with any history of opioid overdose(s) in the past 3 years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past 3 years; pregnant individuals with OUD; individuals with OUD with current or recent involvement (in the past 3 years) with the criminal justice system: must be evaluated for case management and referred as appropriate
- Clinical expertise and judgment must be used to identify and manage any members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster")

Minimum specifications include:

- Buprenorphine Containing Product: Therapy in the past 30 days – AUTOMATIC ENROLLMENT
- **PUMS2** High Average Daily Dose: > 90 morphine milligram equivalents per day over the past 90 days
- **PUMS3** Opioid and Benzodiazepines concurrent use: at least 1 opioid claim and 15 day supply of benzodiazepine (in any order)
- **PUMS4** Doctor and/or Pharmacy Shopping: > 3 prescribers OR > 3 pharmacies writing/filling claims for any controlled substance in the past 60 days
- **PUMS5** Use of a controlled substance with a history of dependence, abuse or poisoning/overdose: Any use of a controlled substance in the past 60 days with at least 2 occurrences of a medical claim for controlled substance abuse or dependence in the past 365 days
- **PUMS6** History of substance use, abuse or dependence or poisoning/overdose: Any member with a diagnosis of substance use, substance misuse or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past 60 days.*
- Medical care providers or social service agencies provide direct referrals to the Department or UnitedHealthcare Community Plan. If the member changes from another health plan to UnitedHealthcare Community Plan. *No prior claims in the previous 2 months or 60-day time frame.

Pharmacy lock-ins

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse and specific therapeutic categories with the potential for high abuse, (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Behavioral Health Toolkit for Medical Providers

Messaging for Primary Care on HEDIS® topics is available on Provider Express. Toolkit includes:

HEDIS Best Practices for Primary Care Screening Tools for behavioral health disorders

Clinical and Quality Measures Toolkit for Behavioral Providers

The 2025 PATH Reference Guide for all HEDIS® Measures (including BH)

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Chapter 8: Member rights and responsibilities

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

Privacy regulations

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

Access to protected health information

Members may access their medical records or billing information through 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 right and responsibilities

The following information is in the member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com**.

Native American access to care

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

General rights

Cardinal Care members have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability

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- Be treated with respect and consideration for their privacy and dignity
- Get information (including through the member handbook) about their health plan, provider, coverage, and benefits
- Get information in a way they can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way
- Get information from their provider and health plan about treatment choices
- Participate in all decisions about their health care, including the right to say "no" to any treatment offered
- Ask their health plan for help if their provider does not offer a service because of moral or religious reason.
- Get a copy of their medical records and ask that they be changed or corrected in accordance with State and Federal Law
- Have their medical records and treatment be confidential and private. UnitedHealthcare Community Plan will only release their information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Live safely in the setting of their choice. If they or someone they know is being abused, neglected, or financially taken advantage of, call their local DSS or Virginia DSS at 1-888- 832-3858. This call is free.
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, UnitedHealthcare Community Plan, or the Department
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- File appeals and complaints and ask for a State Fair Hearing
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example)

General responsibilities

Cardinal Care members have some responsibilities. These include the responsibility to:

- Follow the member handbook, understand their rights, and ask questions when they do not understand or want to learn more
- Treat their providers, UnitedHealthcare Community Plan staff, and other members with respect and dignity
- Choose their PCP and, if needed, change their PCP
- Even though providers cannot bill members for missed appointments, members should be on time for appointments and call their provider's office as soon as possible if they need to cancel or if they are going to be late
- Show their Member ID Card whenever they get care and services
- Provide (to the best of their ability) complete and accurate information about their medical history and their symptom
- Understand their health problems and talk to their providers about treatment goals, when possible
- Work with their care manager and care team to create and follow a care plan that is best for them
- Invite people to their care team who will be helpful and supportive to be included in their treatment
- Tell UnitedHealthcare Community Plan when they need to change their care plan
- Get covered services from UnitedHealthcare Community Plan's network when possible
- Get approval from UnitedHealthcare Community Plan for services that require a service authorization
- Use the emergency room for emergencies only
- Pay for services they get that are not covered by UnitedHealthcare Community Plan or the Department
- Report suspected fraud, waste, and abuse

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

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care
- Follow care to which they have agreed
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible
- Participate in decisions regarding their health care, including the right to refuse treatment directly or through an advance directive
- Be free from any restraint or seclusion
- Free exercise of rights if they do not adversely affect the way UnitedHealthcare Community Plan or our care providers treat the member

Surveys

VA DMAS requires an annual member satisfaction survey. Members are polled to determine satisfaction with:

- Their care manager
- Customer service
- Network availability/service provision
- Member materials

A survey or focus group may be conducted with members who are non-English speaking, or have physical disabilities or are part of a minority ethnic group.

