2026 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Wisconsin

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United Healthcare® Community Plan

Welcome

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

Click the following links to access different care provider manuals

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

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

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-877-651-6677.**

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

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.

Table of contents

Chapter 1: Introduction 4

Chapter 2: Care provider standards & policies 14

Chapter 3: Care provider office procedures and member benefits 24

Chapter 4: Medical management 28

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/prevention 42

Chapter 6: Value-added services 44

Chapter 7: Mental health and substance use 47

Chapter 8: Member rights and responsibilities 50

Chapter 9: Medical records 53

Chapter 10: Quality management program and compliance information 57

Chapter 11: Billing and submission 64

Chapter 12: Claim reconsiderations, appeals and grievances 71

Chapter 13: Care provider communications & outreach 80

Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-877-651-6677**
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal**. New users: **UHCprovider.com/access**	
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal User Guide**	
One Healthcare ID support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	**1-855-819-5909**
Resource library	**UHCprovider.com/resourcelibrary**	

UnitedHealthcare Community Plan supports the Wisconsin Department of Health Services (DHS) goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

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

DHS will determine enrollment eligibility.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-877-651-6677**.

How to join our network

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

Already in network and need to make a change?

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

Approach to health care

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance with appointments with PCP and coordinating appointments, the Clinical Health Advocate (CHA) refers members to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs
- Education and support with complex conditions
- Tools for helping members engage with providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The goals of the Care Model program are to:

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

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **1-800-504-9660**, TTY **711**, or call our local referral line at 1-414-253-8022.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program.

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

- **Cultural competency training and education:** Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:**
  - We provide telephonic interpreter services at **1-844-866-8236** Monday–Friday, 8 a.m.–8 p.m. ET
  - You are responsible for arranging interpreter services for members
- **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, and also provide materials for visually impaired members

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our **UnitedHealthcare Provider Portal Digital Guide Overview Course**.
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, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

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

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

Electronic data interchange

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

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

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

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

Getting started

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

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

Point of Care Assist

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

UnitedHealthcare Provider Portal

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

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

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

Here are the most frequently used portal tools:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies information, go to **UHCprovider.com/claims.**
- **Prior authorizations and notifications** – Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth.**
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile** – View and update your care provider demographic data that UnitedHealthcare members see for your practice information, go to **UHCprovider.com/mypracticeprofile.**
- **Document Library** – Access available correspondence, 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 previous methods of letters, phone calls and spreadsheets.
It also helps:

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

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

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

Privileges

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

Provider Services

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

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer 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**.

How to contact us

**We no longer use fax numbers*

Topic	Contact	Information
Behavioral health mental health & substance abuse	Optum **providerexpress.com** **1-877-614-0484**	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-877-651-6677**	Confirm a member's benefits and/or prior authorization.
Care management/ disease management	**1-800-980-5192**	Refer high-risk members (e.g., asthma, diabetes, obesity).
Chiropractor care	forwardhealth.wi.gov **1-800-873-4575**	The state of Wisconsin covers chiropractic services. Members may get them from a Medicaid-enrolled care provider who accepts their ForwardHealth ID Card.
Claims	**UHCprovider.com/claims** **1-877-651-6677** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5290 Kingston, NY 12402-5290 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue - North Lobby Lake Katrine, NY 12449	Verify a claim status or get information about proper completion or submission of claims.
Claim overpayments	Sign in to **UHCprovider.com/claims** **1-877-651-6677** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.

Topic	Contact	Information
Dental	1-800-822-5353	Call for dental questions about your members in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee counties. The state of Wisconsin covers member benefits if outside of the listed counties.
Electronic data intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315** Optum Support number: **1-866-678-8646** (**1-866-OPTUM GO**)	Contact EDI Support for issues or questions
Eligibility	**UHCprovider.com/eligibility** **1-877-651-6677**	Confirm member eligibility.
Enterprise Voice Portal	**1-877-651-6677**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment integrity information: **UHCprovider.com/WIcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Healthy First Steps/ Obstetrics (OB) referral	**1-800-599-5985** **Pregnancy Notification Form** **uhchealthyfirststeps.com**	Refer pregnant members to this program.
Birth to 3 care coordination	Wisconsin Member Advocate Hotline **1-888-246-8140**	Care coordination for members enrolled in Birth to 3 years old.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network**	The Preferred Lab Network webpage provides a full listing of eligible labs.
Medicaid [Wisconsin Department of Health Services (DHS)]	dhs.wisconsin.gov 1-608-266-1865, TTY 711, or 1-800-947-3529	Contact Wisconsin DHS directly.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-877-651-6677** For further information on reconsiderations and appeals see the **Reconsiderations and Appeals interactive guide**.	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** **1-800-504-9660** / TTY **711** for help accessing member account	Assist members with issues or concerns. Available Monday-Friday, 7 a.m. –7 p.m. CT.
Multilingual/ Telecommunication Device for the Deaf (TDD) services	TDD **711**	Contact the Wisconsin member advocates to arrange TDD services for your members.
National Credentialing Center (VETTS line)	**UHCprovider.com**	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203 or TTY 1-800-692-2326 Mailing address: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059	Apply for a National Provider Identifier (NPI).
Network management	**1-877-362-3002**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat, with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.
NurseLine	**1-866-827-0806**	Available 24 hours a day, 7 days a week.
Obstetrics/Pregnancy and baby care	Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then Sign In to access the UnitedHealthcare Provider Portal. **1-800-599-5985** Babyscripts™ myJourney app To sign up, call **1-800-599-5985**.	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Members sign up for Babyscripts by visiting the Apple App Store or Google Play™ store on their smartphone and downloading the Babyscripts myJourney app.

