2021
Care Provider Manual

Physician, Health Care Professional,

Facility and Ancillary Louisiana

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United Healthcare Community Plan

Welcome

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

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to **UHCprovider.com**. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our

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

Important information about the use of this manual

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

This manual will be amended as policies change.

Participation Agreement

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

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.
- "You," "your" or "provider" refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide.
- Community Plan refers to UnitedHealthcare's Medicaid plan
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide.

- Any reference to "ID card" includes both a physical or digital card.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-675-1607
Training	UHCprovider.com/training	866-675-1607
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID	866-675-1607
Provider Portal Support	ProviderTechSupport@uhc.com	855-819-5909
Online Service Tools	UHCprovider.com > Menu > Resource Library>Online Service Tools	866-842-3278, option 1
Resource Library	UHCprovider.com > Menu> Resource Library	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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

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

The Louisiana Department of Health (LDH) will determine enrollment eligibility.

How to join our network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to UHCprovider. com/join. There you will find guidance on our credentialing process, how to sign up for self-service tools and other helpful information.

Already in network and need to make a change?

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

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call Provider Services at **866-675-**

Our approach to health care

Whole Person Care Model

The Whole Person Care (WPC) 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. WPC 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.
WPC 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 helps improve the health and well-being of the individuals, families and communities we serve. WPC 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.
- Engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Help with appointments with PCP and coordinating appointments. The community health worker refers members to an RN, behavioral health advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard- to-engage members.

The WPC goals 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 needs, measured by number of 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.

Compliance

HIPAA mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who handle business electronically.

Cultural competency resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **800-587-5187**, TTY 711. You may also call Provider Services at **866-**

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 240 non-English languages and hearing-impaired services are available. If a UnitedHealthcare Community Plan member needs interpreter services, we prefer care providers use a professional interpreter.
  - Use your phone's conference feature to place the member on hold.
  - To access a professional interpreter, call 866-874-3972. If you need help placing a call to the member, please inform the interpreter or agent at beginning of the call.
  - Enter your client ID 237724.
  - Press 1 for Spanish. Press 2 for all other languages, and state the name of the language you need. Press 0 for agent assistance if you do not know the language.
  - Enter provider NPI.
  - Enter member Medicaid Identification number.
  - You will be connected to an interpreter who will provide their ID number.
  - Brief the interpreter. Summarize what you wish to accomplish and provide any special instructions.
  - Add the LEP member onto the call.
  - Say "End of Call" to the interpreter when your call is completed.
- **Materials for limited English speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information on cultural competency, refer to the cultural competency library on **UHCprovider.com**. Also find details at:

- **cms.hhs.gov/ocr** – Supports the Office of Civil Rights.
- **LEP.gov** – Maintains importance of language access to federal programs and federally assisted programs.
- **diversityrx.org** – Promotes language and cultural competence to improve health care quality for minorities.
- **ncihc.org** – Advocates culturally competent health care.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses Interqual (formerly MCG) for medical care determinations.

Online resources

UHCprovider.com is your home for care provider information with access to Electronic Data Interchange (EDI), the UnitedHealthcare Provider Portal, online self-service tools, medical policies, news bulletins, and great resources to support administrative tasks including eligibility, claims, claims status and prior authorizations and notifications. Go to **Self Service For Self Service Tool** online training and information.

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' first choice for electronic transactions.

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

Provider Portal - secure care provider website

Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the portal, go to **UHCprovider.com** and click on the Sign in button in the upper right hand corner.
For more information about all the portal's tools, go to **UHCprovider.com** and sign in.

To access the Provider Portal, the secure care provider website, go to **UHCprovider.com** and either sign in or create a user ID. You will receive your user ID and

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnostic~~is~~, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box titled "what can we help you find?" on **UHCprovider.com**, and the search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our **UHCprovider.com** provider portal. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web

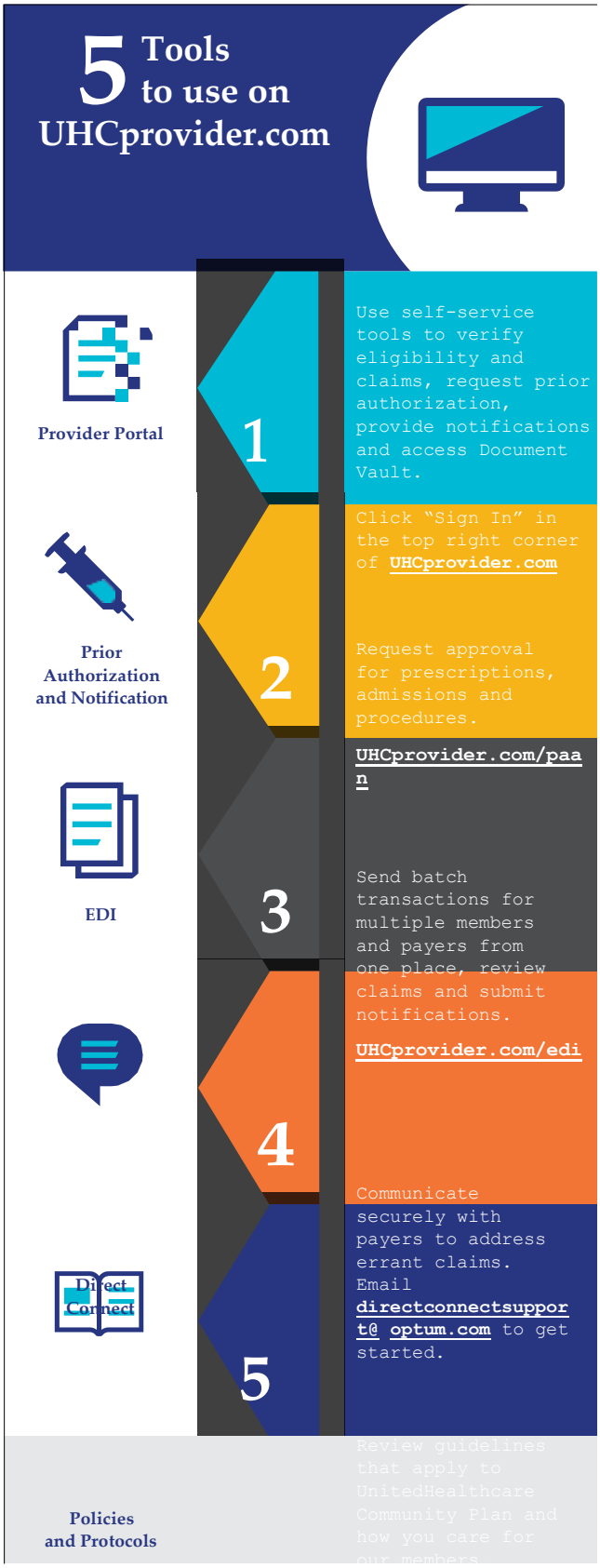
pages on **UHCprovider.com** by typing in that page's direct URL identified by a forward slash in the web address, e.g. **UHCprovider.com/claims**. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

To access the Provider Portal, go to UHCprovider. com, then Sign In.

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

- **Eligibility and Benefits** — View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider. com/claims**.
- **Prior Authorization and Notification** — Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty Pharmacy Transactions** — Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **uhcprovider.com/pharmacy** for more information.
- **My Practice Profile** — View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/ mypracticeprofile**.
- **Document Vault** — Access reports and claim letters for viewing, printing, or download. For more information, go to **UHCprovider.com/ documentvault**.
- **Paperless Delivery Options** — The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters when we add them to your Document Vault. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to Provider Portal One Healthcare ID password owners only.



Watch for the most current information on our self- service resources by email, in the Network Bulletin, or online at **UHCprovider.com/EDI** or the Provider Portal at **UHCprovider.com** then click Sign In.

For more instructions, visit **UHCprovider.com/Training**. Or check out the **Self Service Tools** for online self-service training and information.

Direct Connect

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

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

All users will access Direct Connect using the Provider Portal. On-site and online training is available.

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

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

Find more information about these tools and more at **UHCprovider.com** – your hub for online transactions, education and member benefit information.

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

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

How to contact us

**We no longer use fax numbers for most departments, including benefits, prior authorization and claims.*

Topic	Contact	Information
Applied Behavior Analysis (ABA)	Provider Services: 866-675-1607	Covered for members younger than 21 years who meet specific criteria.
Behavioral, Mental Health & Substance Use	Optum **providerexpress.com** 800-888-2998 (toll-free) 866-675-1607	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** 866-675-1607	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/ cardiology**. 866-675-1607	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Chiropractor Care	**myoptumhealthphysicalhealth.com** 800-873-4575	We provide members 21 years and older ~~than 21~~ with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the Provider Portal at **UHCprovider. com/claims** 866-675-1607 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Ask about a claim status or about proper completion or submission of claims. Also ask about behavioral claim disputes.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal. For information about your recoupment or overpayment request, call the customer service number in your letter. Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental – Adult	866-675-1607	For members age 21 years and older who have adult coverage provided by UnitedHealthcare Community Plan.
Dental – Members younger than 21 years old~~MCNA~~	MCNA: 855-701-6292 DentaQuest: 800-685-0143	For members younger than 21 years old - ~~. For~~ provider enrollment, direct deposit issues, reporting changes and ownership, NPI, etc.
Early Periodic Screening, Diagnostic~~is~~ and Treatment Personal Care Services (EPSDT-PCS), Pediatric Day Health Care (PDHC), and Private Duty Nursing (Extended Home Health)	Intake Department: 866-604-3267	Request prior authorization or notify us of the procedures and services outlined in the prior authorization/notification requirements section of this manual. If you need to speak to the case manager for a member already receiving these services, please call 800-377-5105.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at **UHCprovider.com/edi**.

Eligibility	To access eligibility information, go to **UHCprovider.com** then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility**. 866-675-1607	Confirm member eligibility.

Topic	Contact	Information
Enterprise Voice Portal	877-842-3210	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: website UHCprovider.com/LAcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** 800-455-4521 or 877-401-9430 800-455-4521	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online..
Laboratory Services	UHCprovider.com > Find Dr > **Preferred Lab Network** LabCorp: 800-833-3984 Quest Diagnostics: 866-697-8378	LabCorp and/or Quest Diagnostics are network laboratories.
Maternity Case Management	800-599-5985	
Medicaid Louisiana	**lamedicaid.com** 800-473-2783 or 225-924-5040	Contact Medicaid directly.
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at **UHCprovider.com** or go to **UHCprovider. com/claims** for more information. 866-675-1607 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31365 Salt Lake City, UT 84131-0364 Appeals mailing address: **Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	866-675-1607	Assist members with issues or concerns. Available 7 a.m. – 7 p.m. Central Time, Monday through Friday.

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	866-675-1607 TDD 711	Available 8 a.m. – 5 p.m. Central Time, Monday through Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Resource Team	**networkhelp@uhc.com** 877-842-3210	Self-service functionality to update or check credentialing information.
NICU/NRS	877-505-6245	
NurseLine	866-351-6827	Available 24 hours a day, seven days a week.
Obstetrics, Pregnancy and Baby Care	Healthy First Steps Pregnancy Notification Form at **UHCprovider.com**, then sign in to the Provider Portal.	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
One Healthcare ID Support Center	**providertechsupport@uhc.com** 855-819-5909	Contact if you have issues with your One Healthcare ID. Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services	**professionals.optumrx.com/** 877-305-8952 (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization / Notification for Pharmacy	UHCprovider.com/LAcommunityplan > **Prior Authorization and Notification** 800-310-6826 Prior authorization filed under the medical benefit: **UHCprovider.com** 866-604-3267	Request authorization for medications as required. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

Topic	Contact	Information
Prior Authorization / Notification of Health Services	**To notify us or request a medical prior authorization:** EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self- service available after hours) and select "Care Notifications." Or call 866-604-3267	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/ LAcommunityplan > **Prior Authorization and Notification**.
Provider Services	**UHCprovider.com/LAcommunityplan** 866-675-1607	Available 7 a.m. – 7 p.m. Central Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 866-889-8054	Request prior authorization or view a current list of CPT codes that require prior authorization.
Referrals	UHCprovider.com > Menu > **Referrals** Provider Services 866-675-1607	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	UHCprovider.com/LAcommunityplan > **Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Support	**ProviderTechSupport@uhc.com** 866-209-9320	Call this number if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/ smoking.
Transplants	800-418-4994	
Transportation	866-726-1472	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call two business days in advance. Call 844-525-2329 for hospital discharge non- emergency medical transportation.

Topic	Contact	Information
Utilization Management (Acute Inpatient)	Use the Prior Authorization and Notification application on the Provider Portal to upload medical notes or other attachments to your request.	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program. For UM Policies and Protocols, go to UHCprovider.com, then select **Policies and Protocols**.
Vaccines for Children (VFC) program	504-838-5300	Care providers must participate in the VFC Program administered by the Louisiana Department of Health (LDH) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with LDH to bill for the administration of the vaccine.
Vision Services	866-675-1607	Submit routine vision services claims to March Vision.
Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)	**Louisiana_CareManagement@uhc.com** Provider Services: 866-675-1607	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing. They may call Member Services for more information.
Website for Louisiana Community Plan	**UHCprovider.com/LAcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-675-1607
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	866-675-1607
Referrals	UHCprovider.com > Menu > Referrals	866-675-1607
Provider Directory	UHCprovider.com > Find Dr.	866-675-1607

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, 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 representatives may take part in the planning and implementation of their care. To help ensure

members and/or their representatives have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representatives 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 WPC 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.

Use the care provider demographic information update form to make demographic changes or to update NPI information for your office. This form on **UHCprovider.com** > Demographic/Profile Updates > **Care Provider Paper Demographic Information Update Form**.

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 services for a reasonable time at our in-network rate. Provider Services can 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 listing of network care providers and health care professionals, review our care provider and health care professional directory at **UHCprovider.com** > Find Pr...

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:

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 your Agreement. You may call us to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at UHCprovider.com > Demographic/Profile Updates > Care Provider Paper Demographic Information Update Form.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email address listed on the bottom of the demographic change request form.

Updating your practice or facility information

You can update your practice information through the Provider Data Management application on UHCprovider.com. Go to UHCprovider.com > Demographic/Profile Updates > Group/Organization Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and sending it to the appropriate number listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 877-842-3210.
- For behavioral health care providers, visit providerexpress.com > My Practice Info.

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 10 years or longer if required by applicable statutes or regulations.

Performance data

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

Comply with protocols

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

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

Office hours

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

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve

our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

Follow medical record standards

See 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 about advance directives. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

Care provider bill of rights

You have the following rights under the UnitedHealthcare Community Plan of Louisiana:

- You may act within the lawful scope of practice as you advise or advocate for your patient who is a member about:
  - Their health, care or alternative treatment options.
  - Information they need to make decisions about their care.
  - The risks and benefits of treatment or non-

treatment.
- Their right to take part in decisions about their care. This includes the right to refuse treatment and share preferences about future care.