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Medical record charting standards

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

Topic	Standards
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a 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**
Procedural elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

***Critical element**

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

***Critical element**

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

***Critical element**

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Member record

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

Medical record review

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

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies, initialed by PCP to indicate review
- Consultation and abnormal studies, including follow-up plans

Member hospitalization records should include, as appropriate:

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

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Chapter 10: Quality management program and compliance information

What is the Quality Improvement program?

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

The program consists of:

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

Cooperation with quality-improvement activities

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

- Providing requested timely medical records
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Completing practitioner appointment access and availability surveys
- Allowing the plan to use your performance data
- Offering Medicaid members, the same number of office hours as commercial members (or not restricting office hours you offer Medicaid members

Care provider satisfaction

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

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

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **UHCprovider.com** > Coverage and payments > Policies and Protocols > Clinical Guidelines 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 VA statutes and the National Committee of Quality Assurance (NCQA).

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The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

Health facilities

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

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

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

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

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Peer review

Credentialing process

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

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards.

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

Performance review

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

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NMRT 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 NMRT representative provided.

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

UnitedHealthcare representative will be in touch with you within 2 business days from when we receive your request.

Confidentiality

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

Resolving disputes

Contract concerns

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

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

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

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

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

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

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Health Insurance Portability and Accountability Act compliance - your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program.

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The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

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

Reporting and auditing

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

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

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

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

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with 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. Report any unethical, unlawful or inappropriate activities by any employee to the Ethics and Compliance Help Center at **1-844-359-7736**.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the Commonwealth of VA 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 VA Department of Medical Assistance 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.

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Records must be kept for at least 10 years from the close of the VA 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 VA program standards.

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

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

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

Delegating and subcontracting

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

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and service (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to ensure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

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

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

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Chapter 11: 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 UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

Claims process from submission to payment

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

If you think we processed your claim incorrectly, please see the **Claims reconsiderations, appeals and grievances** chapter in this care provider manual for next steps.

National Provider Identifier

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

If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services**.

Your clean claims must include your NPI and federal TIN.

Virginia Medicaid provider identification number

All care providers serving Medicaid members are required to apply for participation in the Medicaid fee-for-service program and obtain a provider identification number. Future claims submitted by providers without this ID may be rejected. Once you have received your Medicaid care provider ID, please give it to us for your record.

To apply for participating care provider status with the Commonwealth of Virginia go to: dmas.virginia.gov/for-providers.

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

Fee schedule

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

Modifier codes

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

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Medicaid ID. UnitedHealthcare Community Plan prefers you bill with the member ID.

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Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

Clean claims have:

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

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

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians.

Care provider coding

UnitedHealthcare Community Plan complies with 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 UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies**. Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

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

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

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

Electronic data interchange companion documents

UnitedHealthcare Community Plan’s electronic data interchange 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**.

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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), Electronic Funds Transfers (EFTs).

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

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

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for Automated Clearing House (ACH)/ direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose Automated Clearing House/ direct deposit?

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

What does this mean to you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now.

  If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form

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

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

Completing the UB-04 form

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

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

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person seeks care.

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In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary care provider or hospital.

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

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

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

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

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

Form reminders

- Note the attending 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 provider's NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Coordination of benefits

Our benefits contracts are subject to coordination of benefits (COB) rules: We coordinate benefits based on the member's benefit contract and applicable regulations.

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

Hospital and clinic method of billing professional services

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

Global days

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

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

Correct Coding Initiative

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

Comprehensive and component codes

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

- **Separate procedures:** Only report these codes when performed independently

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

Clinical Laboratory Improvements Amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

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

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

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

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Provider Services

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

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

Allow Provider Services 45 days to solve your concern.

UnitedHealthcare Provider Portal

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

Resolving claim issues

View the **appeals and grievances grid** for submission information. Allow up to 30 days for UnitedHealthcare Community Plan to process payment for initial claims and adjustment requests.

For paper claims

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

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

Timely filing

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

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

They 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 clam is considered late billed. It will be denied timely filing.