Topic	Contact	Information
Oncology prior authorization	**UHCprovider.com/oncology** Optum **1-888-397-8129**	For current list of CPT codes that require prior authorization for oncology. Monday-Friday 7 a.m. –7 p.m. CT.
One Healthcare ID support center	Chat, with a live advocate, 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.
Personal care prior authorization	**1-855-821-4163**	Available Monday-Friday, 8 a.m. – 4:30 p.m. CT. Request prior authorization for personal care services (not available online).
Prior authorization/ notification of health services	**UHCprovider.com/priorauth** **1-877-651-6677**	Request authorization/notify of the procedures and services outline in the prior authorization/notification requirements section of this manual. Complete and current list of prior authorizations.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. Request authorization for specialty pharmacy (provider-administered drugs) dispensed at outpatient and inpatient hospital setting.
Prior authorization requests/advanced & admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online tool: **UHCprovider.com/priorauth** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." **1-877-651-6677**	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/WIcommunityplan**
Provider Services	**UHCprovider.com/WIcommunityplan** **1-877-651-6677**	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.

Topic	Contact	Information
Reimbursement policy	**UHCprovider.com/WIcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus**. **1-866-209-9320** for Optum support	Call if you have issues logging in to the UnitedHealthcare Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	MTM 1-866-907-1493	Share the state vendor (MTM) number with members needing transportation to and from health care appointments.
Utilization management	**Provider Services** **1-877-651-6677**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. To find more information on Community and State UM guidelines, go to **UHCprovider.com/protocols.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) Program	dhs.wisconsin.gov	The VFC Program provides public-purchased vaccines for eligible children at no charge to VFC-enrolled public and private care providers.
Vision services	1-800-638-3120	Contact MARCH Vision with questions about vision care services.
Website for Wisconsin Community Plan	**UHCprovider.com/WIcommunityplan**	Access your state specific community plan information on this website.

Chapter 2: Care provider standards & policies

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-877-651-6677**
General care provider assistance	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal.**	
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	
Provider Directory	**UHCprovider.com/findprovider**	

General care provider responsibilities

Non-discrimination

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

Communication between care providers and members

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

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

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

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

Provide official notice

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

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

5. Departure from your practice for any reason.
6. Closure of practice.

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

Transition member care following termination of your participation

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

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals. For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider.**

Administrative terminations for inactivity

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

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

Changing an existing TIN or adding a health care provider

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

Updating your practice or facility information

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

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

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Medical group records provided by EMR access will be available to UnitedHealthcare Community Plan 24 hours a day, 7 days a week. Records provided by electronic file transfer will be available to UnitedHealthcare Community Plan within 24 hours of the request.

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. You may view protocols at **UHCprovider.com/protocols**.

Office hours

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

Protect confidentiality of member data

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

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

Follow medical record standards

Please reference **Chapter 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.

Wisconsin law allows persons 18 and older to execute an advance directive. An advance directive is a legal document established before an incapacitating illness or injury. A Power of Attorney for Healthcare and a Living Will are advanced directives.

UnitedHealthcare Community Plan encourages all members to have a written advanced directive and doesn't discriminate in providing care for members who execute an advance directive, nor against care providers who have policies or beliefs which prohibit them from honoring certain advance directive requests. UnitedHealthcare Community Plan requires you to document in the member's medical record even if the member does not have an advance directive.

Your Agreement

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

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Any arbitration proceeding under your Agreement will be conducted in Wisconsin under the auspices of the American Arbitration Association, as further described in our Agreement. For more information on the American Arbitration Association guidelines, visit their website at adr.org.

Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member's Handbook at **UHCCommunityPlan.com/WI** > **BadgerCare Plus**.

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

Mutual obligations - UnitedHealthcare and care provider professional conduct

Professional conduct

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

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

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

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

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

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

Appointment standards (Wisconsin DHS access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week

- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- HealthCheck (EPSDT) Members less than 1 year old must be provided a HealthCheck screening within 30 days. For members age 1-21, provide a HealthCheck Screening within 60 days.
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for routine appointments within 30 working days of request/referral.

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 calendar days of identification of high risk

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

Provider directory

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

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

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

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

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

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

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

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

Care provider attestation

Confirm your provider data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-877-651-6677**. If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

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

Prior authorization request

Prior authorization request is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, 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 ,** or by calling **Provider Services** at **1-877-651-6677.** Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice
- Get prior authorization from the **UnitedHealthcare Provider Portal**:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In.
  2. Select the Prior Authorization and Notification app.
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

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

Specialists include internal medicine, pediatrics, or obstetrics/gynecology

Primary care providers (PCPs) are an important partner in the delivery of care, and Wisconsin Department of Health Services (DHS) members may seek services from any participating care provider. The Wisconsin DHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

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

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

Members may change their assigned PCP by contacting **Member Services** at **1-800-504-9660**.

