2024
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Mississippi- Coordinated Access Network & Children's Health Insurance Program

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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 submit prior authorization requests. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic transactions on our website at UHCprovider.com.

Click to access different manuals:

- **Administrative guide** - UHCprovider.com/guides. Under Administrative Guide for Commercial, Medicare Advantage and D-SNP, click on View Online Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan manual** - UHCprovider.com/guides > Community Plan Care Provider Manuals for Medicaid Plans by 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 you have questions about the information or material in this manual, or about our policies, please call Provider Services.

Using 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 professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide

• “Community Plan” refers to UnitedHealthcare’s Medicaid plan

• “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us

• “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide

• Any reference to “ID card” includes both a physical or digital card

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

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services – MS CAN	UHCprovider.com	1-877-743-8734
Provider Services – MS CHIP	UHCprovider.com	1-800-557-9933
Training	UHCprovider.com/training	1-877-743-8734
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID	1-877-743-8734 (MississippiCAN) 1-800-557-9933 (CHIP)
Provider Portal Training	CommunityCare Provider Portal User Guide	
One Healthcare ID support	Chat with a live advocate 7 a.m. -7 p.m. CT from the UnitedHealthcare Provider Portal Contact us page	1-855-819-5909
Resource Library	UHCprovider.com > Resources > 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 Mississippi state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Mississippi Coordinated Access Network (MSCAN)
- Children eligible for the Children’s Health Insurance Program (CHIP)

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

How to join our network

For instructions on joining the provider network, go to UHCprovider.com/MScommunityplan. Expand the Join Our Network menu for details.

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 > Our Network > Demographics and Profiles.

Our approach to health care

Care Model

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

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

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

The goals of the Care Model program are to:

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

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call Member Services at **1-877-743-8731**, TTY 711. You may also call Provider Services for CHIP at **1-800-557-9933,** or for MississippiCAN at **1-877-743-8731**.

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 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. UnitedHealthcare Community Plan offers the following support services:

Language Interpretation Line - We provide oral interpreter services 24 hours a day, 7 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, they can call the phone number on their ID card. Sign language services require a 2-week notice.

- If you need to call a professional interpreter during regular business hours, call 1-877-743-8731, TTY: 771. After hours call 1-877-261-6608.
- Enter the client ID. Press 1 for Spanish and 2 for all other languages

- **Materials for limited English speaking members** - We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to uhc.com/legal/nondiscrimination-and-language-assistance-notices.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual (we previously used MCG Care Guidelines) for medical care determinations.

If you have questions about these guidelines or would like a copy of the criteria used for specific determination of medical necessity, please call our Utilization Management nurse assigned to the case through our Provider Service Center at **1-800-557-9933 for CHIP or 1-877-743-8734 for MississippiCAN (TTY: 711).**

You may discuss requested services with the physician who will make the decision by calling our medical director at **1-800-955-7615**.

If you would like a copy of the InterQual guidelines, go to UHCprovider.com > Menu > Health Plans by State > Mississippi > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > Clinical Guidelines, or call Provider Services **(TTY: 711).**

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

API

Application Programming Interface (API) is becoming the newest digital method in health care to distribute information to care providers and business partners in a timely and effective manner.

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit UHCprovider.com/api.

EDI

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

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

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays

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

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

Getting Started

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

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

Point of Care Assist™

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

UHCprovider.com

This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates and quality programs

UnitedHealthcare Provider Portal

This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

To access the portal, go to UHCprovider.com/en/access.html to create or sign in using a One Healthcare ID. To use the portal:

If you already have a One Healthcare ID (formerly known as Optum ID), simply go to UHCprovider.com and click Sign In in the upper right corner to access the portal.

If you need to set up an account on the portal, follow these steps to register.

Here are the most frequently used tools on the 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.
- **Physician Administered Drugs** — Submit notification and prior authorization requests for certain medical injectable drugs that are administered by the clinician. Go to UHCprovider.com/pharmacy for more information.
- **My Practice Profile** — View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mypracticeprofile.
- **Document Library** — Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to UHCprovider.com/documentlibrary.