- You may receive information on the grievance, appeal and state fair hearing procedures.
- You may access our policies and procedures about service authorizations.
- You may be notified of any decision we make to deny an authorization request or to authorize a service in an amount, duration, or scope less than requested.
- You may challenge the denial on the member's behalf.
- We will not discriminate against you if you serve high-risk populations or specialize in high-cost conditions.
- We will not discriminate against you for acting within the scope of your license or certification.

Appointment standards (LDH Access and Availability Standards)

Comply with the following appointment availability standards:

Primary care

You should arrange appointments for:

- Emergency care: immediately. Schedule follow-up visits with the emergency room attending provider's discharge instructions
- Urgent care: within 24 hours
- Non-urgent sick care: within 72 hours or sooner if medical conditions deteriorates into an urgent or emergency condition
- Specialty care consultation: within one month of referral or as clinically indicated
- Routine, non-urgent and preventative care visits: within six weeks

Lab and X-ray services

Arrange lab and X-ray appointments for:

- Lab and X-ray services (usual and customary): not to exceed three weeks for regular appointments and 48 hours for urgent care, or as clinically indicated

Specialty care

Specialists should arrange appointments for:

- Routine appointment types: within 30 days of request/referral

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 14 days of request
- Second trimester: within seven days of request
- Third trimester: within three days of request
- High-risk: within three days of identification of high risk

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

Care providerdirectory

Every year, all UnitedHealthcare Community Plan network physicians and health care professionals are asked to review the accuracy of their information published in our online provider directory. Please check your listing at **UHCprovider.com** in the Find A Care Provider feature and report any updates to Provider Verifications Outreach, your physician advocate, or network management representative.

As part of the UnitedHealthcare Community Plan provider network, you are required to tell us, within 10 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 Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

Call Provider Services to provide your updated roster and demographic changes.

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.

My Practice Profile

UnitedHealthcare Community Plan's application helps you view and update your demographic and practice data online. You can also use it to complete your required quarterly attestation of your demographic information. This application is on your Link dashboard. You may also use the application to submit Disclosure of Ownership and Management forms for Medicaid. In addition, you may update demographic information in the following ways:

- **Phone:** Provider Verification Outreach Team: 877-369-1302
- **Email:** HPDEMO@uhc.com

To help ensure we have your most current provider directory information, submit applicable changes to:

For Delegated providers, email your changes to Pacific_ DelProv@uhc.com or delprov@uhc.com.

For Non-delegated providers, visit UHCprovider.com for the Provider Demographic Change Submission Form and further instructions.

Changing panel status

To change your panel status (i.e., open to new patients, open to existing patients only, or closed), make the request in writing 30 days in advance. Changes to panel status apply to all patients for all lines of business (LOB) and products for which you take part.

You may request a panel status change for one LOB or product under certain circumstances. Include the exception in the written request. UnitedHealthcare Community Plan determines the approval.

We may notify you in writing of other panel status changes. This includes closures based on state and/ or federal requirements, current market dynamics, and patient quality indicators. Access the MyPracticeProfile app on Link to update your information.

Provider attestation

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

Advance notification requirements

For a list of the Prior Authorization review requirements, go to UHCprovider.com/LAcommunityplan > **Prior Authorization and Notification**.

You need prior authorization for the following:

- Medicaid products: CHIP, TANF, ABD, HCBS
- Phone: 866-604-3267
- Online: **UHCprovider.com**
- All services rendered by a non-network physician, facility or other care provider must receive prior authorization.
- All non-emergency inpatient admissions, including planned surgeries, require prior authorization
- Using the Universal Referral Form (URF) does not mean we approve the service.
- For behavioral health prior authorizations, see Chapter 7 of this manual.

Prior authorization request

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.

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

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

Bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **866-842-3278,** option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

Reportable disease surveillance

Reportable Disease Surveillance is a passive surveillance system which includes:

- **How to report a disease**
- **How to report an outbreak**
- **Pregnancy testing and reporting guidelines**
- **Reportable diseases in Louisiana** (sanitary code)
- **Emergency Department Disaster Surveillance Form**
- **Shelter Disaster Surveillance Form**
- **IDRIS 2 External User Training** (Quality better on ILinc – email **rosemarie.robertson@la.gov** for log-on)
- **IDRIS 2 External User Manual**

You must adhere to Sanitary Code - State of Louisiana Part II – The Control of Disease LAC 51:II.105 as it relates to Reportable Diseases and Conditions. LAC 51:II.105: outlines all diseases/conditions declared reportable with reporting requirements by the following classes:

- Class A Diseases/Conditions – Within 24 hours
- Class B Diseases/Conditions – Within one business day
- Class C Diseases/Conditions – Within five business days

- Class D Diseases/Conditions — Within five business days

All classes must be reported to the Infectious Disease Epidemiology Section, Department of Health & Hospitals, Office of Public Health. A complete list of all disease and condition classes is on ldh.la.gov. Reporting requirements and reportable disease reporting forms may be found at: ldh.la.gov/index.cfm/page/1013. You will need to cooperate with the treatment plan developed by the Local Health Department.

Infectious Disease Surveillance 1450 Poydras Street, Ste. 1654 New Orleans, LA 70112

Phone: 504-568-8295

Email: theresa.sokol@la.gov

Requirements for PCP and specialists serving in PCP role

PCPs are an important partner in the delivery of care, and Louisiana Department of Health (LDH) members may seek services from any participating care provider. The LDH 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 four 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, seven days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs)

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

from any of the following practice areas can be PCPs:

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

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

Members may change their assigned PCP by calling **Member Services** at any time during the month. Member Services is available 7 a.m. - 7 p.m., Monday through Friday.

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, seven 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 health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.

- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- 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 two 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 PCPs and specialists serving in PCP role

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Provider Services Department, 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

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

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 Health Administration (OSHA) and Americans with and Disabilities (ADA) standards.
- Complying with the LDH Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual

Assistance with locating specialists for UnitedHealthcare Community Plan members

We're committed to supporting the care you provide to your patients who are our members. That's why we've made some changes to help minimize the challenges PCPs experience locating specialists for UnitedHealthcare Community Plan members.

PCPs can request assistance with locating specialists by calling our Provider Customer Service line at 866-675- 1607, 7 a.m. – 7p.m. Monday – Friday.

- Please provide the following information when you call: The type of specialist required
- The member's geographical location
- The required timeframe for the appointment
- The PCP's contact information

Our Provider Services representative will:

- Locate three specialists within the UnitedHealthcare Community Plan Provider Network
- Ensure the member can secure an appointment within the required timeframe
- Provide the PCP with the specialist's contact information and appointment availability

- The Provider Services representative can't book the appointment since the member needs to confirm their availability.

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

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

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.

If you have questions, please call 866-675- 1607, 7 a.m. – 7 p.m. Central Time, Monday – Friday.

Specialist care providers 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 participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the LDH 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, seven days a week.
  Or they must have arrangements for phone coverage by another participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

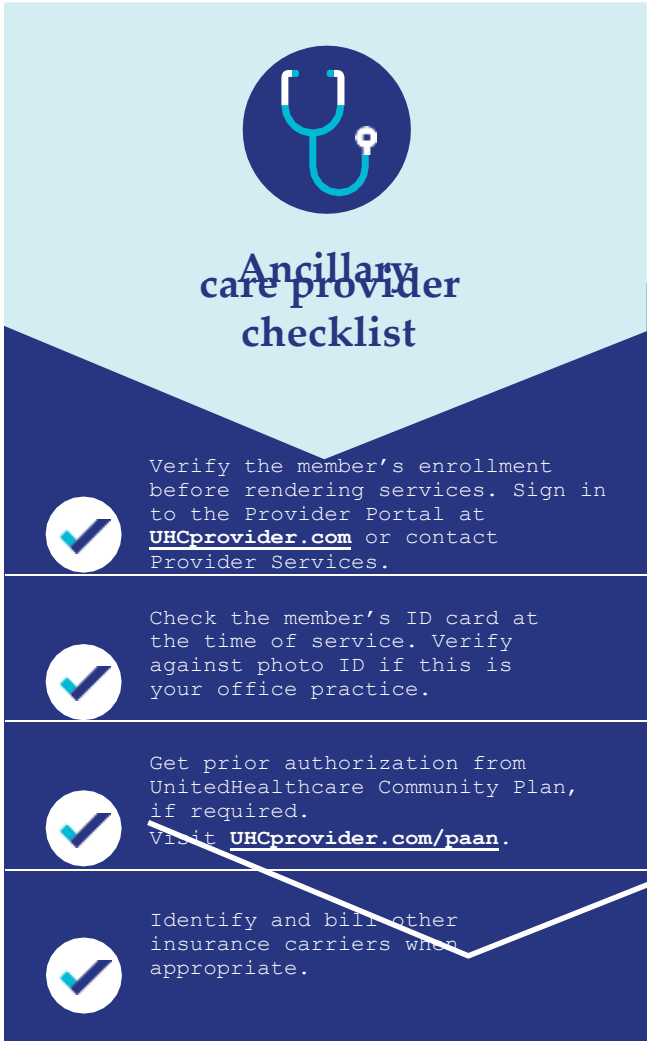
Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

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

Ancillary care provider responsibilities

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

Participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.


Ancillary care provider checklist
Verify the member's enrollment before rendering services. Sign in to the Provider Portal at UHCprovider.com or contact Provider Services.
Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.
Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
Identify and bill other insurance carriers when appropriate.

Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/LA	800-587-5187
Provider Services	UHCprovider.com	866-675-1607
Prior Authorization	UHCprovider.com/paan	866-675-1607
DSNP	UHCprovider.com > Health Plans by State > Louisiana > Medicare > Dual Complete Special Needs Plan	866-675-1607

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Benefit information

View member benefit coverage information online at UHCprovider.com. The following benefits are not all-inclusive.

Benefit	Services Included	Limitations
Acute Inpatient Rehabilitation	Short-term acute rehabilitation	Covered. Prior authorization is required.
	Skilled nursing facility	This is not a Medicaid covered benefit. However, UnitedHealthcare Community Plan may approve short-term skilled care in an appropriate setting. Prior Authorization is required.
	Long-term custodial care	Not covered.
	Long-term acute care (LTAC)	Covered. Prior authorization is required.
Ambulance Services	Emergent and non-emergent transportation.	Covered. Primary care provider (PCP) should coordinate.
	Air ambulance.	Prior authorization not required.

Applied Behavior Analysis (ABA)	Behavioral treatment that seeks to change social behaviors.	Covered for members younger than 21 years who meet specific criteria. Behavioral health care professional or PCP must coordinate care. Prior authorization required.

Benefit	Services Included	Limitations
Bariatric Surgery	Inpatient and outpatient bariatric surgery and specific obesity- related service.	Covered. Prior authorization required. Members must meet criteria to be approved for this procedure, including documentation of participation and failure in legitimate weight loss program.
Behavioral Health Inpatient (Hospital)	See Hospital-Inpatient Services Behavioral Health is available 24 hours a day to help with emergency crises. Select option 1 for emergency crisis.	Call Provider Services: 866-675-1607.
Behavioral Health – Outpatient	Screening, prevention, early intervention, medication management, and referral services.	Covered. PCP to coordinate. For specialty care: • Call Provider Services: 866-675-1607 • **LA.Beh.Auths@uhc.com**
Cancer-Related Treatment	Access to any related medically necessary service. This includes hospitalization, doctor services, other practitioner services, outpatient hospital services, chemotherapy and radiation.	Covered. Potential prior authorization required.
Chiropractic Services	Medically necessary manual manipulation of the spine to correct spinal alignment.	Covered for members younger than 21 years old~~0 – 20 years of age~~. Covered for members 21 and older~~ than 21~~ (Value- Added).
Chronic Renal Disease/End Stage Renal Disease	Services related to chronic renal disease	Covered.
Circumcision	Inpatient or outpatient service.	Covered without prior authorization if performed before discharge from the newborn nursery or in the care provider's office within 30 days after birth. All others will be reviewed for medical necessity.
Cosmetic and/or Reconstructive Surgery	Services or supplies provided in connection with cosmetic surgery are not covered, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member.	Potentially covered. Prior authorization required.

Benefit	Services Included	Limitations
Dental Services	Limited coverage.	Children are covered through the state's benefit (MCNA). Adults are eligible for our value-added dental services.
	For dental services performed in an outpatient setting, UnitedHealthcare Community Plan will cover the facility and anesthesia services when deemed as medically necessary. The facility services require a prior authorization.	Covered. Prior authorization required.
Diabetic Supplies	Durable medical equipment (DME) received at a pharmacy. Pharmacies must file claims to OptumRx. Examples of DME: 1. Diabetic education/home visits/monitoring. 2. Diabetic supplies and equipment. 3. Glucose monitors. OptumRx for providers and pharmacies: 877-305-8952.	Covered. Prior authorization required on all DME equipment valued at more than $500 per line item.
Diagnostic Tests	**Radiology:** Radiology (imaging studies) require prior authorization from UnitedHealthcare Community Plan Clinical for: • CT; X-ray. • MRI (magnetic resonance imaging). • MRA (magnetic resonance angiogram). • PET scan (positron emission tomography). • Nuclear Medicine SPECT MPI (Myocardial perfusion imaging). • Select Nuclear Medicine Studies • Nuclear Cardiology. Call UnitedHealthcare Clinical for care providers.	Covered for specific diagnoses. Some diagnostic tests require a prior authorization and must always be medically necessary.
	Laboratory: LabCorp is the preferred lab provider. Care providers must have a NPI # on file or claims will deny.	Covered.

Benefit	Services Included	Limitations
Durable Medical Equipment (DME) and Medical Supplies	Obtain routine DME supplies through in-network pharmacies. All other pharmacy is carve-out (not covered by UnitedHealthcare Community Plan). Members and care providers should call the Louisiana **Medicaid Agency** for pharmacy benefits. DME may be rented, purchased, or repaired based on the member's duration and use needs. Determination on which one (purchase, rental, etc.) is applicable is made by either Medical Management or the Prior Notification team using the following criteria: • Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment. • Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment. • DME repair will be considered based on the age of the item and cost to repair it. • Medicaid beneficiaries younger than 21 years are entitled to all medical necessary DME.	Covered. An M.D. or D.O. must be the ordering care provider type. Per Louisiana, physician assistants and nurse practitioners cannot be the ordering care provider type for these services. A prior authorization is required on all DME equipment valued at more than $500 per line item.