Customer service is available Monday-Friday, 7 a.m.–7 p.m. ET.

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

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 availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

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

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

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

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs.
- Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards.
- Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the Wisconsin DHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call Provider Services at 1-877-651-6677
- Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required, or visit **UHCprovider.com/priorauth**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

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

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic (RHC), a federally qualified health center (FQHC) or a primary care clinic (PCC) as their PCP.

- **RHC:** 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.
- **FQHC:** 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
- **PCC:** 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 one 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 Wisconsin DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this manual
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week
  Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.
- Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

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

Prenatal care responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating care providers. Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the UnitedHealthcare Healthy First Steps coordinator.

If you have questions, call Healthy First Steps at **1-800-599-5985**.

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. 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.

Ancillary care provider responsibilities

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

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

Ancillary care provider responsibilities

Ancillary care providers include:

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call Provider Services at 1-877-651-6677
- 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

Managed care program

Care provider may:

- Educate and inform their patients about the HMO with which they contract
- Inform their patients of the benefits, services, and specialty care services offered through the HMO in which they participate
- Give a member contact information for a particular HMO, but only at the member's request
- Assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:
  - Apply online at the Access website: access.wisconsin.gov
  - Complete the online form at: dhs.wisconsin.gov/forms/F1/F10182.pdf
  - Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- May assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at forwardhealth.wi.gov, if they qualify
- Refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at 1-800-291-2002

Health Maintenance Organization may:

- Health Maintenance Organization (HMO) - conduct orientations, health fairs, or community baby showers for their members in a private setting at a care provider's office

Care providers are prohibited from:

- Recommending one HMO over another HMO
- Offering patients incentives to select one HMO over another HMO
- Assisting the patient in deciding to select a specific HMO incentives for the purposes of marketing and member materials are any form of financial compensation, including material items, travel or transportation reimbursement, childcare services, etc., offered to members or potential members

Interacting with capitated/ delegated groups

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

What is capitation?

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

What is delegation?

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

We may delegate:

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

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

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

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

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

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

Key principles:

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

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/wi**	**1-800-504-9660**
Member handbook	**BadgerCare+** **Medicaid SSI**	
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-877-651-6677**
Prior authorization	**UHCprovider.com/priorauth**	
D-SNP	**UHCprovider.com/wi** > Medicare > **Dual Complete Special Needs Plan**	

Benefits

Go to **UHCCommunityPlan.com/wi** 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 on the Provider Portal at **UHCprovider.com** then Sign In. Each month, we monitor PCP panel sizes via PCP-to-member ratio reports. When a PCP's panel nears the max limit, we remove it from auto-assignment.

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

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

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

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

Choosing a primary care provider

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the 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

UnitedHealthcare Community Plan does not charge BadgerCare Plus members copayments for many covered services. As a result, you no longer need to collect payment from UnitedHealthcare BadgerCare Plus members before providing treatment for the following services:

- All covered medical services
- All covered dental services in Milwaukee, Kenosha, Ozaukee, Racine, Washington and Waukesha counties

Federal law permits states to charge members a copayment for certain covered services. You are required to request copayments from members. You may not deny services to a Wisconsin Medicaid SSI or BadgerCare Plus member. For more information refer to **Chapter 11**.

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

Wisconsin DHS 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. Wisconsin DHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

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

Download a copy of the Member Handbook online by contacting **UHCCommunityPlan.com/wisconsin**. Go to Plan Details, then Member Resources, View Available Resource.

View the BadgerCare+ and Medicaid SSI member handbooks online.

Immediate enrollment changes

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

Get eligibility information by calling **Provider Services** at **1-877-651-6677**

Newborn enrollment (Medicaid)

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (if the mother was admitted using her ForwardHealth ID card).

If the mother delivers out-of-state, then this baby may not be identified to the city/state and thus not come onto UnitedHealthcare Community Plan in a timely manner. In this case, the Enrollment Department needs to contact the city/state after the birth notification is received and request the baby be added to the health plan.

The hospital significantly supports the enrollment process by providing required birth data at the time of admission.

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.

Unborn enrollment changes

Encourage your members to notify the Wisconsin DHS when they know they are expecting. DHS notifies Managed Care Organizations (MCOs) daily of an unborn when Wisconsin Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Wisconsin website to report the baby's birth. With that information, DHS 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 DHS when the baby is born.

Primary care provider selection

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections. UnitedHealthcare Community Plan Members can go to **myuhc.com/communityplan** to look up a care provider.