Unless otherwise specified in your contract, UnitedHealthcare Community Plan must receive all information necessary to process your claims no more than 365 days from the date of discharge from a facility; or 365 days from the date services are rendered to the UnitedHealthcare Community Plan LTSS or Virginia Medicaid enrollee. Any claims received after this time may be rejected for payment at UnitedHealthcare Community Plan's discretion.

UnitedHealthcare Community Plan will pay claims for health services in accordance to the contractual agreement.

Balance billing

Do not balance bill members if:

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

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. Members do not have a cost share other than the established patient pay amount for certain members receiving LTSS. You may balance bill the member for noncovered services if the member provides written consent prior to getting the service.

If you have questions, please contact your care provider advocate. If you don't know who your care provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT.

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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, you may then submit the claim 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.

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Chapter 12: Claim reconsiderations, appeals, and grievances

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your Provider 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 **UHCproviders.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

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

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Provider contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	• Member • Care provider on behalf of a member with member's written consent • Member's authorized representative (such as friend or family member) with written member consent	**UnitedHealthcare Community Plan** Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-844-284-0146**	N/A	Member appeals must be received within 60 days of the adverse benefit determination. Members must exhaust appeal rights with UnitedHealthcare prior to appealing to DMAS Appeals Division.	Expedited appeals We will respond within 72 hours. Standard appeals = 30 days.
Member grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider on behalf of a member with written member consent • Member's authorized representative (such as friend or family member) with written member consent	**UnitedHealthcare Community Plan** Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-844-284-0146**	dmas.virginia.gov/appeals	N/A	90 calendar days from receipt of the grievance.
Care provider claim resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care Provider	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5240	**1-844-284-0146**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**.	For network providers: timely filing limit is based on the contract. For out-of-network providers: If claim is submitted 12 months after services rendered, then the claim is denied. Resubmitted claims will be accepted within 365 days of the date of service or within 180 days from the last PRA date within 365 days of the date of service, whichever is later.	30 business day.s

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Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Provider contact phone number	Websites (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider		**1-844-284-0146** Provider Services can create reconsideration requests to send to the rework team.	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.**	For network providers: timely filing limit is based on the contract. For out-of-network providers: If claim is submitted 12 months after services rendered, then the claim is denied. Reconsiderations are accepted within 365 days from the date of service or 180 days from the last time the claim was processed, whichever is later.	45 business days.
Care provider claim Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider		**1-844-284-0146**	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.**	30 days from last adverse determination.	60 business days. Providers must exhaust appeal rights with UnitedHealthcare prior to appealing to DMAS Appeals Division.
Provider appeal hearing	A health plan review after all UnitedHealthcare reviews have been used.	Care Provider	Department of Medical Assistance Services (DMAS) Appeals Division 600 E Broad Street Richmond, VA 23219	1-804-371-8488	N/A	30 days from the Virginia Health Plan final internal appeal determination notification. Care providers must exhaust appeal rights with UnitedHealthcare prior to appealing to DMAS Appeals Division.	

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

Denial

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

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

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

Other top reasons for denial include:

- **Duplicate claim** – This is 1 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** – Avoid claim denials for non-covered services using real-time verification
- **Time limit expired** – This is when you don't send the claim in time

Claim correction

What is it?

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

When to use:

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

How to use:

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

Additional information

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

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

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.

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When you send a reconsideration, please send additional support information.

When to use:

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

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

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

- Submit a 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

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.

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Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

If you prefer to mail a refund, send an overpayment return check or the Overpayment Refund/Notification form.

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

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

Where to send:

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

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-01-800

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

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter. We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Sample overpayment report

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

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

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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:

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

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

We have a one-year timely filing limitation to complete all steps in the reconsideration and appeal process. It starts on the date of the first EOB.

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.

You must exhaust your post-service claims appeal rights with UnitedHealthcare Community Plan of Virginia before submitting an informal appeal to DMAS. Once the internal appeal process is completed, you may submit an informal appeal within 30 days of the health plan's final appeal determination notice.

Provider Appeal Hearing

The Virginia Department of Medical Assistance Services (DMAS) has a system and portal to manage the appeals process – the Appeals Information Management System (AIMS). The AIMS portal allows Medicaid providers – and your patients with Medicaid – the convenience of filing an appeal, submitting documents, and monitoring the status of their appeal online throughout the process.

AIMS portal will handle the next level of appeal after you have exhausted your appeal with United Healthcare Community Plan of Virginia.

The AIMS portal is easy to use and includes step-by-step instructions to walk you through the entire appeals process.