Early and Periodic Screening, Diagnostic~~is~~, and Treatment (EPSDT)	EPSDT service is Medicaid's comprehensive preventive child health service for individuals younger than 21 years old. ~~Annual physicals~~ [NS1]Preventive services [HYM2]for children younger than 21~~20~~ years old~~ and younger~~ must meet EPSDT criteria. Preventive screenings and ~~interim~~ interperiodic screenings must ~~may~~ include: • Care provider exam • Comprehensive health history • Vision screen • Health and developmental history • Hearing screenings • Measurements • Blood pressure[NS3][HYM4] • Vital signs • Nutritional counseling • Laboratory procedures • Health education/anticipatory guidance • Immunizations • Lead screenings • Environmental investigation • Dental screening	Covered. ~~Vision services performed by an optometrist are reimbursable for routine and non-routine services and must be submitted to March Vision for processing. This is due to the expanded scope of the services the Louisiana Board of Optometry now allows optometrists to perform in the office setting~~.[NS5][HYM6]

Benefit	Services Included	Limitations
EPSDT Organ and Tissue Transplantation Services	Medically necessary and approved non-investigational solid organ and tissue transplantation.	EPSDT-covered services for members younger than 21 years old. PCP to coordinate services.
EPSDT Psychological and Behavioral Services (PBS) – Specialty Care	Services provided by a psychiatrist, psychologist and/ or mental health rehabilitation/habilitation care provider for members with a primary diagnosis of a mental and/or behavioral disorder.	Covered for members younger than 21 years old who meet the criteria for Pervasive Development Disorder (PDD). PCP to coordinate. For services requiring prior authorization: • Call Customer Service: 866-675-1607
EPSDT Physical and Occupational Therapy Services	Physical therapy (PT) for enrollees to restore, maintain or improve muscle tone, joint mobility or physical function. Occupational therapy (OT) for EPSDT enrollees to improve and restore functions that have been impaired by illness or injury or have been permanently lost or reduced by illness or injury.	Covered for members younger than 21 years old. The condition for which PT is prescribed must have the potential for improvement due to rehabilitation. The condition for which OT is prescribed must have the potential to improve the enrollee's ability to perform tasks required for independent functioning. PCP to coordinate.
EPSDT Supplemental Nutritional Feedings	Supplemental nutritional feedings, provided on either an enteral, parenteral or oral basis, when determined medically necessary.	Our medical director determines medical necessity for members younger than 21 years old on an individual basis. Documentation must show unsuccessful trials in using alternatives such as blenderized foods. PCP to coordinate.

Benefit	Services Included	Limitations
Early Steps Program	Medicaid services include: • Family support coordination • OT • PT • Speech/language therapy • Psychology • Audiology Additional services covered under Early Steps include: • Nursing services/health services (only to enable an eligible child/family to benefit from the other Early Steps services) • Medical services for diagnostic and evaluation services only • Special instruction • Vision services • Assistive technology devices and services • Social work • Counseling services/Family training • Transportation • Nutrition • Sign language and cued language services	Covered for children up to 3 years old with a development delay. All members must meet developmentally disabled qualifications. PCP to coordinate. Call 225-342-0095 for more information about referrals. Vision services performed by an optometrist are reimbursable for routine and non-routine services. Claims must be submitted to March Vision for processing due to the expanded scope of services the Louisiana Board of Optometry allows optometrists to perform in the office setting.
Family Planning	Preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health	Covered for female members 10-60 years old.
Federally Qualified Health Centers (FQHC)	Professional medical services furnished by physician, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists; Immunizations are covered for recipients younger than 21 years old; Includes regular encounter visits, EPSDT screening services; EPSDT dental.	Covered. Members may choose a local FQHC as their PCP.
Femoroacetabular Impingement Syndrome (FAI)	All planned elective hip arthroscopy for CPT codes 29914, 29915, and 29916	Prior authorization required.
Habilitation Services	Provided in the home or community. Services assist with getting, keeping, and improving self-help, socialization, and adaptive skills necessary to live successfully in the home- and community-based (HCBS) settings.	Covered. PCP to coordinate.

Benefit	Services Included	Limitations
Hearing Services	Includes diagnostic screening, preventive visits and hearing aids.	Covered.
	Adults: As part of the Adult Health Screening Services, audiometry sweeps are covered for once every four years for adults 21 years and older~~over 21 years~~.	Covered. No prior authorization required when service is given by a participating physician in an outpatient setting.
	Hearing aid services and repairs.	Covered for members younger than 21 years old~~ages 0-20~~ with prior authorization.
	Hearing aid batteries.	Covered, but limited to 32 per month.
Hemodialysis Services – See OP	Includes routine lab, dialysis, medically necessary non-routine lab work, and medically necessary injections.	Covered. PCP to coordinate.
Home Health Services		Covered. PCP to coordinate. Prior authorization required.
Hospice	In-home hospice and short-stay inpatient hospice.	Covered. PCP to coordinate.
	Residential inpatient hospice services are covered.	
Hospital – Inpatient	Inpatient hospital care. Includes medical, surgical, post- stabilization, acute and rehabilitative services.	Covered. Elective and scheduled admissions require prior authorization. Urgent/emergent admissions require notification within one business day of admission to obtain authorization for inpatient days. PCP to coordinate.
	Maternity services.	We don't require notification for normal deliveries and cesarean sections if members are discharged within two days from vaginal deliveries or within four days from C-section deliveries. Any additional days will require notification for authorization.

Benefit	Services Included	Limitations
Hospital – Outpatient	Outpatient professional/Medical services professional component (in/outpatient) of surgical services, including: • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care. • Administration of anesthesia by care provider (other than surgeon) or CRNA. • Second surgical opinions. • Same-day surgery performed in a hospital without an over-night stay. • Invasive diagnostic procedures such as endoscopic examinations. Electroconvulsive therapy (ECT) does not require a prior authorization.	Covered for outpatient, habilitation and rehabilitation services. Prior authorization required for some services. Electroconvulsive therapy (ECT) does not require a prior authorization.
	Out of network: Not covered except in situations where members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization.	Prior Authorization required for non-emergent/non-urgent hospital services.
	Emergency room prescription. Contact the state **Medicaid Agency** for pharmacy benefits.	Not covered.
Immunizations	Covered for adults.	Covered.
	Coverage for children, birth through 18 years, is through the Vaccines For Children (VFC) program.	Covered.
Injectable Medications	Outpatient basis. Please visit **UHCprovider.com** to view the current notification requirements for Louisiana for the list of injectable medications requiring a prior authorization.	Covered. Prior authorization is required.
Laboratory Tests and Radiology Services	Most testing services the attending or consulting physician orders. Portable (mobile) X-rays are covered only for recipients who cannot leave their residence without special transportation.	Covered. Prior authorization may be required for some services. PCP to coordinate.
Mid-level Practitioners Services	Includes care physician assistants (PA), advanced registered nurse practitioners (ARNP), family practice nurse practitioner (FPNP), pediatric nurse practitioner (PDNP), nurse anesthetists (CRNA), and nurse midwives.	Covered.
Neuropsych Testing	No prior authorization required if in-network.	Covered.

Benefit	Services Included	Limitations
Newborn Services	Facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.	Covered. Notification is required.
	Non-routine newborn care, i.e. care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review.	Authorization is required.
	Out of network: not covered except when members require urgent or emergent medical care. In urgent or emergent medical situations, coverage limited up to the point of medical stabilization. UnitedHealthcare Community Plan receives a daily unborn notification file. These unborn, potential members will not be loaded into our system. UnitedHealthcare Community Plan will outreach to the mother to provide education about prenatal care and to contact ACCESS Louisiana as soon as the baby is born to have the baby enrolled in coverage.	Prior authorization required for non- emergent/ non-urgent hospital services.
Nutritional Counseling	Services include outpatient education.	Covered.
Observation	48-hour observation. For more information about the observation process, refer to Healthy Louisiana Informational Bulletin 18-7.	Covered.
Orthotics and Prosthetics	Orthotics and prosthetics with a retail purchase or cumulative rental cost of more than $500.	Prior authorization required.
Outpatient and Care Provider Visits	Services at a hospital or care center when a member stays less than a day. Doctor, other care provider visits, family planning, preventive services, and clinic visits. Specialty care provider visits. Emergency room visits including both hospital and care provider charges.	Covered.

Benefit	Services Included	Limitations
Outpatient Surgery	Services include: Medically necessary surgeries are covered when performed in an ambulatory surgery center (ASC and hospital ASC). Covered when medically necessary and not otherwise excluded.	Covered. Some surgeries require pre-authorization. Ambulatory surgical procedures performed in an outpatient hospital setting are reimbursed at a flat rate. Hospitals bill all outpatient surgery charges for ambulatory surgery procedures with revenue code 490. All other charges associated with the surgery (e.g., observation, labs, radiology) must be billed on the same claim as the ambulatory surgery charges. The only revenue code that will be paid is the flat fee for the ambulatory surgery. Minor medically necessary surgeries performed in the hospital operating room and the associated CPT code not listed on the Louisiana Medicaid Outpatient Ambulatory Surgery Fee Schedule require revenue code 361-Operating Room Services-Minor Surgery. When more than one surgical procedure is performed on the same date of service, we pay only the primary surgical procedure.
Pediatric Day Health Care (PDHC)	Nursing care, respiratory care, physical therapy, speech – language therapy, OT, personal care services and transportation to and from PDHC facility.	Covered for members younger than 21 years old who have a medically fragile condition. Prior authorization required. PCP to coordinate.
Personal Care Services	Toileting and grooming activities; eating and food preparation; household chores; and accompanying, not transporting, recipient to medical appointments.	Covered for Medicaid members 65 or older, or members 21 or older with disabilities. Does not cover medical tasks such as medication administration, tube feedings. For more information about the waiver program for adults, call the Healthy Louisiana Program at LDH at 888-342-6207.

Benefit	Services Included	Limitations
Podiatry Services	Covered for medically necessary services only; typically associated with severe circulatory disease or loss of sensation of feet or member has been diagnosed with a systemic condition by a care provider that there is medical necessity for professional foot care, such as: • Debridement of non-mycotic nails • Diabetes mellitus • Arteriosclerosis • Buerger's disease • Chronic thrombophlebitis • Peripheral neuropathies	Covered.
Pregnancy-Related Services	UnitedHealthcare Community Plan covers all OB services through the member's pregnancy. Services include pre- and post-natal care, tests, doctor visits and other services that affect pregnancy outcomes.	Covered.
	UnitedHealthcare Community Plan recommends, but does not require, hospitals notify us of a maternity admission. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review. If the member is inpatient longer than the federal requirements, a prior authorization is required. Please call for **prior authorization**.	Authorization required.
	Non-routine newborn care, i.e. care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress).	Prior authorization required.
Prescription Drugs, including Certain Prescribed Over-the-Counter Drugs	Obtain routine durable medical equipment (DME) supplies through participating pharmacies. Pharmacies must file claims with OptumRx.	Covered. DME may be dispensed by a pharmacy licensed as a DME provider and that has a DME taxonomy.
	Obtain prescription drugs, including certain prescribed over- the-counter drugs.	Covered. Refer to the Preferred Drug List at **UHCprovider.com**.
Rehabilitation Therapies	Includes physical, occupational, speech and therapies. Must be restorative in nature and be related to an injury or acute episode. Physical, occupational, and speech therapy benefits limited to 60-combined visit per calendar year for members age 21 and older. Maintenance physical therapy is not covered.	Covered.

Benefit	Services Included	Limitations
Sexually Transmitted Diseases	Screening, diagnosis, and treatment coordinated by PCP.	Covered service when medically necessary.
Sleep Studies	Either an outpatient hospital setting or sleep study clinic.	Covered when medically necessary.
	ATTENDED sleep studies typically performed in a sleep clinic, facility or lab.	Prior authorization required.
	UNATTENDED sleep studies performed in the member's home	Prior authorization not required.
	Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a one to four lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).	
	For a sleep study to be reported as a polysomnography, sleep must be recorded and staged.	
Spinal Surgery	Inpatient and outpatient spinal surgeries.	Covered. Prior authorization required.
Sterilization and Hysterectomies	The plan covers once requirements are met. Requirements include, but are not limited to: Sterilization: the regulations require a written consent form (MMS – 110), male or female, must be signed by the individual at least 30 days, but not more than 180 days, before any sterilization procedure is performed. The individual must be at least 21 years of age at the time the consent form is signed by the member.	Covered. All inpatient services require a prior authorization in addition to the appropriate state consent form. Ancillary care providers (anesthesia, radiology, pathology) claims can be paid if a sterilization form is provided with the claim, or if the form was received on the surgeon's claim that was paid.
	Reversal of voluntary sterilization.	Not covered

	Hysterectomies: services cannot be reimbursed if performed for sterilization purposes. Members undergoing hysterectomies for medical reasons other than sterilization purposes must be advised orally and in writing that sterility will result. Per Louisiana Administrative Code, "All claims for hysterectomies (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by Form MMS-101," Informed Consent Form," signed and dated by the member in which she states that she was informed before the surgery was performed that this surgical procedure will result impermanent sterility.	All inpatient services require a prior authorization, in addition to the appropriate state consent form.

Benefit	Services Included	Limitations
Synagis (drug)	Synagis requires prior authorization from **OptumRx**. Complete the Season Respiratory Syncytial Virus Enrollment Form and send to **OptumRx**.	Covered. Prior authorization required.
Tobacco Education and Prevention	The Louisiana Tobacco Quitline and website offer free, confidential phone counseling and online support programs. We encourage you to assist members with setting a quit date and developing a quit plan. Free nicotine gum or patches are available.	Covered.
	Call 866-726-1472 or 844-488-9724 if the member has not completed the program. Call **800-784-8669** or enroll at **quitwithusla.org**.	Some limitations may apply.
	You may suggest one of these programs to members. For more information, call Provider Services at **866-675-1607**, TTY **711**.	Covered.

Benefit	Services Included	Limitations
Transportation Non-Emergency	All non-emergent transportation services are provided by ModivCare. They provide non-emergent transportation services to our members. Members must make transportation arrangements at least two business days before their medical appointment. Call **866-726-1472** to schedule a trip. We cannot ~~dispatching trips~~ [JO7][HYM8]dispatch trips to out-of-region transportation providers without documentation ~~that supporting s no~~**[VG9]**[HYM10]~~carethat all~~ **providers ~~are~~ willing and available** in the region where the enrollee lives~~,~~ **are unavailable** ~~—~~or that the out-of-region provider is the least costly option.[JO11] Hospital discharges will be transported within three hours of notification by a medical facility. Value added non-emergent transportation will only be covered by ModivCare to: • WIC visits • Parenting classes • Lamaze classes • Pregnancy classes • Substance use support groups • Routine vision for adults 21 years and older **Attendants:** In some cases, attendants may be allowed to accompany the enrollee to and from the medical appointment. Attendants are permitted when the member being transported meets one or more of the following criteria: • Sensory deficits; • Need for human assistance for mobility; • Dementia or other cognitive impairments; • At risk of elopement; • Behavioral disorders; • Need for interpretation or translation assistance; or • Special needs such as: - Convalescence from surgical procedures; - Decubitus ulcers or other problems that prohibit sitting for a long period of time; - Incontinence or lack of bowel control; - Assistance with toileting; and - Artificial stoma, colostomy or	Prior authorization may be required for some trips.

	gastrostomy.	