Member eligibility

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

Member ID card

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

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

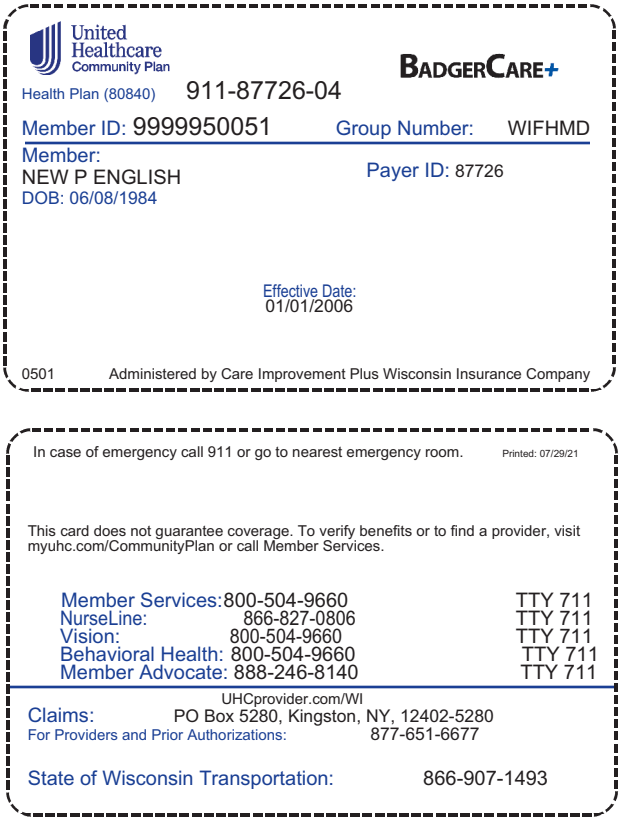
The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services**.

Also document the call in the member's chart.

Member identification numbers

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

Sample health member ID card



ForwardHealth card

The ForwardHealth card is the standard card issued to recipients who are eligible for BadgerCare Plus and Medicaid SSI. Possession of a ForwardHealth card does not guarantee eligibility. Recipients may become ineligible for Wisconsin Medicaid, only to regain eligibility at a later date. A recipient may present a card when they are not eligible; therefore, it is essential that you confirm eligibility before providing services. Wisconsin Medicaid encourages recipients to keep their cards even though they may have ineligibility periods.

If the card is lost, stolen, or damaged, Wisconsin Medicaid will replace the card at no cost to the recipient. If a family has more than 1 eligible recipient, each eligible family member receives a ForwardHealth card. Members enrolled in BadgerCare Plus or Medicaid SSI receive a ForwardHealth member identification card. Always verify a member's enrollment before providing non-emergency services to determine if there are covered service limitations and to obtain the correct spelling of the member's name.

Primary care provider - initiated transfers

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

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

   Mailing address:
   UnitedHealthcare Community Plan
   125 S. 84 Street
   Milwaukee, WI 53214
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

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

- ForwardHealth Portal: access the ForwardHealth portal through forwardhealth.wi.gov/WIPortal
- UnitedHealthcare Provider Portal: access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from Monday-Friday, 7 a.m. -5 p.m. CT

Benefit information

Find member benefit information online in the state Member Handbook at forwardhealth.wi.gov.

UnitedHealthcare Dual Complete

UnitedHealthcare Dual Complete Special Needs Plan (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about DSNP, go to: **uhc.com/medicaid/dsnp**.

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

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-877-651-6677**
Prior authorization	**UHCprovider.com/priorauth**	
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

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

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

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

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

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

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

Non-emergent ambulance transportation

UnitedHealthcare Community Plan members may get non-emergent stretcher/ambulance transportation services through the DHS NEMT manager for covered services. NEMT is arranged by MTM. Members may get transportation when they are bed-confined before, during and after transport.

Non-emergent stretcher/ambulance transportation must be requested at least 3 business days in advance. Call 1-866-907-1493.

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

Non-emergent stretcher/ambulance requests are accepted between 7:00 a.m. and 6:00 p.m. Call 1-866-907-1493.

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) services are arranged by MTM. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity. NEMT requests are accepted between 7 a.m. and 6 p.m.

Durable medical equipment

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

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

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, 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 water transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal

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

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

Emergency room care

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

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room 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 one 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 one 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 one of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-877-651-6677.**

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal at **UHCprovider.com/priorauth,** EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-877-651-6677**.

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 in writing upon request by contacting **Provider Services** at **1-877-651-6677**.

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

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

Family planning

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

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

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

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy **Note:** Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact the state of Wisconsin to verify state coverage.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

For more information about Voluntary Sterilization, view the ForwardHealth handbook, search 1584.

Care coordination/health education

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

The program goals are to:

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

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

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

Facility admission notification requirements

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

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

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger. For more information about hearing aid models, view the ForwardHealth handbook, search 2996.

Hospice

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

Home hospice

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

Respite hospice

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

Inpatient hospice

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

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

Laboratory

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

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive.

CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services. See **Chapter 11** for more information.

Maternity/pregnancy/ well-child care

Pregnancy Notification Risk Screening

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

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

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care 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 the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **Provider Services** at **1-877-651-6677** or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/WIcommunityplan** > Prior Authorization and Notification.

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

1. The 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.

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

Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or by calling **Provider Services** at **1-877-651-6677**.

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
- Gender
- Birth weight
- Gestational age
- Baby name

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

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

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

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

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

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her ForwardHealth ID card).

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

Bright Futures assessment

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

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

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care prior authorization

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

All home care services require the use of Electronic Visit Verification (EVV).

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 ForwardHealth Portal at forwardhealth.wi.gov.

Exception: Wisconsin DHS does not require informed consent if:

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

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

Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the woman's life.

In this case, follow the Wisconsin 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.