Go to UHCprovider.com/portal to learn more about the portal. You can access self-paced user guides for many of the tools and tasks available in the portal at UHCprovider.com/training > Digital Solutions.

Direct Connect

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

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

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

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

Privileges

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

Provider services

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

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

Provider Services works closely with all departments in

UnitedHealthcare Community Plan.

How to contact us

Topic	Contact	Information
Behavioral, Mental Health & Substance Abuse	Optum providerexpress.com 1-800-888-2998 (toll-free) 1-800-980-7393 1-800-867-6758 (Interactive Voice Response System) 1-866-673-6315 1-877-743-8731 (Prior Authorization)	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits 1-877-743-8734	Confirm a member's benefits and/or prior authorization.
Care Management/ Disease Management (formally known as Whole Person Care Model)	Case Management: 1-877-743-8731 Disease Management: 1-877-743-8731 Private Duty Nurse (PDN)/Prescribed Pediatric Daycare (PPEC): 1-877-743-8731 Fax: 1-888-310-6858	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Chiropractor Care	myoptumhealthphysicalhealth.com 1-800-873-4575	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the Provider Portal or UHCprovider.com/claims 1-877-743-8734 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5032 Kingston, NY 12402-5032 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to the Provider Portal, or go to **UHCprovider.com/claims** 1-877-743-8734 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Credentialing	**Gainwelltechnologies.com** Gainwell: 1-800-844-3222	For issues with how you or your practice is registered with the state.
Dental	**UHCprovider.com** Dentist Inquiries: 1-800-508-4862 Customer Inquiries: 1-800-445-9090	For information and questions about dental benefits.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 1-800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	1-800-842-1109	Information is also available at **UHCprovider.com/edi**.
Eligibility	To access the app, sign in to the Provider Portal or go to **UHCprovider.com/eligibility** 1-877-743-8734	Confirm member eligibility.
Enterprise Voice Portal	1-877-842-3210	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 Information** **UHCprovider.com/MScommunityplan** > Integrity of Claims, Reports, and Representations to the Government **Reporting** **uhc.com/fraud** 1-800-455-4521 or 1-877-401-9430 1-800-557-9933 (CHIP) 1-866-242-7727 (anonymous reporting)	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.

Topic	Contact	Information
Laboratory Services	UHCprovider.com > Our Network > **Preferred Lab Network** **LabCorp.com** LabCorp: 1-800-833-3984 **QuestDiagnostics.com** Quest Diagnostics: 1-866-697-8378	LabCorp and/or Quest Diagnostics are network laboratories.
Medicaid [Mississippi Division of Medicaid Services]	**medicaid.ms.gov** 1-800-421-2408 (for English and/or another language) 1-228-206-6062 (deaf and hard of hearing VP)	Contact Medicaid directly.
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal or go to **UHCprovider.com/claims** MississippiCAN: 1-877-743-8734 CHIP: 1-800-992-9940 Appeals and grievances mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 5032 Kingston, NY 12402-5032	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** 1-877-542-9239 / TTY 711 for help accessing member account MississippiCAN: 1-877-743-8731 CHIP: 1-800-992-9940	Assist members with issues or concerns. Available: • 7:30 a.m.–5:30 p.m. Central Time, Monday–Friday • 7:30 a.m.–8:00 p.m. Central Time, Wednesdays • 8:00 a.m.–5: 00 p.m. Central Time, the first Saturday and Sunday of each month.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-877-743-8731 1-877-261-6608 (after hours) 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** 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Support	Chat with a live advocate 7 a.m. -7 p.m. CT from the UnitedHealthcare Provider Portal **Contact us page**	Self-service functionality to update or check credentialing information.