Benefit	Services Included	Limitations
Transportation Non-Emergency	An attendant shall be required when the enrollee is under the age of 17. This attendant **must**[JO12][HYM13]: • Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and • Be able to authorize medical treatment and care for the enrollee. **This attendant may not:** ~~1.~~ • Be under the age of 17; ~~2.~~ • Be a Medicaid provider or employee of a Medicaid provider that is providing services to the enrollee being transported, except for employees of a mental health facility in the event an enrollee has been identified as being a danger to themselves or others or at risk for elopement; or [JO14][HYM15][JO16][HYM17] ~~3.~~ • Be a transportation provider or an employee of a transportation provider.[JO18][HYM19] Exclusions: We will not reimburse for transportation to or from the following locations (not an exhaustive list): • Pharmacies; • Nursing facilities: • Hospice care; or • WIC service appointments at the Office of Public Health. We **may**~~—~~, in certain situations, authorize reimbursement for transportation to or from a pharmacy, WIC appointment, or other value-added benefit as an approved transport, regardless if it is a standalone trip or as an additional stop.	
Transplant Evaluations	**Organ Transplant Services:** Transplant surgery and after care are covered.	Covered. Prior authorization required.
	Kidney Transplant Services: Services covered only when provided by a certified end-stage renal disease facility (recipient may become Medicare-eligible after three months facility treatment or one month home dialysis). Services covered as an outpatient only.	

Benefit	Services Included	Limitations
Vision Services	Vision exams, prescription lens and eyeglasses.	Covered for members younger than 21 years old. For vision care for members age 21 and older ~~than 21~~, refer to Value-Added Services. Members can access the services of any vision care provider, or eyewear vendor in the March Vision network. Call 866-675-1607. Polycarbonate lenses, contact lenses and custom frames require preauthorization.
	Eye Exams: • One every 12 months (from date of last visit) for members younger than 21 years old ~~ages 20 and younger~~ • One every 24 months (from date of last visit) for ages 21 and older • Diabetic eye exams, for any age, every 12 months	Member must use a participating March Vision care provider. NOTE: Diabetic screenings/tests including vision exams are covered yearly, when performed by an ophthalmologist and/or optometrists.
	Eye glasses (lenses and frame): One pair every 12 months if there is a significant change in prescription. If a member has additional exams/eye glasses in the same 12-month period, a prior authorization is required from March Vision.	Prior authorization required.

Non-covered services

Services not covered by Medicaid include:

- Services provided by non-approved physicians or health care providers.
- Services or items furnished solely for beauty or cosmetic reasons.
- For persons 21 or older, hearing aids.
- Services defined by Louisiana Medicaid as experimental or provided solely for the purpose of research.
- Sex-change operations.
- Care not deemed medically necessary by Louisiana Medicaid, UnitedHealthcare Community Plan or the physician, and/or care not covered under Medicaid.
- Medical services provided to a member who is an inmate or who is in the care of a state mental health center.
- Man-made hearts or xenografts.

- Organ transplants, except those identified in this manual or the state plan.
- Services provided in a center or facility or in an area of a center or facility that is not Medicare/Medicaid certified for such services.
- For adults 21 and older, foot and ankle services provided by a podiatrist.

Assignment to PCP panel roster

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

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice

when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

1. Go to **UHCprovider.com**.
2. Select Sign In on the top right.
3. Log in.
4. Click on Community Care.

The Community Care Roster has member contact information, clinical information to include HEIDIS 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 Vault for member contact information in a PDF at the individual practitioner level.

You may also find the "Document Vault" Quick Reference Guide at **UHCprovider.com** > Menu > Resource Library > Self-Service tools > Document Vault >Reference Guides, Training and Other Resources. Click on the available report you want to view.

Choosing a PCP

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

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

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary services are those health care services based on generally accepted, evidence-based medical standards. They include those that most physicians (or other independent licensed practitioners) consider within respective professional organizations and communities to be the standard of care.

Member assignment

The LDH assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. The LDH 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 Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

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.

Assignment to UnitedHealthcare Community Plan

Obtain copies of the Member Handbook by contacting **Provider Services**.

Get eligibility information by calling **Provider Services**.

Unborn enrollment changes

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

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.

PCP 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.

Verifying and validating PCP assignments

We're working with the LDH to help ensure the PCP assigned to UnitedHealthcare Community Plan members is correctly updated in our records. The member may not be aware of their assigned PCP and may be seeing a different PCP. This will help ensure members are notified in case of PCP changes, and also that claims are paid to you correctly.

Each quarter:

- We'll run a report to show which members have not seen their assigned PCP in the past 12 months.
- Members who have seen a different PCP in that time

will be assigned to that PCP.

- You'll be able to see if a member has been assigned to you or transitioned from you using your panel reports, available in Document Vault.

Re-evaluating member removals

If you feel a member is incorrectly removed from your panel, you can ask us to reconsider that change before the member is moved. You'll have 15 business days to contact us with documentation of a visit from that member in the 12 months covered in the report. Contact information will be included in the letter we send to PCPs, along with the list of members being removed from their panel.

Member eligibility

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

Members must meet Louisiana eligibility requirements. We are not involved in eligibility determination or enrollment/disenrollment.

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,**

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 nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with us about a specific subscriber/member. The LDH Medicaid Number is also on the member ID card.

Sample health member ID cards

Medical only


United Healthcare Community Plan
Health Plan (80840) 911-87726-04
Member ID: 002200451
Member:
REISSUE ENGLISH
Payer ID: 87726
PCP Name:
DOUGLAS GETWELL
PCP Phone/24 hours (337) 407-0084
DOC 4 KIDS
1270 ATTAKAPAS DR STE 401K
OPELOUSAS, LA 705706557
DOB:
08/12/2013
OPTUMRx
Rx Bin: 610494
Rx Grp: ACULA
Rx PCN: 9999
0501
Administered by UnitedHealthcare of Louisiana , Inc.


In an emergency go to nearest emergency room or call 911.
This card does not guarantee coverage. By using this card you agree to the release of medical information as stated in your Member Handbook. To find a provider or file a grievance call Member Services or visit www.MyUHC.com/CommunityPlan.
For Members: 1-866-675-1607 TTY 711
NurseLine: 1-877-440-9409 TTY 711
Report Fraud: 1-800-488-2917 TTY 711
Mental Illness & Addiction Crisis Line: 1-866-675-1607 TTY 711
For Providers: UHCprovider.com 1-866-675-1607
Claims: PO Box 31341, Salt Lake City, UT 84131-0341
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 1-866-328-3108 Rx Prior Auth:1-800-310-6826

Medical and behavioral


UnitedHealthcare Community Plan
Health Plan (80840) 911-87726-04
000000421
Member:
NEW ENGLISH
Payer ID: 87726
Medicaid ID: 9999999421192
PCP Name:
DOUGLAS GETWELL
PCP Phone/24 hours (225) 756-5633
OUR LADY OF THE LAKE PHYSICIAN GROUP
8415 GOODWOOD BLVD STE 100
BATON ROUGE, LA 708067851
DOB:
01/17/2012
OPTUMRx
Rx Bin: 610494
Rx Grp: ACULA
Rx PCN: 9999


In an emergency go to nearest emergency room or call 911.
This card does not guarantee coverage. By using this card you agree to the release of medical information as stated in your Member Handbook. To find a provider or file a grievance call Member Services or visit www.MyUHC.com/CommunityPlan.
For Members: 1-866-675-1607 TTY 711
NurseLine: 1-877-440-9409 TTY 711
Report Fraud: 1-800-488-2917 TTY 711
Mental Illness & Addiction Crisis Line: 1-866-675-1607 TTY 711
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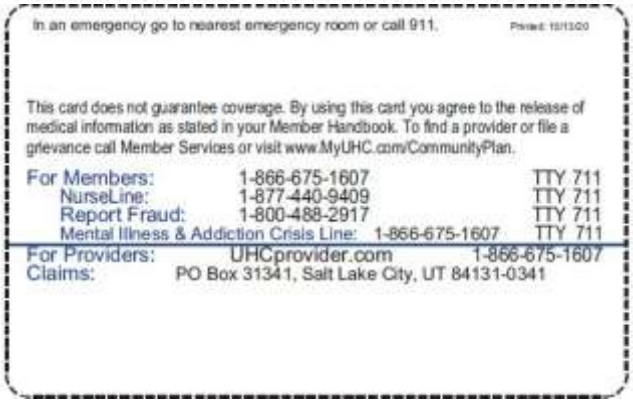
Claims: PO Box 31341, Salt Lake City, UT 84131-0341
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 1-866-328-3108 Rx Prior Auth:1-800-310-6826

Behavioral health only


United Healthcare Community Plan
Health Plan (80840) 911-87726-04
Member ID: 002200454
Member:
NEW ENGLISH
Payer ID: 87726
DOB:
05/15/2008
0501
Administered by UnitedHealthcare of Louisiana , Inc.


In an emergency go to nearest emergency room or call 911.
This card does not guarantee coverage. By using this card you agree to the release of medical information as stated in your Member Handbook. To find a provider or file a grievance call Member Services or visit www.MyUHC.com/CommunityPlan.
For Members: 1-866-675-1607 TTY 711
NurseLine: 1-877-440-9409 TTY 711
Report Fraud: 1-800-488-2917 TTY 711
Mental Illness & Addiction Crisis Line: 1-866-675-1607 TTY 711
For Providers: UHCprovider.com 1-866-675-1607
Claims: PO Box 31341, Salt Lake City, UT 84131-0341

Member missed appointments

Sometimes members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact a member who has not attended or canceled an appointment without rescheduling. Contact the member by phone to:

- Educate them about the importance of keeping appointments.
- Encourage them to reschedule the appointment as soon as practicable.

For members who frequently cancel or fail to attend appointments, please call Provider Services at 866- 675-1607 to address the situation and discuss our case management program.

Our goal is to help members recognize the importance of maintaining preventive health visits and adhere to a plan of care recommended by their PCPs.

Non-compliant members

Contact Provider Services at 866-675-1607 if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide education and counseling to address the situation, and report to you the outcome of counseling efforts.

Verifying member enrollment

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

- Provider Portal: access the Link portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Community Plan Provider Services** is available from 7 a.m. - 7 p.m. Central Time, Monday through Friday.

UnitedHealthcare Community Plan Welcome Packet

Upon enrollment with UnitedHealthcare Community Plan, new members will receive a Welcome Packet and member ID card. This packet includes information about how to:

- Use their member ID card.
- Call their doctor and schedule a checkup.
- Discover their health plan online.
- Register on **myuhc.com/communityplan** for more information about their benefits.
- Complete a Health Risk Assessment (HRA).
- View, download or request a copy of the Member Handbook or care provider directory.
- Access the Member Handbook online, or call to request a paper copy. The handbook includes member rights and responsibilities. It also includes Notice of Privacy Practices.

UnitedHealthcare Dual Complete (HMOSNP)

DSNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For more information about DSNP, go to: uhc.com > Explore Health Plans > Individual and Family > Health Insurance Plans > **Medicare-Medicaid Overview**.

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Administrative Guide for Commercial, Medicare Advantage and DSNP. For state- specific information, go to **UHCprovider.com** > Menu > Health Plans by State.

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Menu > **Referrals**	866-675-1607
Prior Authorization	**UHCprovider.com/paan**	
Pharmacy	**professionals.optumrx.com**	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major[VG24][BKR25]:

- Injury to their overall health.
- Impairment to bodily functions. Or
- 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

Members may get non-emergent stretcher/ambulance transportation services for covered services. Members may get transportation when they are bed-confined before, during and after transport[VG20][BKR21]. A Certification of Ambulance Transportation form is required and must be completed.

Non-emergent stretcher/ambulance transportation must be requested at least ~~three~~ two business days in advance.

Schedule transportation up to 30 days in advance.

If members need help scheduling rides, a Transportation Customer Service Representative (CSR) can assist. Services may be scheduled up to 14 days in advance. Hotel stays and meals will be paid for trips that require an overnight stay with prior approval for eligible members.[VG26][BKR27]

Call 844-525-2329 for all non-emergency hospital

[VG28][BKR29]
discharge transportation requests:

- Press 1 for a hospital discharge, including a same day or next day discharge, or a facility-to-facility transfer for higher level of care.
- Press 2 to schedule a non-emergency ambulance trip, including a same day or next day request.
- Press 3 to speak with a care manager.

Non-emergency medical transportation (NEMT)

Non-emergency medical transportation services are available through ModivCare. Transportation is provided by taxi, van, ~~bus~~bus, or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

For non-urgent appointments, members must call for transportation

at least two business days

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

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

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants).

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

Request prior authorization online or by phone.

- Online: **UHCprovider.com/cardiology.** Select the Go to Prior Authorization and Notification Tool.
- Phone: 866-889-8054 Monday through Friday. Make sure the medical record is available.

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

Durable medical equipment

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

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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

- Hospital emergency department room, ancillary and

See our Coverage Determination Guidelines at UHCprovider.com/Policies and Protocols/ Community Plan Policies/ **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan**

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

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

Emergency room care

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

Before they are treated, our 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, and they cannot be safely discharged, the hospital must determine if the member will move to an observation or inpatient status. If the member will transition to observation, we do not require authorization. If the member is transitioning to inpatient, the hospital has one business day to notify UnitedHealthcare Community Plan.

Hospitals notify us of admission by:
- Calling **866-604-3267**.
- Using the online Prior Authorization and Notification tool at **UHCprovider.com/paan**.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services.

Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

Urgent care (non-emergent)

Urgent care services are covered.

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

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

If a member meets an acute inpatient level of stay, admission starts at the time the member presented to the ER.

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and

The criteria are available in writing upon request or by calling Provider Services at **866-675-1607**. For policies and protocols, go to UHCprovider.com, then select Policies and Protocols, **Community Plan Policies**

When an emergency visit results in an inpatient admission, bill all charges associated with the emergency visit on the inpatient bill. This policy applies to members admitted from the ER or if the member has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. Bill the ER charges as a separate line. Include all associated charges for the emergency visit by revenue code with the total charges for the inpatient stay.

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

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
- Morning-after pill

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.

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the LDH Regulations for more information on sterilization.

Women's health

Women's health care providers provide direct access to members for core benefits and services necessary for women's routine and preventive health care services.
This access is in addition to the member's PCP if that care provider is not a women's health specialist.

Care coordination/health education

Work with us to help members receive care coordination services. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle.
- Improve 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.
- Collaborate with other care providers to improve member outcomes.
- Prevent disease progression and illnesses related to poorly managed disease processes.
- Support member empowerment and informed decision making.
- Effectively manage members' conditions and co- morbidities. This includes depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues.

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

Programs are based upon the findings from our Health Risk Assessment and will identify the health education, cultural and linguistic needs.

Health Homeprogram

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

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

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

For more information about Health Home, call Provider Services at **866-675-1607**.