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

A member has only given informed consent if the Wisconsin Department of Health 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 Wisconsin 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 find the form by visiting our UnitedHealthcare Provider Portal at **UHCprovider.com/WICommunityPlan** > Provider Forms and References.

Have 3 copies of the consent form:

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

Neonatal Intensive Care Unit case management

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

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

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

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 **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

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 one or more of the following characteristics:

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

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**.

Personal care services

UnitedHealthcare Community Plan covers personal care services. Personal care services are medically oriented activities related to helping a member with activities of daily living so the member can stay in their place of residence in the community.

Personal care providers must comply with Electronic Visit Verification (EVV) guidelines as mandated by the Federal Century Cures Act. Find additional details in **Chapter 11**.

These services require prior authorization. Access by calling **1-855-821-4163**.

Radiology

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

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

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

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

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

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

Request prior authorization online or by phone at:

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

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

Screening, brief interventions, and referral to treatment services

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

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

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

Screening

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

Brief intervention

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

Referral to treatment

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

SBIRT services will be covered when all are met:

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

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

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

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

Medication-assisted treatment

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

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

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

To find a medical MAT provider in Wisconsin:

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. Refine the search by selecting "Medication Assisted Treatment."

If you have questions about MAT, please call **Provider Services** at **1-877-651-6677** and enter your Tax Identification Number (TIN). Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Tuberculosis screening and treatment; Direct Observation Therapy

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

Responsibilities

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment.

You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

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

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 go to **providerexpress.com**.

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

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

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

Concurrent review details

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

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

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

UnitedHealthcare Community Plan uses InterQual (formally MCG 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, skilled nursing facilities, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member
- Not experimental treatments

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

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

Referral guidelines

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

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity 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**, then Sign In, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Wisconsin Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-877-651-6677.**
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs
  - Long-term care services in a nursing home
  - Intermediate care facilities for members with mental handicap

  - Home- and community-based waiver services
  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
  - Residential inpatient hospice services
  - Community-based Rehabilitation Services/County-based mental health programs (CCS, CSP and crisis intervention)
  - Behavioral treatment
  - Targeted case management
  - Residential substance use disorder treatment
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services
- Chiropractic
- Prenatal care coordination (PNCC)
- Targeted case management

Services requiring prior authorization

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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

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

Utilization management guidelines

Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** to discuss the guidelines and utilization management.

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

Utilization management appeals

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

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

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

Key contacts

Topic	Link	Phone number
HealthCheck (EPSDT)	forwardhealth.wi.gov	1-800-947-3529
Vaccines for Children	dhs.wisconsin.gov	1-608-267-9959

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members 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. For questions, call **Provider Services** at **1-800-947-9627** or go to forwardhealth.wi.gov.

The Wisconsin Birth to 3 Program

The Wisconsin Birth to 3 Program provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families. UnitedHealthcare Community Plan has to coordinate health care services with the Birth to 3 Program.

Referring a child - Refer a child to Birth to 3 services if the child has a visual, hearing, or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

How to refer - Contact dhs.wisconsin.gov/birthto3/contacts.htm.

Next steps - The Birth to 3 team will evaluate your request to determine eligibility, then a service coordinator will be assigned to help the child's parents through the process.

The assigned coordinator from Birth to 3, who is employed by the state, will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the Individualized Family Service Plan (IFSP). UnitedHealthcare Community Plan provides member case management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

Interperiodic Screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded Healthy Children and Youth Program (HCY) services.

Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

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

Lead screening/treatment

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

Targeted case management

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

Identification – The 5 target populations include:

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

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

Vaccines for children program

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

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

Contact VFC if you have questions. Phone: 1-608-267-9959, Email: VFC@dhs.wisconsin.gov or DHSImmProgram@dhs.wisconsin.gov.

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

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from a FQHC or RHC. They cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-877-651-6677**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value added services	**uhccommunityplan.com/wi** > Plan details	**1-877-651-6677**

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 **1-877-651-6677** unless otherwise noted.

Babyscripts

Pregnant members can sign up for Babyscripts™ by visiting the Apple App Store or Google Play™ store on their smartphone and downloading the Babyscripts myJourney app. Babyscripts engages members in a variety of methods (app notifications, email, and text messages) and provides daily education on important topics that are specific to pregnancy stages. Members will also receive appointment reminders for recommended doctor visits and can earn up to 3 Walmart Healthy Living gift cards for completing important prenatal and postpartum visits.

How You Can Help

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

Members sign up for Babyscripts by visiting the Apple App Store or Google Play™ store on their smartphone and downloading the Babyscripts myJourney app.

Chronic condition management

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

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

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

Referral – PCPs may make referrals to support practice-based interventions by contacting the Health Services team:

- Call **1-800-980-5192**
- Email **wi_caid_prov_ref@uhc.com**

Dental services

Covered

All dental services are covered in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee counties. If the member lives outside of the above counties, benefits are covered by the state of Wisconsin and may have a $0.50 to $3.00 copayment per service.