Topic	Contact	Information
Network Management	1-866-574-6088	Ask about contracting and care provider services.
NurseLine	MississippiCAN: 1-877-370-4009 CHIP: 1-877-410-0184	Available 24 hours a day, 7 days a week.
Obstetrics/ Pregnancy and Baby Care	Healthy First Steps Pregnancy Notification and Prenatal Risk Assessment Form at **UHCprovider.com/MScommunityplan** > Provider Forms and References or **UHCprovider.com** > Sign in to the Provider Portal **UHChealthyfirststeps.com** 1-800-599-5985 Fax: 1-877-353-6913	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form or calling. Refer members to uhchealthyfirststeps.com to sign up for Healthy First Steps Rewards.
Oncology Prior Authorization	Uhcprovider.com > Prior Authorization > **Oncology** Optum 1-888-397-8129 Monday -Friday 7a.m.–7p.m. CT	For current list of CPT codes that require prior authorization for oncology
One Healthcare ID Support Center	**ProviderTechSupport@uhc.com** 1-855-819-5909	Contact if you have issues with your 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	1-833-660-2402 (Gainwell)	The pharmacy benefit is administered by Gainwell Technologies.
Prior Authorization Pharmacy	Gainwell **medicaid.ms.gov/pharmacy-prior-authorization** 1-833-660-2402 Fax: 1-866-644-6147	Request authorization for medications as required.

Topic	Contact	Information
Prior Authorization Requests / Advanced & Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: UHCprovider.com/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 1-800-557-9933 for CHIP or 1-877-743-8734 for MississippiCAN Fax: 1-888-310-6858	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/MScommunityplan > Prior Authorization and Notification
Provider Services	UHCprovider.com/MScommunityplan 1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)	Available 7 a.m.–5 p.m. Central Time, Monday through Friday.
Radiology Prior Authorization	UHCprovider.com/radiology 1-866-889-8054 Fax: 1-888-310-6858	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	UHCprovider.com > Referrals or Referrals on the Provider Portal- Click Sign In in the top right corner of UHCprovider.com Provider Services 1-877-743-8734	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	UHCprovider.com/MScommunityplan > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Support	UHCprovider.com/en/contact-us/technical-assistance.html Chat with a live advocate 7 a.m. -7 p.m. CT from the UnitedHealthcare Provider Portal Contact us page 1-866-209-9320 for Optum support or 1-866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/ smoking.

Topic	Contact	Information
Transportation	MississippiCAN only Medical Transportation Management (MTM) 1-844-525-3085	To arrange nonemergent transportation, please contact MTM at least 3 business days in advance.
Utilization Management	Call the general provider services number and follow the prompts. 1-888-980-8728	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Our utilization management team is available Monday–Friday, 8 a.m.–5 p.m. Central Time. Assistance is also available after hours. For UM policies and protocols, go to: UHCprovider.com > Health Plans, Policies, Protocols and Guides > **For Community Plans.** Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program	601-576-7751 or 1-800-634-9258 Contact the Mississippi Department of Health to enroll as a care provider.	Care providers must participate in the VFC Program administered by the Mississippi Department of Health and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with the Mississippi Department of Health to bill for the administration of the vaccine.
Vision Services	March Vision **marchvisioncare.com** 1-844-606-2724	
Website for Mississippi Community Plan	**UHCprovider.com/MScommunityplan**	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	1-877-743-8734
Enterprise Voice Portal		1-877-842-3210
Eligibility	UHCprovider.com/eligibility	1-877-743-8734
Referrals	UHCprovider.com > Referrals	1-877-743-8734
Provider Directory	UHCprovider.com > Our Network > Find a Provider	1-877-743-8734

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

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

Provide official notice

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

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

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

You may use the Care Provider Demographic Information Update Form for demographic changes or to update NPI information for care providers in your office. This form is located on the Provider Portal at UHCprovider.com > Sign In > Provider Practice Profile.

Transition of care - newly enrolled members

Newly enrolled members may continue to see the same care providers for ongoing treatment for up to 90 calendars day, or until the member is transferred to a network care provider, whichever comes first.