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants. This includes 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 younger than 21 years old~~20 years or younger~~.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice.

Home hospice

We cover 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 five 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. The LDH covers residential inpatient hospice services. The LDH will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

LabCorp and Quest are the preferred lab providers. Contact **LabCorp** or Quest directly. For more information on our in-network labs, go to

Use an 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.

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

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

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

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

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

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment.
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Provide multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed 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 Community Plan 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 three or more consecutive months or had seven 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 three 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 866-604-3267 or go to or go to **UHCprovider.com/paan.** For more information about prior authorization requirements, go to UHCprovider.com/LAcommunityplan > **Prior**

Pregnant UnitedHealthcare Community Plan members should receive care from network 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.

We 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

UnitedHealthcare Community Plan recommends, but does not require, hospitals notify us of maternity admissions. 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/paan**, or by calling 866-604-3267.

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

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

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

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

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

For additional pregnant member

Post maternity care

We cover post-discharge care to the mother and her newborn. A case manager completes a postpartum assessment by phone two weeks after discharge and follows up as needed. If the infant is admitted into the NICU, a NICU case manager is assigned to the mother to coordinate care for the newborn. Prior authorization is
required for home health care visits for post-partum follow- up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital is responsible to notify the parish of all deliveries, including our members.

If the mother delivers out of state, the member should contact LDH's Enrollment Department to provide birth notification. The Enrollment Department would then add the baby to the health plan.

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 Bright Futures primary goal 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 help ensure that patients receive information and support that is consistent from family and youth perspectives.

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

Hysterectomies

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

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

Find the form on **Louisiana.gov**.

The LDH 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

Home care and all prior authorization services

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

You may also find the form on louisiana.gov.

Have three copies of the consent form:

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

Neonatal ResourceServices

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

The NRS program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. NRS follows all babies brought to the NICU.

NRS neonatologists and NICU nurses manage NICU members through evidence-based medicine and care plan use.

The NRS nurse case manager will:

- Work with the family, the care providers, and the facility discharge planner to help ensure timely

discharge and service delivery.

- Develop care management strategies and interventions based on infant and family needs.
- Coordinate services prior to discharge and after discharge if the member is under NRS case management.

The NRS nurse case manager's role includes:

- Planning and arranging the discharge.
- Coordinating care options and prior authorization, including home care, equipment and skilled nursing.
- Arranging post-discharge support based on infant ongoing acuity
- Educating parents and families about available local resources and support services.
- Coordination with the WPC Team for additional case management needs and services.

Case managers provide benefit solutions to help families get the right services for the baby.

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > **Policies and Protocols >** **Clinical Guidelines**.

Patient-centered medical home

The Patient-Centered Medical Home (PCMH) is how we approach providing complete primary care. The PCMH is a health care setting that helps develop relationships between members, their family, and you. A medical home is accessible, continuous, complete, family- centered, coordinated, compassionate, and culturally effective primary care.

This clinical model is at the heart of health care reform and delivery system. Engaging patients in communities of care will improve the efficiency and effectiveness of the health care system. This model expands our relationship with care providers from a payment model to clinical, value-added services in delivering more efficient and effective care to our members. It also improves trust and satisfaction with our network community.

UnitedHealthcare Community Plan supports activities such as risk stratification, evidence-based interventions and advanced analytics. The core principal characteristics of a PCMH are based on:

- Physician-directed practice
- Whole-person care orientation
- Coordinated care
- Quality and safety
- Enhanced care access
- Optimization through health information technology integration (e.g., pharmacy, patient registry)
- Practice operates as a team
- Comprehensive scope of services

Pharmacy

Pharmacy Preferred Drug List

UnitedHealthcare Community Plan determines and maintains its prescription drug list (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of Louisiana members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

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

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at 800-310-6826. You may also fax a Pharmacy Prior Notification Request form to 866-940-7328.

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**.

Pharmacy prior authorization

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

To request pharmacy prior authorization, call the OptumRx Pharmacy Help Desk at 800-310-6826. You may also fax your authorization request to 866-940-7328. We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members.

A specialty pharmacy medication is a high-cost drug that generally has 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

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

Requirement of specialty pharmacy and home infusion providers to be a network care provider

We have contracted care providers for the distribution of specialty pharmacy and home infusion medications.

They distribute specialty medications covered under a member's medical benefit. This national network provides specialty medication fulfillment and distribution to meet the needs of our members and our participating care providers. The contracted specialty pharmacy or home infusion care provider's agreement identifies their full program participation requirements.

We may deny, in whole or in part, any claim when you use a non-participating specialty pharmacy provider, wholesaler, or direct purchase from the manufacturers without prior approval from us. Hospitals may also be subject

Requirement to use a participating specialty pharmacy provider for certain medications

ed on their Agreement.

Hospitals contracted with UnitedHealthcare Community Plan are required to obtain certain specialty pharmacy medications from a participating specialty pharmacy when they are administered in an outpatient hospital setting, unless otherwise authorized by us. The specialty pharmacy will dispense these drugs in compliance with the corresponding drug policy and the member's benefit plan and eligibility, and bill us for the medication.

The hospital needs only to bill UnitedHealthcare Community Plan for medication administration and should not bill for the medication itself. Members cannot be billed for the medication.

For a list of the medications and participating specialty pharmacy care provider(s), go to: UHCprovider.com >Menu > Policies and Protocols > Community Plan Policies > **Community Plan Drug Lists for Limited Supplier Protocol**.

This requirement does not apply in situations in which the member has Medicare or another health benefit plan as the primary payer and UnitedHealthcare Community Plan is the secondary payer.

We anticipate that all hospitals should be able to procure the medications from a participating specialty pharmacy provider. If a hospital does not obtain the specialty medication through the indicated specialty pharmacy, we will issue a denial of payment for the medication, in whole or in part, for failure to follow the protocol. Hospitals may not bill members for medication that is denied for failure to follow the protocol.

Please contact your UnitedHealthcare Community Plan Provider Advocate if you have questions.

Radiology

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

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

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

- Nuclear cardiology

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

- ER
- Observation unit
- Urgent care
- Inpatient stay

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

Request prior authorization online or by phone at:

- Online: **UHCprovider.com/Radiology** > Go to Prior Authorization and Notification Tool
- Phone: **866-889-8054** from 8 a.m. - 5 p.m. Central Time, Monday through Friday. Make sure the medical record is available.

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

Screening, brief interventions, and referral to treatment (SBIRT) services

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed health care 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.
- Part of an Evaluation and Management (E/M) exam. Screening 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.

What is included in SBIRT?

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 s are. Three 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 intervention. 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 dependence to a licensed and registered 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 lives for treatment.**

SBIRT services are covered when all the following are met:

- The billing provider and servicing provider are SBIRT certified.
- The billing provider has an appropriate taxonomy to bill for SBIRT.
- The diagnosis code is V65.42.
- The treatment or brief intervention does not exceed four encounters per client, per 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

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 complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

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

To find a medical MAT provider in Louisiana:

1. Go to **UHCprovider.com**
2. Select "Find a Care Provider" from the menu on the home page
3. Select "Search for Care Providers in the General UnitedHealthcare Plan Directory"
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

For more SAMHSA waiver information:
Physicians – **samhsa.gov**
NPs and PAs – **samhsa.gov**

If you have questions about MAT, please call **Provider Services**, enter your TIN, then say "Representative," and "Representative" a second time. Say "Something Else" to speak to a representative.

Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT)

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

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 coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow- up. 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 one day of identification.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD CM.
- Anticipated dates of service.
- Type of service (primary and secondary) procedure codes and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.

If you have questions, go to UHCprovider.com/LAcommunityplan > **Prior Authorization and Notification Resources**.

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within two business days of the decision
Urgent/Expedited Pre-service	Within three days of request receipt	Within three days of the request	Within three days of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within two business days

Prior authorization adverse determinations

UnitedHealthcare Community Plan will ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease determines service authorization request denials or approval of a service in an amount, duration or scope that is less than requested.

UnitedHealthcare Community Plan will include in all final adverse determination notices all of the following available and applicable information:

- Medical criteria name
- Website link to access the criteria; the page number and section/paragraph the criteria can be found.

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department

assesses members who may be at risk for multiple hospital admissions, increased medication use, or would

benefit from a multidisciplinary approach to medical or psychosocial needs.

Case managers use a holistic approach to assess members. They consider Medicaid-covered services and other community resources as applicable. Case managers are expected to:

- Respect the member's rights.
- Provide adequate information and training to help the member and their representative/family make informed decisions about their care.
- Provide service options that support the care plan.
- Coordinate access to non-Medicaid covered services available throughout the community.
- Educate the member and their representative/family on how to report issues with service delivery to UnitedHealthcare Community Plan so they can be addressed as quickly as possible.
- Advocate for the member/family/representative and others as the need occurs.
- Allow the member and their representative/family to identify their role in the service system.
- Provide members with flexible service delivery

options.

- Provide you with information about changes in member's functioning to assist the provider in planning, delivering, and monitoring services.
- Coordinate across all facets of the service system to maximize the efficient use of resources and minimize any negative impact to the member.

We offer specialized case management for EPSDT PCS, PDN and/or PDHC recipients by calling 800-377-5105.

Refer members for case management by calling Care Management at **877-856- 6351.** Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities. We conduct reviews by phone, record review and electronic medical records exchange 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 on site or by phone or electronic medical record review.

Your cooperation is required with all our 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, CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Utilization management guidelines

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

UM appeals are considered medically necessary

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

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.

Continuance of higher level of care

UnitedHealthcare Community Plan will not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless we can provide the service through an in-network or out-of-network care provider for a lower level of care.

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

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.

Discharge planning coordination

Effective and timely discharge planning is a key part of using appropriate services and preventing re-admissions. The hospital staff and the attending physician develop the discharge plan. This plan involves the member, family and the UnitedHealthcare Community Plan case manager.

Our concurrent review nurse works with the hospital discharge team and attending physicians to help ensure cost-effective and quality services are provided at the appropriate level of care. This may include:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex discharge needs.
- Providing hospital staff and attending physician with names of participating care providers.
- Informing hospital staff and attending physician of covered benefits.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at **UHCprovider.com**.

UnitedHealthcare Community Plan encourages all hospitals, physicians, and other care providers to adopt certified electronic health record technology (CEHRT). Please comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).

Before adopting, approving, amending or implementing a policy or procedure, UnitedHealthcare Community Plan will submit the proposed policy or procedure to LDH for approval. LDH will publish the policy on a publicly accessible LDH website page for no less than 45 days to solicit public comments. The proposed policy or procedure will be published in a format determined by LDH, and will include both the existing policy or procedure and the proposed policy and procedure, with the proposed language in the text printed in boldface type and underscored. All present policy or procedure language and punctuation, which are to be deleted, will be struck through.

UnitedHealthcare Community Plan will not implement the proposed policy or procedure unless LDH has provided its written approval after the expiration of the public notice period.

Physician medical review

Our concurrent review nurse or the prior authorization nurse reviews the documentation for medical necessity based on Interqual criteria. When the criteria are not met, the case is referred to the medical director. The medical director reviews the documentation and discusses the case with the nurse. The medical director may call the attending or referring physician for more information. The requesting physician may be asked for more information. Based on the discussion, the medical director may approve, deny, modify, reduce, suspend or end a pending service.

For inpatient denials, the attending physician and hospital are notified in writing. They may dispute the medical director's finding by filing a formal grievance. For denial of outpatient authorizations, the referring physician, the PCP (if not the referring physician) and the member are notified in writing. The care provider or member may ask for an expedited appeal for any treatment denial, suspension or reduction in services.

Our prior authorization requirements are outlined in the Louisiana Revised Prior Authorization List. The list is on **UHCprovider.com**. If we are the member's primary payer, we may require prior authorization. If we are the secondary payer, we may be responsible for member copays and deductibles.

Prior authorization is not
requ
secc
bala
Community Plan member per
Louisiana Medicaid guidelines.

Medical policies and procedures updates or changes

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 Provider Portal on **UHCprovider.com**, calling Provider Services Department, or the Louisiana 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 dates 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 LDH. 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 his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. They should contact UnitedHealthcare Community Plan at **866-675-1607**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services requiring prior authorization

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

Seek authorization within the following time frames

- **Emergency or Urgent Facility Admission:** one business day from inpatient admission.
- **Inpatient Admissions; After Ambulatory Surgery:** one business day.
- **Observation:** After a maximum of 48 hours of observation, hospitals have one business day from the transition to inpatient status to notify us of the admission. Notifications received after one business day will be administratively denied. Approval must be obtained within one business day of the admission. Approval for inpatient days subsequent to the notification will be based on medical necessity.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Direct access services – Native Americans

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

Chapter 5: Early, Periodic Screening, Diagnostic~~is~~ and Treatment

Key contacts

Topic	Link	Phone Number
EPSDT	~~U~~uhcprovider.com~~[state website]~~	Intake phone number 1-866-604-3267~~[state phone number]~~[NS30][HYM31]
Vaccines for Children	**[state website]**	800-219-3224

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

The Early Periodic Screening, Diagnostic~~is~~ and Treatment (EPSDT) program is a complete health care program for eligible children younger than 21 years old who are enrolled in Medicaid. ~~Louisiana law requires you report all immunizations given to children in the age group at least monthly using the Louisiana LINKS at LaLinks.org.~~ All Medicaid enrolled providers that provide EPSDT well child preventative screenings must be enrolled in the VFC program and utilize VFC vaccines for recipients aged birth through 18 years of age.~~.~~[NS32][GKM33]

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members younger than ~~up to age~~ 21 years old, including pregnant women.

~~Full~~ EPSDT Preventive ~~s~~Screening

Perform a full screen according to the most current American Academy of Pediatrics (AAP)/Bright Futures™ periodicity schedule for members younger than 21 years old~~through age 20~~. Include:

- Complete health and developmental history (including physical, nutritional, and behavioral)
- Unclothed yet suitably draped, comprehensive physical examination
- Health education, to include anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead risk assessment
- Psychosocial/behavioral assessment
- Developmental assessment and objective screening (including global developmental screening at 9, 18 and 30 months; autism screening at 18 and 24 months)
- Hearing, and vision assessment and objective testing

- ~~Anthropometrics~~[NS34][BKR35]~~,~~ ~~to include~~ ~~D~~documentation of BMI for children 2 years and older
- Dental/oral health

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. They are often used for sports physicals, Head Start enrollment, and to rule out alternate causes for behavioral issues such as ADHD. Office visits and screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Developmental and autism screening

Developmental and autism screenings administered during EPSDT preventive visits are based on the (AAP)/Bright Futures™ periodicity schedule. We will only reimburse the use of age-appropriate, caregiver-completed, and validated screening tools as recommended by the AAP.

If an enrollee screens positive on a developmental or autism screen, you must give appropriate developmental health recommendations, refer the enrollee for additional evaluation, or both, as clinically appropriate. Also document the screening tool(s) used, the result of the

screen, and any action taken, if needed, in the enrollee's medical record.