Early intervention program

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

Mental health and substance use resources for members and clinicians

Substance use disorder helpline

Callers have direct access to a licensed behavioral health clinician/specialized Substance Use Recovery Advocate (SURA) who can provide assistance and provide referrals. Helpline staff are trained specifically in substance use disorder (SUD) and clinical assessment and can provide immediate help for callers by encouraging treatment that is local to the caller's home. Staff help the caller understand the nuances of a complex health care system; the benefits of in-network, community-based services; the importance of evidence-based care and community resources available to them. Callers can choose to be "authenticated" if they are a UnitedHealthcare/ Optum Behavioral Health benefit holder. Those who authenticate can learn even more about their specific benefit, referrals to treatment and receive case management follow-up. Callers who do not have health insurance can be referred to state and local resources to assist in receiving insurance. Callers do not have to have UnitedHealthcare or Optum Behavioral Health coverage. Callers can use the helpline to seek help on behalf of themselves, a friend or loved one.

The SUD helpline is a free, anonymous resource available 24 hours a day, 7 days a week for anyone who is seeking help for themselves or a loved one.
1-855-780-5955

Calm Health

Calm Health is a self-directed digital solution for member mental health and wellbeing. This solution combines evidence-based digital clinical programs with the sleep, meditation, and mindfulness content of Calm (the #1 app for sleep, meditation and relaxation).

The Calm Health app allows for on-demand, integrated support with no out-of-pocket costs for members

OptumHealth Education

Available at **OptumHealth Education**, this is a free tool that provides online resources and accredited training for providers across a number of physical and behavioral health topics.

Non-emergency transportation

Non-emergency transportation (NEMT) is available through the DHS NEMT manager. The NEMT manager arranges and pays for rides to covered services for members who have no other way to receive a ride. NEMT can include rides using:

- Public transportation, such as a city bus.
- Non-emergency ambulances.
- Specialized medical vehicles.
- Other types of vehicles, depending on a member's medical and transportation needs.

If a member uses their own private vehicle for rides to and from your covered health care appointments, you may be eligible for mileage reimbursement.

Members must schedule routine rides at least 2 business days before their appointment. Members can schedule a routine ride by calling the NEMT manager at **1-866-907-1493** or TTY **711**, Monday-Friday, 7 a.m. -6 p.m. Members may also schedule rides for urgent appointments. A ride to an urgent appointment will be provided in 3 hours or less. For non-urgent appointments, members must call for transportation at least 3 days before their appointment.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop
- Has an appointment less than half a mile from the bus stop

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-866-827-0806** to reach a nurse.

Quit for Life

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

UHC Latino

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

State-funded program

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

For more information about WIC:

- Well Badger Resource Center: 1-800-642-7837
- dhs.wisconsin.gov

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral Health/Provider Express	**providerexpress.com**	**1-877-614-0484**
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-877-651-6677**

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

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

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

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

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

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

Covered services

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

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

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

Benefits included through the UnitedHealthcare Community Plan:

- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric and day treatment programs
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy

  - Electroconvulsive therapy
  - Telemental health

Members have access to additional behavioral health benefits through Fee-For-Service.

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the **UnitedHealthcare Provider Portal** > Sign In.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care (day treatment only). Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, or by calling **1-877-651-6677**.

Collaboration with other care providers

Coordination of care

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

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

Please talk to your patients about the benefits of sharing essential clinical information.

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.

View the Prior Authorization list, find forms and access the care provider manual. Or call **Provider Services** at **1-877-651-6677** to verify eligibility and benefit information, available Monday-Friday, 8 a.m. -5 p.m. CT.

Website: **providerexpress.com**

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call **Provider Services** at **1-877-651-6677**.

Claims

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

Monitoring audits

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

Training resources and materials

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

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

Addressing the opioid epidemic

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

Brief summary of framework

- **Prevention:**
  - Prevent opioid use disorders (OUD) before they occur through pharmacy management, 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 & 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 our UnitedHealthcare Provider Portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com/pharmacy.** Click "Opioid Programs and Resources-Community Plan" to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization. For BadgerCare Plus, Wisconsin Medicaid, and SeniorCare members, visit forwardhealth.wi.gov for opioid prescription limits.

Pharmacy lock-in

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

Expanding medication assisted treatment access & capacity

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

To find a behavioral health MAT provider in Wisconsin:

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

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

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/wi**	**1-800-504-9660**
Member handbook	**UHCCommunityPlan.com/wi** > Community Plan > Member benefits	

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

Privacy regulations

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

Access to Personal Health Information

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

Amendment of Personal Health Information

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

Accounting of disclosures

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

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

Right to request restrictions

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

Right to request confidential communications

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

Member rights and responsibilities

The following information is in the Member Handbooks at the following links under the Member Information tab:

- **UHCCommunityPlan.com/WI** > BadgerCare Plus
- **UHCCommunityPlan.com/WI** > Medicaid SSI

Native American Access to Care

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

Member rights

Members have the right to:

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

Member responsibilities

Members should:

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

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

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

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

View the full list of UnitedHealthcare Community Plan of Wisconsin member rights and responsibilities in the Wisconsin Member handbooks at **UHCCommunityPlan.com/WI**.