During the first 30 days of enrollment, a new prior authorization is not required for medically necessary covered services. This includes services rendered by out-of-network care providers. To help ensure timely processing of claims, out-of network care providers should contact us for administrative approval for those dates of service. To expedite administrative approval, please identify yourself as an out-of-network care provider.

If a claim denial for services is provided within the first 30 days of member eligibility, you will need to submit a claim reconsideration request. To expedite approval for this request, include any treatment authorizations received before the member transitioning to UnitedHealthcare Community Plan.

We may require medical necessity review after the initial 30 days with us. Review our prior authorization requirements and seek prior approval through our standard procedures as needed.

Transition member care following termination of your participation

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

Member notification of care provider plan termination

At least 15 calendar days before the effective date of your termination or your group's termination from the network, UnitedHealthcare Community Plan will send, through regular mail, notification to our affected members/your patients. Your affected patients/our members will include members for whom a claim was filed on your behalf or on behalf of your medical group within the 12 months before the effective date of termination or departure.

Arrange substitute coverage

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

For the most current list of network professionals, review our Provider Directory UHCprovider.com > Our Network > Find a Provider.

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

Mississippi Medicaid ID

MississippiCAN

You must be enrolled in Mississippi Medicaid and have a state provider Medicaid ID to be reimbursed for services provided to a MississippiCAN member. If you do not have a current Mississippi Medicaid ID, a care provider enrollment application can be found at ms-medicaid.com/msenvision.

If you have a current Mississippi Medicaid ID and your claims have denied due to missing Medicaid ID, please contact the Network Management Phone Team at **1-866-574-6088**. We can update your records and adjust affected claims.

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.

- Download the W-9 form at irs.gov > Forms & Instructions > Form W-9.
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Care Provider Paper Demographic Information Update Form.
- To update your care provider information online, go to UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Go To My Practice Profile Tool.

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 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 Portal on UHCprovider.com. Go to UHCprovider.com then Sign In > My Practice Profile. Or submit your change by:

- Completing the Care Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at 1-877-842-3210.

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

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

Performance data

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

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this 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 member data confidentiality

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

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

Follow medical record standards

Please reference Chapter 9 for Medical Record Standards.

Inform members of advance directives

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

No member is required to have an advance directive and cannot be denied care if they do not have an advance directive. Once completed, a member keeps the original. Be aware of the advance directive and maintain a copy in the member's medical record. Do not send a copy to UnitedHealthcare Community Plan. If a member believes that you have not complied with an advance directive, they may file a complaint with our medical director or physician reviewer. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

Your Agreement

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

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

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

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

Appointment standards (Mississippi Division of Medicaid [DOM] access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- **After-hours care phone number** - 24 hours, 7 days a week (without prior authorization)
- **Emergency care** - immediately or referred to an emergency facility
- **Urgent care appointment** - within 24 hours
- **Routine sick appointment** - within 7 calendar days
- **Well care visit** - within 30 calendar days

Specialty care

Specialists should arrange appointments for:

- **Urgent care** - within 24 hours of request
- **Appointment** - within 45 calendar days

Behavioral health/substance use disorder

Behavioral health care providers should arrange appointments for:

- **Urgent care appointment** - within 24 hours
- **Routine appointment** - within 21 calendar days
- **Post-discharge from an acute psychiatric hospital when the UnitedHealthcare Community Plan is aware of the member's discharge** - within 7 calendar days

Notifying members of test results

Care providers should notify members of test results for:

- **Urgent or emergent laboratory or radiology test results** - within 24 hours of receipt of results
- **Nonurgent, nonemergent laboratory and radiology test results** - within 10 business days of receipt of results

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

Provider directory

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

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

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

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

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

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

For delegated providers, email your changes to delprov@uhc.com.

For nondelegated providers, visit UHCprovider.com for the Care Provider Demographic Change Submission Form and further instructions.

Find the medical, dental and mental health care provider directory at UHCprovider.com > Our Network > Find a Provider.

Care provider attestation

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

Prior authorization request

Prior authorization request is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, and/or physician administered drugs.

Coverage may only be provided if the service is deemed medically necessary, or meets specific requirements provided in the benefit plan.