Developmental screening and autism screening are currently reimbursed using the same procedure code. You may only receive reimbursement for one developmental screen and one autism screen per day of service. To receive reimbursement for both services performed on the same day, submit claims for two units of the relevant procedure code.

Developmental and autism screening are reimbursed separately when performed based on the AAP/Bright Futures™ periodicity schedule or when medically indicated. Use a standardized tool referenced by the AAP/ Bright Futures™.

Perinatal depression screening

Administer perinatal depression screening to an enrollee's caregiver based on the AAP/Bright Futures periodicity schedule. The screening can be administered from birth to 1 year during an EPSDT preventive visit, interperiodic visit, or evaluation and management (E&M) office visit. This service is a recommended part of well-child –care.

Perinatal depression screening must employ one of the following validated screening tools:

- Edinburg Postnatal Depression Scale (EPDS).
- Patient Health Questionnaire 9 (PHQ-9).
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9.

You must document the tool used, the results and any follow-up actions taken. If an enrollee's caregiver screens positive, refer the caregiver to available resources, such as their PCP, obstetrician, or mental health professionals. Document the referral. If screening indicates possible suicidality, concern for the safety of the caregiver or enrollee, or another psychiatric emergency, you must refer them to emergency mental health services.

Though the screening is administered to the caregiver, we reimburse this service under the child's Medicaid coverage. If two or more children younger than 1-–year present to care on the same day (e.g., twins or other siblings both younger than 1 year), you must submit the claim under only one of the children. When performed on the same day as a developmental screening, you must append modifier -59 to claims for perinatal depression screening.

Development disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment.

The Office for Citizens with Developmental Disabilities (OCDD) serves is the entry into the developmental disabilities service system. OCDD services and programs include Early Steps, Flexible Family Fund, Individual and Family Support, Supported Living, Resource Centers, Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), and Waiver Services.

Referral – If you determine supportive services would benefit the member, refer the member to an OCDD local human services district or authority. The OCDD Resource Center's mission is to collaborate with care providers to help identify and support needs. It also helps develop activities, interventions and products that strive to achieve positive outcomes for persons with disabilities. Find out more the Early Steps referral form, and resources, at **ldh.la.gov/ocdd**.

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

Early Steps program

Early Steps, an OCDD program, provides early intervention services to infants and toddlers aged birth to 3 years with delays in cognitive, motor, vision, hearing, communication, social, emotional or adaptive development. Services are provided in the child's natural environment, such as the child's home, care setting, or

other community setting typical for infants to toddlers.

Referral – refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. State and federal regulations require care providers who serve infants/toddlers from birth to age 3 make referrals to the OCDD for early intervention services. Make referrals within seven days of determining an infant/toddler may need early intervention services due to a developmental delay or a disability likely to result in a developmental delay if early intervention services are not provided. After contacting the regional center or local office, a service coordinator will be assigned to help the child's parents through the process to determine eligibility for needed intervention services. For more information, the Early Steps referral form and referral resources, go to **ldh.la.gov**.

Continuity of Care –support the development of the IFSP created by the Early Steps Program through either the local Regional Center (RC) or LEA. This helps ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP.

Lead screening/treatment

All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the 24 months and 72 months of age must receive
a screening blood lead test if they have not been previously screened. A blood lead test result equal to or greater than 5ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months to 6 years to assist in determining risk.

The CDC Lead Poisoning Management Summary Chart provides management guidelines. Find out more at **lead.dhh.la.gov**.

Healthy Louisiana Applied Behavioral Analysis (ABA) Program

UnitedHealthcare Community Plan is one of the selected managed care plans providing coverage

to Healthy Louisiana members. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Healthy Louisiana members. Your participation in our network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

To assist you in your participation in this program, learn more about the process for applying to the network, and the clinical protocols required in this unique network, please review the resource materials at providerexpress.com > Clinical Resources > Autism/Applied Behavioral Analysis > abaLAMedicaid.

Vaccines for Children program (VFC)

The Vaccines for Children program provides immunizations. Immunizations offered in the state VFC program must be ordered at no cost to children through VFC-enrolled care providers. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

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

Any child through 18 years old 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 the uninsured category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Contact **VFC** if you have questions. Phone: **504-568-2600**

Additional resources

UnitedHealthcare Community Plan does not require specific EPSDT documentation forms. For more details information, risk assessments, forms and information, please visit the following sites:

- American Academy of Pediatrics – **aap.org**
- The Advisory Committee on Immunization Practices – **cdc.gov/vaccines/recs/acip**
- The American Academy of Family Physicians – **aafp.org**
- Louisiana Immunization Network for Kids Statewide (LINKS) – **lalinks.org/linksweb/main.jsp**
- Bright Futures – **brighfutures.aap.org**

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-675-1607
Healthy First Steps	uhchealthyfirststeps.com	800-219-3224

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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 **866-675-1607** unless otherwise noted.

- **Unlimited visits** offered to members with participating PCPs and specialists if deemed necessary by their PCP.
- **$20 gift card** offered for members completing a PCP visit within 90 days of enrollment.
- **$20 gift card** offered for one well-child visit each year between the ages of one and 17.
- **$10 gift card** offered for completing a HRA within 90 days of enrollment.
- **Asthma Home Assessment** offered for moderate to severe asthmatics when referred by your PCP or care manager with a certified in-network asthma educator. One visit per year.

Adult access to health

- **Adult Immunizations**
- **Adult Dental Benefit:** Members 21 years and older ~~than 21~~ will be provided routine dental exams, X-rays, cleanings, fillings and extractions with in-network care providers limited to $500 per year.
- **Adult Vision Benefit:** Members 21 years and older ~~than 21~~ will be provided additional vision services to complement the limited Medicaid vision benefits. Services include one routine eye exam every two years and $100 allowance for frames/ lenses every two years. Note: Vision services performed by an optometrist

are reimbursable for routine and non-routine services and must be submitted to March Vision for processing. This is due to the expanded scope of the services the Louisiana Board of Optometry now allows optometrists to perform in the office setting.

- **Adult Pain Management:** Members 21 years and older ~~than 21~~ will be provided six visits per year to an in-network chiropractor.
- **Diabetic Screening Incentive:** Members 21 years and older ~~than 21~~ who complete their HbA1c labs and LDL-C screening within 90 days of enrollment are eligible for a $50 voucher toward a catalog of over-the- counter health products.

Adult pain management/ chiropractic services

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

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

Use the following steps to access the fee schedules online:

1. Go to **myoptumhealthphysicalhealth.com**.
2. Enter your provider ID & password.
3. Click "Tools & Resources."

4. Click "Plan Summaries" or "Fee Schedules." For more information on chiropractic care, go to **myoptumhealthphysicalhealth.com** or call **800-873-4575**.

Chroniccondition 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 at **866-270-5785**.

Doctor Chat— virtual visits

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

disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

EarlySteps program

The EarlySteps Program is handled by the state of Louisiana and provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families.

Referring a child: Refer a child to EarlyStep 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.

Next steps: The EarlySteps 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 EarlySteps, 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.

For more information, go to **earlysteps.dhh.louisiana. gov**.

Healthy First Steps Rewards

Healthy First Steps™ (HFS) Rewards is a specialized case management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

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

How It Works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.

Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

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

Hypoallergenic bedding

Improve asthma control and reduce allergies caused by dust or synthetic bedding. Controlling these issues can help lower asthma-related hospitalizations and ER visits.

Hypoallergenic bedding is limited to members with asthma in case management. It is limited to $150 annually per member. The program requires prior authorization and documentation stating they have severe asthma. The member's service coordinator decides eligibility.

Mindfulness: Be here now

We deliver this program to social worker and community partners. The focus is caregiver well-being. It provides mindfulness techniques to reduce burnout, raise performance and improve quality of care.

Mobile apps

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

- **SMART Patient** allows users to track important numbers such as blood pressure, record appointments, and record doctors' orders. It also helps them view educational videos.
- **OptumizeME** allows users to set health and fitness goals, challenge other users to set their own goals, and post the results on Facebook.
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan's provider

network and obtain travel directions to a care provider's location. The app provides users with the ability to call a care provider by tapping on the search result.

- **Social Media** provides assistance on Facebook, Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) by delivering health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven 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 **866-351-6827** 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 percent for a Medicaid population. It also has an 88 percent member satisfaction. Quit for Life is for members 18 years and older.

SUD recovery coaching

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

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

UHC Latino

uhclatino.com, our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Youth membership program

A Boys & Girls Club membership is offered to members younger than 19. The program bolsters confidence and promotes a healthy lifestyle. Where not available, the plan finds an alternative youth organization for the child to join.

Women, Infants and Children supplemental nutrition program (WIC)

This program provides federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age 5 who are at nutritional risk.

Eligibility –

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

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

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding six-month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months
- For infants younger than 9 months old, height/length and weight dated within 60 days of enrollment and with each six-month recertification

Contact Information:

504-568-8229

ldh.la.gov

Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	800-888-2998
Provider Services	UHCprovider.com	866-675-1607

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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 resource is accessible by selecting Our Network > State-Specific Provider Information > Louisiana.

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

The UnitedHealthcare Community Plan Behavioral Health Provider manual is located on providerexpress. com. This resource is accessible by selecting Our Network > State-Specific Provider Information > Louisiana.

You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the louisiana.gov.

Addictive Disorders Regulatory Authority (ADRA), to be a substance use (SU) treatment provider.

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 use 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

For member resources, go to providerexpress.com > Clinical Resources >Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency. This page includes tools to help members addressing mental health and substance use

How to Join Our Network:
Credentialing information is available at **providerexpress.com** > Clinical Resources >Guidelines/Policies & Manuals > Credentialing

Benefits include:

- Crisis intervention and stabilization services.
- Inpatient psychiatric hospital (acute and sub-acute).

- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Social detoxification
  - Substance use intensive outpatient treatment
  - 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 48 hours of medically necessary care for a member to be in an observational status. Note: Observation and ancillary services do not require notification, precertification or authorization. They are covered up to 48 hours. However, observation lasting more than 48 hours requires authorization.)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Homebuilders
- Assertive community treatment
- Dual-disorder (MH and SU) residential
- ASAM 3.7 WM Medically Monitored Inpatient Withdrawal Management
- ASAM 3.7 Medically Monitored High Intensity Inpatient Services
- ASAM 3.5 Clinically Managed High Intensity Residential Services
- ASAM 3.3 Clinically Managed Population Specific High Intensity Residential Services
- ASAM 3.2 WM Clinically Managed Residential Withdrawal Management
- ASAM 3.1 Clinically Managed Low-intensity Residential Services

UnitedHealthcare Community Plan case manager

The case manager coordinates behavioral health

services within our network. Case managers work with the member, their family, significant other or authorized decision-maker, PCP, medical case manager and any community resources that may be serving the member.

To help ensure coordination of care, we provide a referral for specialized behavioral health. If a member needs emergency behavioral health services and notifies us or you, we help them access the nearest emergency medical care provider. A case manager follows up with the member within 48 hours. Payment for the emergency service is the responsibility of UnitedHealthcare Community Plan as well as any follow-up care.

If you or the member identifies a need for behavioral health services, contact their case manager. If you do not know the case manager's name, call Provider Services at 866-675-1607 and select the behavioral health option.

Psychotropic medication management

Members who need psychotropic medications that cannot be managed by a PCP should be referred to medical psychologists, a psychiatrist or an NP with psychiatric care experience. For detailed information on behavioral health services, refer to the behavioral health care provider manual at **providerexpress.com**.

Eligibility

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

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, inpatient or residential care. Ensure prior authorizations are in place before rendering non-emergent services. Get
prior authorizations by going to
providerexpress.com
>Our Network > State-Specific Provider information
>Louisiana > Authorization Templates. Request

authorizations for PRTF, ECT, ACT, Crisis Intervention/ Stabilization, IOP, and TGH by email at **LA.Beh.auths@uhc.com**.

Submit authorizations for CPST, PSR, FFT, MST, and Homebuilders using the Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form. Find this and other request forms on the Louisiana Resource Page. Go to providerexpress.com >United States > Our Network > State-Specific Provider information > **Louisiana** > Authorization Templates.

You must request all authorizations for mental health inpatient, substance use inpatient, and residential substance abuse by calling 866-675-1607.

Portal access

Website: **UHCprovider.com**

Access Provider Portal, the gateway to our online tools, on this site. Use the tools to verify eligibility, review electronic claim submission, view claim status, and submit notifications.

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at 866-815-5334 to verify eligibility and benefits (available 7 a.m. - 7 p.m. Central Time, Monday through Friday). Website:

providerexpress.com

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at 866-675-1607.

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.

For more information on Louisiana-specific resources visit **providerexpress.com**.

Addressingthe opioid epidemic

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

Brief summary of framework

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

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 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/

Increasing and education awareness of opioids

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**. Then click "Drug Lists and Pharmacy". Click Resource Library to find a list of tools and education.

Prevention

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

Pharmacy/prescriber lock-in

The Pharmacy/Prescriber Home Program (lock-in) identifies and manages members with potentially inappropriate patterns of medication use. Members with high abuse (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances) are identified using pharmacy and medical claims data. The program limits members to fill their prescriptions at one pharmacy and only from their assigned prescriber(s). When lock-in is determined appropriate, a member is placed into the program for at least one year.

Expanding MAT access and capacity

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

SUD providers, when clinically appropriate, shall:

- Educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
- Provide on-site MAT or refer to MAT offsite; and
- Document member education, access to MAT and member response in the progress notes.

Residential SUD providers shall provide MAT on-site or facilitate access to MAT offsite which includes coordinating with the member's health plan for referring to available MAT provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient.

To find a behavioral health MAT provider in Louisiana:

1. Go to **UHCprovider.com**
2. Select "Find a Care Provider" from the menu on the home page
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "Louisiana" for options
6. If needed, refine the search by selecting "Medication Assisted Treatment"

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.

To find medical MAT providers, see the **MAT section** in the Medical Management chapter.

Tobacco/gambling resources

Members in case management are provided with a screening focused on gambling/tobacco.

For more information on this contact the Louisiana Tobacco Quitline at 800-QUIT-NOW(24/7) or visit **quitwithusla.org**. The quit line offers a quit coach who will work with the member to develop a customized quit plan which includes counseling sessions and a quit kit.

Free information and referral assistance is available from experienced problem gambling counselors 24/7 from the state's helpline at 877-770-7867, or **helpforgambling.org** and **dhh.la.gov** gamblers anonymous.

Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/LA	800-587-5187
Member Handbook	UHCCommunityPlan.com/LA > Community Plan > Member benefits	800-587-5187

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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

Privacy regulations

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

Access to protected health information

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

Amendment of PHI

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

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means.

You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member Handbook at UHCCommunityPlan.com.

Native American access to care

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

Member rights

Members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers at any time for any reason.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.

- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes 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 health care professionals 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 three primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

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

Chapter 9: Medical Records

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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 determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location. • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern. • Coordination of care between medical and behavioral care providers.
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Have a procedure for monitoring and handling missed appointments. • 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.

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

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

***Critical element**

Member copies

A member or their representative is entitled to one 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 five years unless federal requirement mandate a longer time frame (e.g., immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 90% 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 two visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as

allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)
- 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 primary care provider 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

Screening and documentation tool

This tool was developed to help you follow regulatory requirements and practice.

Medical Record Documentation Standards Audit Tool Sample

Provider Name

Provider ID#: Provider Specialty:

Reviewer Name: Review Date: Score:

Member Name/Initials: Member ID#:

Confidentiality & Record Organization & Office Procedures	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office. location (as applicable).									
2. Staff is trained in medical record confidentiality.									
3. The office uses a Release of Information form that requires member signature.									
4. There is a policy for timely transfer of medical records to other locations/ care providers.									
5. There is an identified order to the chart assembly.									
6. Pages are fastened in the medical record.									
7. Each member has a separate medical record.									
8. Medical records are stored in an organized fashion for easy retrieval.									
9. Medical records are available to the treating practitioner where the member									

generally receives care.									
10. Medical records are released to entities as designated consistent with federal regulations.									
11. Records are stored in a secure location only accessible by authorized personnel.									
12. There is a mechanism to monitor and handle missed appointments.									

Procedural Elements	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The medical record is legible.*									
2. All entries are signed and dated.									
3. Patient name/identification number is located on each page of the record.									
4. Medical records contain patient demographic information.									
5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable.									
6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record.									
6a. **OR** If the answer to the above # 6 is **No**, then adults 18 and older, emancipated minors, and minors with children are given information about advance directives which is noted in a prominent part of the medical record.									
7. A problem list includes significant illnesses and active medical conditions.									
8. A medication list includes prescribed and over-the-counter medications and is reviewed annually.									
9. The presence or absence of allergies or adverse reactions is clearly displayed.									

History	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Medical and surgical history is present.									
2. The family history includes pertinent history of parents and/or siblings.									
3. The social history minimally includes pertinent information such as occupation, living situation, etc.									

Preventive Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Evidence of current age appropriate immunizations.									
2. Annual comprehensive physical (or more often for newborns).									
3. Documentation of mental & physical development for children and/or cognitive functioning for adults.									
4. Evidence of depression screening.									
5. Evidence of screening for high-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition .counseling									
6. Evidence that Medicare members are screened for functional status and pain.									
7. Evidence of tracking and referral of age and gender appropriate preventive health services.									
8. Use of flow sheets or tools to promote adherence to clinical practice guidelines/preventive screenings.									

Problem Evaluation and Management	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation for each visit includes:									
1. Appropriate vital signs (i.e., weight, height, BMI measurement annually).									
2. Chief complaint.									
3. Physical assessment.									
4. Diagnosis.									
5. Treatment plan.									

Treatment plans are consistent with evidence-based care and with findings/diagnosis	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Appropriate use of referrals/ consults, studies, tests.									
2. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.									

Treatment plans are consistent with evidence-based care and with findings/diagnosis	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
3. Timeframe for follow-up visit as appropriate.									
4. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.									
5. Unresolved issues from the first visit are followed-up on the subsequent visit.									
6. There is evidence of coordination of care with behavioral health.									
7. Education, including counseling, is documented.									
8. Member input and/or understanding of treatment plan and options is documented.									
9. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented.									

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If a care provider scores less than 85%, review five more charts. Only review those elements the care provider received a "NO" on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element is recalculated as a "YES" in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation remains.

***Items are MUST PASS**

Provider Name

Provider ID#: Provider Specialty:

Reviewer Name: Review Date: Score:

Member Name/Initials: Member ID#:

Addendum for Louisiana requirements

Procedural Elements	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. The name and credentials of the provider rendering the services (e.g., MD, DO, OD, NP, PA) are documented.																		
2. Initials of Providers must be identified with correlating signatures.																		
3. The begin and end times of the visit are documented.																		
4. Signed and dated consent forms (as applicable).																		

Medical Records	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
1. Documentation of each visit must include medication prescribed includes member identifying information including name, ID number, DOB, sex, and legal guardianship, if applicable.																		

Preventive Services	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Documentation of EPSDT requirements not already listed above.																		
A. Lead																		
B. Vision																		
C. Unclothed Physical																		
D. Hearing																		
E. Oral Health Assessment & Dental Home Status/Referral																		
F. Dyslipidemia Risk/ test																		
G. STI/HIV Risk/Test																		
H. TB Risk/Test																		
I. Hemoglobin																		
J. Cervical Dysplasia Risk/test																		
K. Newborn Blood Screening/Critical congenital Heart Defect Screening																		

Questions

Administrative / Judicial Action

Element: The medical record include administrative or judicial action brought on by or on behalf of the state or federal government (as applicable).

(Questions) (# N/A) (Adjusted # of Questions)

If a provider scores less than 90%, review an additional five charts. Only review those elements that the provider received a "NO" on in the initial phase of the review. Upon secondary review, if a data element scores at 90% or above, that data element will be recalculated as all "YES" in the initial scoring. If upon secondary review, a data element scores below 90% the original calculation of that element will remain.

Chapter 10: Quality Management (QM) Program and Compliance Information

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team at Networkhelp@uhc.com Chiropractic: myoptumphysicalhealth.com	877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	800-455-4521

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

What is the Quality Improvement program?

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

The program consists of:

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

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

Cooperation with quality-improvement activities

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

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

Care providersatisfaction

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

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

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

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

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Louisiana statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

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

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

Credentialing and recredentialing process

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

UnitedHealthcare Community Plan will completely process credentialing applications from all provider types within 60 calendar days of receipt of a completed credentialing application. The application should include all necessary documentation and a signed provider Agreement.

"Completely process" means UnitedHealthcare

Community Plan will:

- Review, approve and load approved applicants to our provider files in our claims processing system; and
- Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or
- Deny the application and assure that the provider is not used by UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an accrediting body.
- Have malpractice coverage/liability insurance that meets contract minimums.

Care providers subject to credentialing and recredentialing

- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions

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

The NMRT completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

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

For chiropractic credentialing, call **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 three years. This process helps assure you update time-limited documentation and

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

Performance Review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application, please email us at **swproviderservices@uhc.com**. Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare representative will be in touch with you within two business days from when we receive your request.

Confidentiality

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

Resolving disputes

Contract concerns

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

UnitedHealthcare Community Plan
Central Escalation Unit
P.O. Box 31365
Salt Lake City, UT 84131

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 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 it. If you disagree with the outcome, you may file for arbitration. If your concern is about UnitedHealthcare Community Plan procedures, such as credentialing or care management, follow the dispute procedures in your agreement. If one of us is dissatisfied after following those procedures, 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 for arbitration as described in your agreement. Your agreement states where arbitration proceedings are held. The dispute must state the factual and legal basis for the dispute and the relief requested. Not meeting these requirements will result in a denial. All arbitration requests must be in writing and mailed to the American Arbitration Association. See Chapter 12 for more information. For further instructions on how to request binding arbitration, refer to **adr.org**.

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. Locate the Member Handbook at **UHCCommunityPlan.com**.

HIPAA compliance–your responsibilities

Health Insurance Portability and Accountability Act

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

The NPI number is issued by the

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Compliance program

regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Ethics and integrity

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

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 seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

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

Reporting and auditing

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

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

To report questionable incidents involving members or care providers, call our **Fraud, Waste and Abuse line** or

Please refer to the Fraud, Waste and Abuse section of this manual for more 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 Louisiana 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 LDH.

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 Louisiana 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 Louisiana program standards.

You must cooperate with the state or any of its authorized representatives, the LDH, 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 services (QOS) 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 primary care provider 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 rooms for providing member care.
- Privacy in exam rooms.
- 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.

QOS Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	One complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

Chapter 11: Billing and Submission

Key contacts

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

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Our claims process

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

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, go to UHCprovider.com/guides > View online version > Chapter 9 Our Claims Process.

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 the

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 dates 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.

Fee schedule updates

We will update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or LDH. Code set updates will be complete no later than 30 days after notification, unless otherwise directed

by LDH. This includes annual and other fee schedule updates.

We will notify you as to when the updates will be in production, and the time frame to recycle all claims denied due to the system update delays.

All denied claims will be automatically recycled no later than 15 days after the system update. You will not be required to resubmit impacted claims.

Modifier codes

Use the appropriate **modifier codes** on your claim form. 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 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and some hospital services.

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

Initial claims filing time limits

Submit initial claims within 365 days of the date you render services. For non-participating care providers, the timely filing limit is 365 days from the date of service.

We are always the payer of last resort. This means you must bill any other insurance, including Medicare, first before submitting your claim to us.

Claims involving coordination of benefits must be submitted within 365 days from the date of the Explanation of Benefits (EOB) from the primary and/or

secondary payer for contracted care providers. Non- participating care providers have 365 days from the date of service.

Attach a copy of the payer's EOB with your claim, even if we originally denied the claim. Refer to your Agreement for more information.

For Prior Period Coverage (PCC) and Retroactive Eligibility, submit claims within 180 days from the member's linkage date to the MCO.

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'.

Prompt pay requirements

- Ninety percent of all clean claims must be paid within 15 business days of the date of receipt.
- Ninety-nine percent of all clean claims must be paid within 30 calendar days of the date of receipt.
- UnitedHealthcare Community Plan will pay you interest at 12% per annum. This is calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed to you must be paid the same date that the claim is paid.
- At a minimum, UnitedHealthcare Community Plan will run one care provider payment cycle per week, on the same day each week.

Prior period coverage or retroactive eligible claims

PPC is the period, before our notification of a member's enrollment, during which we are retroactively liable for paying their covered services. You may bill UnitedHealthcare Community Plan for medically necessary services members used during the PPC period if the service is a PPC-covered benefit. Prior authorization is not required during the PPC period for medically necessary services that are a Louisiana Medicaid PPC-covered benefit. You must have a valid Louisiana Medicaid ID number.

Submit claims using a CMS 1500 or UB-04 claim form. Please contact the member's UnitedHealthcare Community Plan case manager for more information. You may also call Provider Services to verify the enrollee's PPC eligibility status.

We have a timely filing exception for PCC or Retroactive Eligibility. Submit claims within 180 days from the member's linkage date to the MCO. Eligible PPC services include medications, physician visits, hospitalizations, therapies, DME, medical supplies, home and community-based services (HCBS) and SNF care. For members who have HCBS in place before enrollment (during the PPC enrollment), document a retrospective to determine whether those services are medically necessary, cost-effective and if a registered Louisiana Medicaid care provider rendered them. If so, develop a care service plan to show that services will be retroactively authorized and reimbursed by the program contractor.

Send PPC claims to:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

Electronic claims submission and billing

You may submit claims by EDI. EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

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

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

EDI companion documents

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

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

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

The companion documents are located on **UHCprovider.com/edi** > Go to companion guides.

Clearinghouse and status reports

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

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

e-Business support

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

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

To find more information about EDI online, go to **UHCprovider.com** > Menu > Resource Library to find Electronic Data Interchange

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Menu, then Resource Library to find the EDI section.

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.

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

Form reminders

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

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.

For the LaHIPP enrollee claims we process as the secondary payer for Act 421 Children's Medical Option, we pay at the full patient responsibility (copay, coinsurance and/or deductible) regardless of Medicaid's

allowed amount, billed charges or primary carrier's payment amount.

Hospital and clinic method of billing professional services

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

Global days

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

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Menu >Policies and Protocols > Community Plan Policies > 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 pairs 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, including CLIA-waived tests. The number must include the "X4" qualifier, followed by the CLIA certification number which includes the two-digit state code, followed by the letter "D", and the unique CLIA number assigned to the care provider.

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**.

Refer to the CMS-1500 Billing Instructions at lamedicaid. com > Claims and Billing > Billing Information > **CMS 1500 Billing Instructions**. The CLIA number is not required for UB-04 claims.

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.

Ambulance claims (emergency)

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

National Drug Code

Claims must include:

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

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

Medical necessity

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

Place of Service codes

Go to **CMS.gov** for Place of Service codes.

Asking about a claim

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

Provider Services

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

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

Allow Provider Services 30 days to solve your concern. Limit phone calls to five issues per call.

UnitedHealthcare Community Plan Provider Portal

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

The portal also lets you move quickly between applications. This helps you:

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

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

Find training on **UHCprovider.com/training**.

Resolving claim issues

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

The complaint resolution analyst acknowledges your complaint either immediately by phone or within three business days from when we receive the complaint.

To resolve claim issues, contact **Provider Services**, use the Provider Portal, or resubmit the claim by mail.

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 these 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.

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

Do not balance bill members if:

- The charge amount and the UnitedHealthcare

Community Plan fee schedule differ.

- A claim is denied 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.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an 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.

If you don't know who your provider advocate is, email **Louisiana PR Team@ uhc.com**. A provider advocate will get back to you.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

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

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

Please refer to LDH Informational Bulletin 19-3 which outlines the options for pursuing issue resolution with managed care organizations (MCO). We encourage you to seek resolution with us directly before engaging with LDH or other third parties.

For issues about claims or services rendered under fee-for-service Medicaid, contact: DXC Technology (Formerly Molina Medicaid Solutions)
P.O. Box 91024
Baton Rouge, LA
70821 Phone: 800-473-2783

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM 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 • Authorized representative or care provider on behalf of a member with the member's written consent	UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131	Forms may be found on **UHCprovider.com**	866-675-1607, TTY 711	We accept member appeals by phone or in writing. They cannot be submitted online.	60 calendar days from the date of adverse determination	Urgent/expedited appeals: 72 hours Standard appeals: 30 calendar days May be extended up to 14 calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of LDH, upon its request) a need for more information and how the delay is in the member's interest.
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Authorized representative or care provider on behalf of a member with the member's written consent	UnitedHealthcare Community Plan Appeals and Grievance Unit P.O. Box 31364 Salt Lake City, UT 84131	Forms may be found on **UHCprovider.com**	866-675-1607, TTY 711	We accept member grievances by phone or in writing. They cannot be submitted online.	N/A	90 calendar days

Care Provider Claim Resubmission	Creating a new claim. If a claim was denied, and you resubmit the claim as if it were a new claim, you will receive a duplicate claim rejection.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	866-675-1607	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In or go to **UHCprovider.com/claims**.	365 days from the date of service	30 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION 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 Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	866-675-1607	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In or go to **UHCprovider.com/claims**.	180 calendar days from the denial date	30 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	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	866-675-1607	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In or go to **UHCprovider.com/claims**.	60 calendar days from the first-level claim dispute determination letter	30 calendar days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	Forms may be found on **UHCprovider.com**	866-675-1607	Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In or go to **UHCprovider.com/claims**.	File a complaint at any time. This excludes requests for reconsideration or appeal for specific claims.	30 calendar days

Independent Review Provider Reconsideration	A process to resolve dispute options (e.g., claims payment, reconsideration, appeal, medical claims review) before seeking an external review through Louisiana Department of Health.	Care Provider	Submit Independent Review Reconsideration requests through secure email **CS_LA_AG_IRO@uhc.com**.		866-675-1607 **CS_LA_AG_IRO@uhc.com**		180 days from the date a claim denied in whole, partially or recoupment date of a claim or the MCO failed to issue a RA within 60 calendar days	45 calendar days from the date of the receipt of the request for reconsideration

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 contracted providers may agree to more stringent requirements within provider contracts 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?