Chapter 9: Medical records

Medical record charting standards

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

Topic	Contact
Confidentiality of record & record organization & office	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 • Have a policy that provides medical records timely upon request. Urgent situations require copies be provided within 48 hours. • Release of Information form that requires a patient signature • Maintain medical records in a current, detailed, organized, and comprehensive manner. The records should be: – In order – Fastened, if loose – Separate for each member – Filed in a manner for easy retrieval – Readily available to the treating care provider where the member generally receives care – Promptly sent to specialists upon request • Medical records are: – Stored in a manner that helps ensure privacy – Released only to entities as designated consistent with federal requirements – Kept in a secure area accessible only to authorized personnel • There is a mechanism to monitor and handle missed appointments

Topic	Contact
Procedural elements	**Medical records are legible*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language and/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 • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually. • Document the presence or absence of allergies or adverse reactions
History	History should include: • Medical and surgical history* • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history.
Preventive services	Preventive services should include: • Current and history of immunizations of children, adolescents, and adults • Annual comprehensive physical (or more often for newborns) • Documentation of mental & physical development for children and/or cognitive functioning for adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression in patients 12 and older – High-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise, and nutrition counseling for patients 12 and older • Evidence of tracking and referral of age and gender appropriate preventive health services • Use of flow sheets or tools or promote adherence to Clinical Practice Guidelines/ Preventive Screenings

Topic	Contact
Problem evaluation and management	Documentation for each visit includes: • **Appropriate vital signs** (Measurement of height, weight and BMI annually) • **Chief complaint*** • **Physical assessment*** • **Diagnosis*** • **Treatment plan***
Follow-up, test/labs, referrals and education	Treatment plans are consistent with evidence-based care and with findings/diagnosis: • Timeframe for follow-up visit as appropriate • Appropriate use of referrals/consults, studies and tests • X-rays and lab consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow up when abnormal results are detected • 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

***Critical element**

Member copies

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

Medical record review

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

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Comprehensive health and development 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.
- Family and social history (to include occupation)
- 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)
- Preventive screenings, including mental health and depression screening
- 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)

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**. Chiropractic: **myoptumhealthphysicalhealth.com**	
Fraud, waste, and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the quality improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

- Providing requested timely medical records
- 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

We require your cooperation and compliance to:

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

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts.

We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Provider Advisory Committee

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **Clinical Practice Guidelines (National) - UnitedHealthcare Community Plan** 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 Wisconsin statutes and the NCQA. The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse Midwives)
- C.R.N.P.s (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
- N.P.s and P.A.s who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

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

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

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

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

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

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

Peer review

Credentialing process

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

Recredentialing process

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

Performance review

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

Applicant rights and notification

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

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

Confidentiality

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

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

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

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, an arbitration proceeding may be filed as described in your Provider Agreement.

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

Covered entities must meet basic security measures:

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

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

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

Ethics & integrity

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

Compliance program

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

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

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

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office at **1-844-359-7736**.

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

To report questionable incidents involving members or care providers, call our Fraud, waste, and abuse hotline 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.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Wisconsin 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 Wisconsin Department of Health Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Wisconsin 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 one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

You must cooperate with the state or any of its authorized representatives, the Wisconsin Department of Health 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 service and care (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

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

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

Criteria for site visits

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

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

Chapter 11: Billing and submission

Key contacts

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

Our claims process

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

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare. 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

You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.

1. All claims are checked for compliance and validated.
2. Claims are routed to the correct claims system and loaded.
3. Claims with errors are manually reviewed.
4. Claims are processed based on edits, pricing and member benefits.
5. Claims are checked, finalized and validated before sending to the state.
6. Adjustments are grouped and processed.
7. Claims information is copied into data warehouse for analytics and reporting.
8. 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 NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-877-651-6677**.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

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

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

Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the 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 visit verification

Wisconsin DHS implements EVV for personal care services and home health care services.

UnitedHealthcare Community Plan requires personal care service and home health care services claims to have a matching EVV record; if there is no matching EVV record, the claim will be denied.

Services are considered verified by the DHS EVV system when all of the following information is captured:

- Service received
- Who provided service
- What and where service was provided
- Service date
- Service check in and check out times

Electronic claims submission and billing

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

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

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

Electronic data interchange companion documents

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

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

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

The companion documents are located on **UHCprovider.com.edi** > **EDI transaction and code sets.**

Clearinghouse and status reports

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

e-Business Support

Call **Provider Services** at **1-877-651-6677** for help with online billing, claims, Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to **Chapter 1** under Online Services. For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find Electronic Data Interchange menu.

Electronic payment solution: OptumPay

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

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

- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form

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

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

Completing the UB-04 form

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

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

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA).

In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

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

- 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
- 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

- If your contract rate is tied to the Medicaid fee schedule (i.e., 100% of Medicaid fees), you must bill your services on the claim form that is required by the state of Wisconsin Medicaid program. The use of any other form will result in denials or recoveries.
- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims

- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

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

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

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

You are required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to UnitedHealthcare Community Plan. If you are unable to obtain such reimbursement by reasonable means, submit supporting documentation indicating you have made at least 2 outreach attempts, at least 15 days apart.

Hospital and clinic method of billing professional services

Hospital 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
- **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 one 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 410-786-3531 or go to the CMS.gov.

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The Department of Health Services covers medically necessary, non-experimental transplants.