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

- Verify eligibility using the 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 from UnitedHealthcare Community Plan: at UHCprovider.com/paan. Visit UHCprovider.com/MScommunityplan > Prior Authorization and Notification to locate and view the current prior authorization information and notification requirements

Identify and bill other insurance carriers when appropriate.

If you have questions, please call the UnitedHealthcare Web Support at **1-866-842-3278**, 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
- **Nonurgent** - 10 business days

Requirements for PCP and specialists serving in PCP role

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

PCPs are an important partner in the delivery of care, and Mississippi Division of Medicaid (DOM) members may seek services from any participating care provider. The Mississippi DOM programs require members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

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

- General practice
- Internal medicine

- Family practice
- Pediatrics
- Obstetrics/gynecology

Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot; they must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer Service is available 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.

Women have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners 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. Women can have routine check-ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services. **Recorded messages are not acceptable.**

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services. Copayments are not required for well child checkups or preventive visits. Consider payment from us as payment in full.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 16 hours a week for a 1 MD practice and at least 30 hours per week for a 2 or more MD practice.
- Be available to members by telephone any time.
- Respond to after-hour patient calls within 30–45 minutes for nonemergent symptomatic conditions and within 15 minutes for emergency situations.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.
- Encourage all members to receive all necessary and recommended preventive health procedures
- Provide preventive care services to all members in accordance with age, gender and health status.
- Screen members for behavioral health problems using the Behavioral Health Toolkit for the PCP found at **providerexpress.com**. File the completed screening tool in the patient's medical record.
- Provide all Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to members up to 21 years.
- Contact members who are noncompliant with EPSDT services. Report repeated noncompliance to the DOM and UnitedHealthcare Community Plan's Case Management office at 1-877-743-8731.
- Inform UnitedHealthcare Community Plan Case Management at 1-877-743-8731 of any member showing signs of End Stage Renal Disease.
- Give appropriate notice to terminate members per the terms of your Agreement.

Responsibilities of PCPs and specialists serving in PCP role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Follow up with members who are not compliant with the EPSDT screening requirement and EPSDT services. See the EPSDT section in this manual for more information.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services or UnitedHealthcare Community Plan Clinical as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Allow members to change PCPs through a member selected or contractor-reassignment process. This can be due to a variety of reasons including when a care provider terminates relationship with us or Medicaid, when a member chooses to seek a new care provider, or a formal grievance or complaint is filed.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.

PCP checklist

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

- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record

keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.

- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the Mississippi DOM Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

RHC and FQHC

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, physician assistant, nurse practitioner and/or social worker
  - Mental health services
  - Immunizations (shots)

Specialist responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Mississippi DOM Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. A medical director or physician reviewer must approve coverage arrangements that vary from this requirement. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.
- Offer the same office hours to UnitedHealthcare Community Plan members as those offered to our commercial plan members.

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.