YoYou 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:

Use the claims reconsideration application on the Provider Portal. To access the Provider Portal, sign in to **UHCprovider.com** using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

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.

If UnitedHealthcare Community Plan, the LDH or its subcontractors discover an error when UnitedHealthcare Community Plan adjudicates a claim, we will reprocess the claim within 30 calendar days of discovery. If UnitedHealthcare Community Plan cannot meet this time frame, the LDH will approve a specified date. UnitedHealthcare Community Plan will automatically recycle all affected claims. We will not require you to resubmit those claims.

Resubmitting a claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

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

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

How to use:

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

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131-0341

Level 1 dispute — claim reconsideration

What is it?

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

When to use:

Reconsiderations can be done repeatedly but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed. You must submit your request within 180 days from the date of the EOB or Provider Remittance Advice (PRA).

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.

- **Phone:** Call Provider Services at **866-675-1607** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail:** Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 31365
  Salt Lake City, UT 84131

  Available at **UHCprovider.com/claims**.

To learn more, access the Claim/Clinical Request Reference Guide at **UHCprovider.com/LAcommunityplan**.

Claim dispute time frame

The complaint resolution analyst acknowledges your complaint by phone immediately or in writing within three business days from when we receive the complaint.

Allow up to 30 days to process claim disputes.

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

How to use:

Submit a reconsideration request electronically, phone, mail with the following information:

Valid proof of timely filing documentation (reconsideration)

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.
- **Mail reconsiderations:** 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.

Questions about your appeal or need a status update? Call Provider Services.

If you filed your appeal online, you should receive a confirmation email or feedback through the secure provider portal link.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- Submit a letter withdrawing the dispute if you file about nonpayment, but payment is made before a decision is made.
- 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 us.
- 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.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

UnitedHealthcare Community Plan will provide you with written notification if we seek to recoup any overpayment within one year of the claim paid date following an audit or review, including an automated review. Overpayments discovered due to a FWA audit or an examination, audit or inspection by a governing entity may be recouped more than one year following the claims paid date..

UnitedHealthcare Community's notification will include:

- The member's name.
- Date of birth or Medicaid identification number.
- The date or dates of services rendered.
- A list of the claims and amounts subject to the recoupment.
- The date the recoupment will be executed.
- The mailing address or electronic mail address where you may respond.
- The date LDH notified UnitedHealthcare Community Plan of the member's disenrollment through the ASC X12N 834 Benefit Enrollment and Maintenance Transaction, when applicable.
- Effective date of disenrollment.
- The specific reason for each claim's recoupment.

Before the recoupment is executed, you will have 60 days from receipt of recoupment notification to write a response saying why the recoupment should not be put into effect on the specified date. If you do not reply within that time frame, UnitedHealthcare Community Plan may execute the recoupment as stated.

Upon receiving your response, we will consider the statement, including any pertinent additional information submitted within 30 days.

UnitedHealthcare Community Plan will provide a written notice of determination to each written response with determination rationale. If a recoupment is valid, you will remit the amount to us or permit us to deduct the amount from future payments due.

LDH reserves the right to review and prohibit any recoupment for members disenrolled due to the invalidation.

How to use:

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

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

If you 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, 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 more information is needed, we will ask you to provide it.

Sample overpayment report

Payment adjustments and recoupments

If a member's aid category and/or type case changed from UnitedHealthcare Community Plan eligible to excluded, LDH will recoup all previous capitation payments for the excluded months from UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will initiate recoupments of payments to you within 60 days of the date LDH notified of the change. You will be instructed to resubmit the claim(s) to the Medicaid fee-for-service program (if applicable).

In cases of a retroactive effective date for Medicare enrollment of a member, UnitedHealthcare Community Plan will recoup payments made to you within 60 days of the date LDH's notification. You will need to resubmit the claim(s) to Medicare and the payer with financial responsibility for the claim(s) (if applicable).

If a member is disenrolled due to the invalidation of a

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance

55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

duplicate Medicaid ID, UnitedHealthcare Community Plan will not recoup payment under the invalid duplicate Medicaid ID if both the valid and invalid Medicaid IDs are linked to UnitedHealthcare Community Plan

Level 2 dispute — appeals

What is it?

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

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process. Send appeals 60 calendar days from the first-level reconsideration decision date or the PRA.

How to use/file:

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

- **Electronic claims:** Use the Claims Management application on the Provider Portal. To access the portal, go to **UHCprovider.com**, then Sign In. You may upload attachments.
- **Mail:** Send the appeal to:

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

Appeal resolution time frame

The appeals analyst acknowledges your appeal receipt in writing within three business days from when we receive the appeal. Allow up to 30 days to process Level 2 disputes and appeals.

Arbitration

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 we have a concern about your Agreement, we'll send you a letter

containing the details.

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 by a private, independent arbitrator.

Submit arbitration requests either at adr.org or in writing to any of the Regional American Arbitration Association offices. Send Louisiana cases to:

American Arbitration Association
Atlanta Regional Office
2200 Century Parkway, Suite 300
Atlanta, GA 30345

Once the case is registered, and all fees are paid, the office sends a notice to:

United Healthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0341

The request must state the factual and legal basis for the dispute. It must also list the relief requested. Otherwise, the request will be denied. You must exhaust UnitedHealthcare Community Plan's claim dispute process before making a request. You may not ask for a state fair hearing for claim issues.

Mail the request to the American Arbitration Association. The arbitrator will be certified by a nationally recognized association (American Arbitration Association) and provide training and certification in dispute resolution. For more information, visit **adr.org**.

If the request is approved, the arbitrator conducts a hearing. Then they issue a ruling within 90 calendar days, unless we both agree to extend the time frame. All arbitration costs, not including attorney's fees, are shared equally. Arbitration is binding on all parties.

Unless otherwise agreed to in writing by the parties, the party pursuing the dispute must initiate the arbitration within one year after the date on which notice of the dispute was given.

Independent review requests

In reference to the 2017 Regular Session ACT No. 349, HOUSE BILL NO. 492 relative to the Louisiana Medicaid program; effective Jan. 1, 2018, the LDH has

developed and implemented a process to allow health care providers the right to request an independent review of claims submitted to Medicaid managed care organizations; to provide for review of claim payment determinations which are adverse to care providers.

Before requesting an independent review, you must first request an Independent Review Claims Reconsideration from UnitedHealthcare Community Plan by completing the Independent Review Provider Reconsideration Form. The form is on **UHCprovider.com**.

Complete the form within 180 days from the adverse determination. Email it to **CS LA AG IRO@uhc.com**. UnitedHealthcare Community Plan will acknowledge in writing its receipt within five calendar days UnitedHealthcare Community Plan will render a final decision and provide a response within 45 calendar days from the date of receipt of the request for reconsideration. The exception is if a longer time is needed. An agreed-upon date will be decided in writing.

If UnitedHealthcare Community Plan upholds the adverse determination or does not respond to the request within the time frames allowed, you may file a written notice with the LDH requesting the adverse action be submitted to an independent reviewer.

If you are not satisfied with the Independent Review Provider Reconsideration's result, you may request an independent review within 60 days from the reconsideration decision date or if UnitedHealthcare Community Plan does not respond to the appeal request within the time frames allowed.

For more about the independent review process and how to request an independent review, go to LDH's Independent Review website. A separate Independent Review Request Form must be obtained from LDH. The Independent Review Committee will provide the appropriate address for submission of the independent review. Along with a completed Independent Review Form, include a copy of the Independent Review Provider Reconsideration Form and decision letter with the request for an Independent Review to the LDH's Independent Review Committee.

If UnitedHealthcare Community Plan reverses the adverse determination following the review of the reconsideration, claim payment will be paid no later than 20 days from the decision date. Upon receipt of a notice of request for independent review and all required

supporting information and documentation, the LDH will refer the adverse determination to an independent reviewer.

For more about the Independent Review process and to learn how to submit a request, call Provider Services at 877-675-1607. You may also refer to HOUSE BILL NO. 492; ACT No. 349. This bill outlines the policy and procedure of this act or the LDH's Independent Review website at ldh.la.gov.

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, in writing or in person.

- **Phone:** Call Provider Services toll free at **866-675- 1607**
- **Mail:** Send care provider name, contact information and your grievance to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
- **In person:** Contact your Provider Advocate to file in person.

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 claim determination.

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

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

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate. Expedited appeals do not need be in writing.

Where to send:

Call or mail the information within 60 calendar days from the date the service was denied to:

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

8413-0364 Toll-free: **800-587-5187** (TTY **711**)

How to use:

Whenever a service is denied, 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.

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

We must resolve an expedited appeal within 72 hours from when we receive it. The health plan may extend the processing time for either expedited or standard member appeal requests if the following conditions apply:

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

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

A copy of the form is online at UHCprovider.com/claims > Need a Form? >**UnitedHealthcare Community Plan 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 file a grievance on the member's behalf as their representative with their written consent.

Where to send:

You, with the member's written consent, or the member may file a grievance verbally by calling **Member Services**

or writing UnitedHealthcare Community Plan:

Mailing address:

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

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance.

The member may also file a grievance in writing to the state of Louisiana.

State fairhearings

What is it?

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

When to use:

Members have 120 calendar days from the date of the Notice of Adverse Action letter.

How to use:

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

Division of Administrative Law
Health and Hospitals
Section P.O. Box 4189
Baton Rouge, LA 70821-4189

The member may also call **225-342-5800** or **225-342-0443**.

- 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.

Continuance of care

If the member wishes to have continuation of benefits during the state fair hearing, they must make the request within 10 calendar days of the date on the notice of action.

Processes related to reversal of our initial decision

If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, waste and abuse

Call the toll-free UnitedHealthcare Special Investigations hotline at **800-455-4521** to report member or care provider fraud, waste or abuse. Or go to **uhc.com/fraud**. You can also call the Louisiana Medicaid Fraud Hotline at **800-455-4521**. In addition, please write to **UnitedHealthcare Community Plan, Attention: Compliance/ Fraud and Abuse Officer**, 3838

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts.

Provider training and awareness

You are encouraged to take the training on the Louisiana Medicaid website, "Fraud Awareness for Providers." It covers:

- Billing educational opportunities
- New care provider education
- Ongoing training

More educational information may be found on **cms.hhs.gov/home/medicaid.asp**. On medicare.gov, you can find information about **how to report** and **how to fight fraud**.

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.

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

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

You 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. You may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month and report immediately to UnitedHealthcare Community Plan any exclusion information discovered. 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**

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.

OIG List of Excluded Individuals and Entities (LEIE)

- **General Services Administration (GSA) System for Award Management > Data Access**
- **Louisiana Adverse Actions List Search (LAALS)**

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Menu > **Resource Library**	866-675-1607
News and Bulletins	UHCprovider.com > **News and Network Bulletin**	866-675-1607
Provider Manuals	**UHCprovider.com/guides**	866-675-1607

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Connect with us on social media:

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Louisiana's managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care providerwebsites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The **UHCprovider.com** portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on **UHCprovider.com**. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical practice guidelines (which cover diabetes,

ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (e.g., PreCheck MyScript)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is **UHCCommunityPlan.com** > select Member.

Care provider office visits

Care Provider Advocates regularly visit PCPs and specialist offices. We offer on-site visits to help you gain a better understanding of our policies and procedures. Our Provider Education includes orientation for all care providers new to United Healthcare Community Plan

You may also find training on various topics at **UHCprovider.com** > Menu > Resource Library. Look under More Resource Topics, then

and those who have enrolled with new UnitedHealthcare Community Plan products. The orientations take place monthly through webinars. You will receive emailed invitations as well as outreach from an advocate to validate participation.

Provider education sessions also include monthly town halls, mobile service centers, spring and fall provider expos ,and participation at quarterly/annual association meetings. Examples include Louisiana Hospital Association, La MGMA, and RHC conferences.

If your practice is new to our network, or if you would like to schedule an on-site orientation to learn more about our policies and procedures, please email UnitedHealthcare Community Provider Relations at **southeastprteam@uhc.com**.

Discussion topics may include:

- Claim submission procedures
- Timely filing guidelines
- Billing and prior authorization policies
- Dispute and resolution process.

Care providernewsletters

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Louisiana network at least three times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

Network Bulletin

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources.

Care providermanual

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

State websites and forms

Find the following forms on the state's website at **lamedicaid.com**:

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

View the latest news or sign up to receive the monthly bulletin at **UHCprovider.com** > News and Network Bulletin.

Glossary

AABD
Assistance to the aged, blind and disabled

Abuse (by Care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of Member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance Directive
Legal papers that list a member's wishes about their end-of-life health care.

Adverse Benefit Determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.

6. For a resident of a rural area, the denial of a member's request to exercise his or her right, to obtain services outside the network.
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal
A member request that their health insurer or plan review an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan enrollee.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned enrollees that is made to a care provider for providing covered services for a specific period.

Case Manager
The individual responsible for coordinating the overall service plan for an enrollee in conjunction with the enrollee, the enrollee's representative and the enrollee's Primary Care Provider (PCP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

CHIP
Children's Health Insurance Program.

Clean Claim
A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Contracted Health Professionals
Primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in- network rates.

- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnostic~~is~~ and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
A process of determining whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required

for immediate attention to review or stabilize a medical emergency.

Encounter
A record of health care-related services rendered by care providers registered with Louisiana Medicaid to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term "member". Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process by which a person who has been determined eligible to receive Medicaid or Medicare benefits becomes an enrollee of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Fee For Service (FFS)
A method of payment to care providers on an amount- per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute).

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure

to respect the member's rights regardless of whether remedial action is requested. Grievance includes an member's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided
by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

In-Network Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

LDH
Louisiana Department of Health, the state agency mandated to serve the public health needs of all Louisiana residents.

Louisiana Medicaid
The state Medicaid program managed by the Louisiana Department of Health (LDH). Louisiana Medicaid uses a competitive bid process to select prepaid Program Contractors such as UnitedHealthcare Community Plan to provide services to eligible enrollees. Louisiana Medicaid is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person defined by LDH.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is to be used on all electronic transactions.
It is a single unique provider identifier assigned to a provider for life that replaces all other health care provider identifiers.
It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive
enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by the LDH.

Specialist
A care provider licensed in the state of Louisiana and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of
symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.