UnitedHealthcare Community Plan covers Cornea, heart, kidney, liver, lung, heart-lung, pancreas and pancreas-kidney transplant.

Get prior authorization for the transplants.

Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

UnitedHealthcare Community Plan does not cover bone marrow or stem cell transplants.

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 **Provider Services** at **1-877-651-6677** and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to **UHCprovider.com**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services at **1-877-651-6677** helps resolve claims issues. Have the following information ready before you call:

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

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

UnitedHealthcare Community Plan Provider Portal

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

UnitedHealthcare Provider Portal training course is available using the **UnitedHealthcare CommunityCare Provider Portal user guide**. You can also visit the ForwardHealth Portal at forwardhealth.wi.gov/WIPortal/ to check for member eligibility (you will need a login).

Resolving claim issues

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

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

For paper claims

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

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

Timely filing

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

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

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

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

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

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

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

Balance billing

UnitedHealthcare Community Plan contracted care providers are generally prohibited by the terms of their Agreement and Wisconsin state law from billing members for costs related to services they provide, other than any applicable copayment amount. For covered services, UnitedHealthcare Community Plan payment is considered payment in full. Do not balance bill members if:

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

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT.

Third-party resources

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

Chapter 12: Claim reconsiderations, appeals and grievances

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

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

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim resubmission *A resubmission of a claim is not a formal appeal.	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 5290 Kingston, NY 12402-5290	**UHCprovider.com/claims**	**1-877-651-6677**	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or **UHCprovider.com/claims**.	Must receive within 180 calendar days of the original remittance date.	30 calendar days.
Care provider claim reconsideration (step 1 of claim dispute) *A reconsideration of a claim is not a formal appeal.	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider		**UHCprovider.com/claims**	**1-877-651-6677**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**	Must receive within 60 calendar days of the original remittance date.	45 business days.
Care provider claim formal appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider		**UHCprovider.com/claims**	**1-877-651-6677**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations**. For further information on appeals, see the **Reconsiderations and Appeals interactive guide**	60 calendar days from the most recent remittance date or benefit determination letter.	45 calendar days.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131	**providerforms.uhc.com/ProviderAppealsandGrievance.html** AOR Consent Form on this site for member appeals.	**1-800-504-9660**		Standard appeals – 60 calendar days from the date on the adverse benefit determination notice.	Urgent appeals – we will respond within the lesser of 72 hours or 2 business days. Standard appeals – 30 calendar days.
Member grievance	An expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131		**1-800-504-9660**		N/A	30 calendar days.

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

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

Denial

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

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

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

When to use:

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

How to use:

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

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

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

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

Claim reconsideration (step 1 of dispute)

What is it?

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

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 supporting documentation

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** at **1-877-651-6677** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

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

- Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within 60 days or less of receiving notification of the overpayment or, if self-identified, within 60 days or less of your discovery of the overpayment. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

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

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

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

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

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

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

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

If you do not agree with the overpayment findings, submit a dispute within the required timeframe 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.

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.

Questions about your appeal or need a status update?
Call Provider Services for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone**: Call **Provider Services** at **1-800-587-5187** TTY **711**
  - Most care providers in your state must submit requests electronically

  - For those care providers exempted from this requirement, requests may be submitted at the below address:
- **Mail**: Send care provider name, contact information and your grievance to:

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

You may only file a grievance on a member's behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

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

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

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

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.

Toll-free: **1-800-587-5187** TTY **711** For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

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

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

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

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

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

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

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

Member grievance

What is it?

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

When to use:

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

Where to send:

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

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

State fair hearings

What is it?

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

When to use:

Members have 90 calendar days from the date of receipt of the health plan's notice of resolution.

How to use:

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

State of Wisconsin Division of Hearing and Appeals
Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875

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

Processes related to reversal of our initial decision

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

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

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

Fraud, waste and abuse

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

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

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

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

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

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

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

Chapter 13: Care provider communications & outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-877-651-6677**
News and bulletins	**UHCprovider.com/news**	
Care provider manuals	**UHCprovider.com/guides**	

Communication with care providers

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

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 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.
- **UnitedHealthcare Community Plan of Wisconsin page**: **UHCprovider.com/wicommunityplan** has resources, guidance and rules specific to Wisconsin. Be sure to check back frequently for updates.
- **Policies and protocols**: **UHCprovider.com/policies** > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Health plans by state**: **UHCprovider.com/wi** is the fastest way to review all of the health plans UnitedHealthcare offers in Wisconsin. To review plan information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) 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 allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the UnitedHealthcare Provider Portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal**. You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  - Bookmark **UHCprovider.com/news**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor- led sessions. View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication - required contact information

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

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
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 an ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to Profile & Settings, then Account Information, to manage your email.

Care provider office visits

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

Care provider manual

UnitedHealthcare Community Plan publishes this care provider 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 care provider manual by contacting **Provider Services** at **1-877-651-6677**.

State websites and forms

Find the following forms on the state's website at **UHCprovider.com** > Coverage and payments > Health plans > Wisconsin > UnitedHealthcare Community Plan of Wisconsin Homepage > **Provider Forms and References**:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

If you are a behavioral health provider or have questions about behavioral health policies and processes, please go to **providerexpress.com** or reference the National Network manual.