DMAS has posted helpful resources online at https://www.dmas.virginia.gov/#/appealsresources to walk you through the AIMS system. Questions? Contact DMAS Appeals at 1-804-371-8488.

While you are encouraged to use the new AIMS portal, DMAS will continue to accept appeals by email, fax, mail and phone

1. **Electronically:** Online at https://www.dmas.virginia.gov/appeals or email to appeals@dmas.virginia.gov.
2. **By fax:** Fax your appeal request to DMAS 1-804-452- 5454.
3. **By mail:**

   Department of Medical Assistance Services (DMAS) Appeals Division
   600 E Broad Street Richmond, VA 23219

4. **Phone:** 1-804-371-8488, **TTY:** 1-800-828-1120.

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:

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

You may only file a grievance on a member's behalf with their written consent. See member appeals and grievances definitions and procedures.

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Member appeals and grievances definitions, and procedures

UnitedHealthcare Community Plan uses 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:

Makes a harmful determination or limits a requested service(s). This includes the type or level of service.

- 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:

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

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

How to use:

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

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

We must resolve an expedited appeal within 72 hours from when we receive it. We may request an extension to the response up to 14 calendar days if the following conditions apply:

1. Member makes a request for the health plan to extend the response time.
2. We request additional information and explain how the delay is in the member's interest.
3. DMAS grants the Health Plan an extension as it is in members best interest to obtain needed information.

If submitting an appeal on behalf of the member (via mail, or phone), the member needs to complete the Authorized Representative form or provide signed, written documentation indicating whom they are appointing to submit the appeal on their behalf.

A copy of the form is online at **providerforms.uhc.com**.

Member grievance

What is it?

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

When to use:

You may file a grievance as the member's representative.

Where to send:

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

We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance.

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State fair hearings

What is it?

A State Fair Hearing lets members share why they think VA Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 calendar days from the appeal resolution letter to ask for a hearing. At that point, they will be mailed a hearing form. Once they complete the form and send it back, we set a hearing date.

Providers must exhaust appeal rights with UnitedHealthcare prior to appealing to DMAS Appeals Division.

How to use:`

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

Department of Medical Assistance Services (DMAS)
Appeals Division
600 E Broad Street
Richmond, VA 23219

Email: appeals@dmas.virginia.gov

Appeals Information Management System (AIMS) Portal

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter

- A FAMIS member must exhaust our member appeals process before requesting an external review. They may send a written request to:

  KEPRO External Review
  2810 N. Parham Road, Suite #305
  Henrico, VA 23294

  - A member may also submit a written request on the KEPRO website at dmas.kepro.com and clicking on the external appeal link. The member must submit a request for external review within 30 days of the MCO's appeal decision.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
- Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or take part from home.

Processes related to reversal of our initial decision

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

1. As quickly as the member's health condition requires.
2. No later than 72 hours from the date UnitedHealthcare.

Community Plan receives the determination reversal. If the state fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services specified in the policy and/or regulation.

Fraud, waste, and abuse

Call the Fraud, Waste and Abuse line to report questionable incidents involving plan members or care providers. You may also file and track a report at **uhc.com/fraud**.

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.

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Find out how we follow federal and state regulations around false claims at **UHCprovider.com/vacommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

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

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Chapter 13: Care provider communications and outreach

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goals are to make it easier for you to work with us and to 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/vacommunityplan**: The UnitedHealthcare Community Plan of Virginia page has state-specific resources, guidance and rules.
- **Policies and protocols**: **UHCprovider.com/policies** > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols.
- **Social media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (Twitter)
- **Virginia health plans: UHCprovider.com/va** is the fastest way to review all of the health plans UnitedHealthcare offers in Virginia. To review information for another state, use the drop-down menu at **UHCprovider.com** > Administrative Guides and Manuals to select a state, then select the type of plan (commercial, Medicare Advantage, etc.), then review the specific plans offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

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View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

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

Submit your email address in 1 of the following ways:

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

Care provider office visits

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

Care provider manual

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

Find the following forms on the state's website at dmas.virginia.gov:

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

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Appendix

Central Region					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLES CITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
49	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		

Tidewater Region					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	1-800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK

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Northern/Winchester Region					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER

Charlottesville Western Region					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBERG		
540	CHARLOTTESVILLE	113	MADISON		

Roanoke/Alleghany Region					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
063	FLOYD	141	PATRICK		

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Southwest Region					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

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