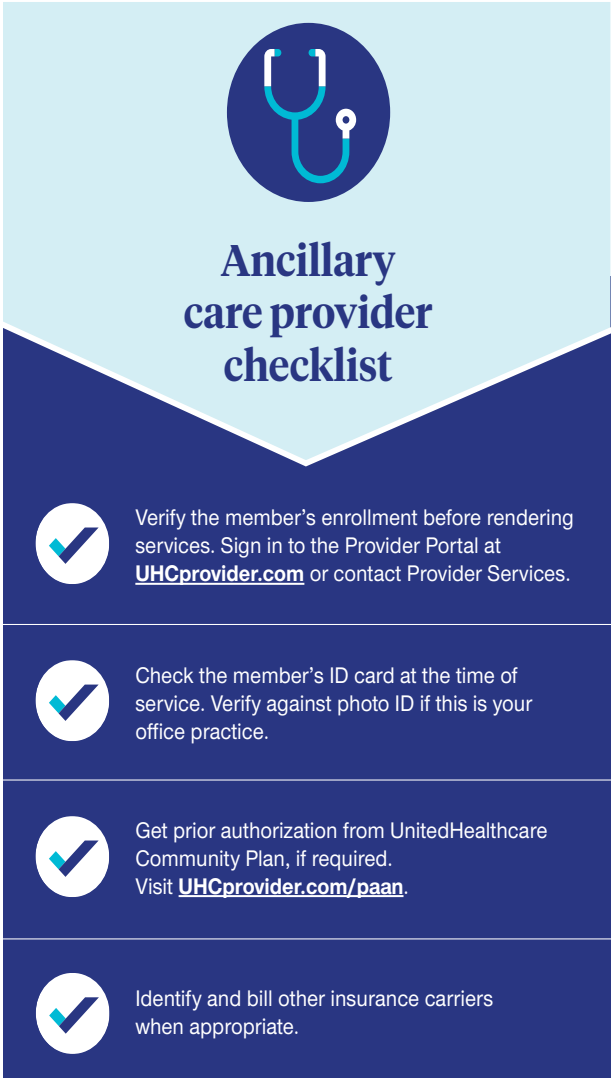
Ancillary provider responsibilities

Ancillary providers include:

- Freestanding radiology
- Freestanding clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment
- Infusion care
- Therapy
- Ambulatory surgery centers
- Freestanding sleep centers
- Other non-care providers

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

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



Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/MS	MississippiCAN: 1-877-743-8731 CHIP: 1-800-992-9940
Member Handbook	UHCCommunityPlan.com/MS Go to Plan Details, then Member Resources, View Available Resources	
Provider Services	UHCprovider.com	1-877-743-8734
Prior Authorization	UHCprovider.com/paan	1-877-743-8734
D-SNP	UHCprovider.com > Resources > Health Plans > Choose a Location > MS > Medicare	1-877-743-8734

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

Member benefits

Go to UHCcommunityplan.com/MS for benefits or UHCprovider > Eligibility for more information.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the 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. Click the Sign In button
3. Log in
4. Click on Community Care

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

You may also find the Document Library user guide at UHCprovider.com > Resources > UnitedHealthcare Provider Portal Resources > Document Library > Self Paced User Guide.

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- MississippiCAN

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

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

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

Member assignment

Assignment to UnitedHealthcare Community Plan

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

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

Download a copy of the Member Handbook online at UHCCommunityPlan.com/MS. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

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

Get eligibility information by calling Provider Services.

Unborn enrollment changes

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

Members may call 1-800-421-2408.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the member has enrolled the 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.

Member eligibility

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

Member ID card (Mississippi Division of Medicaid)

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. Or you may call the Fraud, Waste, and Abuse Hotline.

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

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member.

The Mississippi Medicaid Number is also on the member ID card.

Sample health member ID card

MississippiCAN

Mississippi CHIP


In an emergency go to nearest emergency room or call 911.

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call. If you receive emergency services, notify Member Services within 48 hours of receiving such care.

For Member Service: 800-992-9940 TTY 711
NurseLine 24-7: 877-410-0184 TTY 800-855-2880
Website: myuhc.com/communityplan
Health Plan: 795 Woodlands Parkway, Suite 301, Ridgeland, MS 39157
For Providers: UHCprovider.com 800-557-9933
Medical Claim Address: PO Box 5032, Kingston, NY, 12402-5032
For use of non-participating providers, prior authorization is required: 1-866-604-3267

Member Pharmacy Service: 800-884-3222
For Pharmacists: 833-660-2402

PCP-initiated transfers

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

To transfer the member call Provider Services at 877-743-8734 or mail us and include the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

Mailing address:

UnitedHealthcare Community Plan
c/o Medical Director
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

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

Verifying member enrollment

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

- Provider Portal - access the portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Services** is available from 7 a.m.-5 p.m. Central Time, Monday through Friday.

UnitedHealthcare Dual Complete (D-SNP)

D-SNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

- For general information about D-SNP, go to **uhc.com/medicaid/dsnp**
- For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the **Administrative Guide for Commercial, Medicare Advantage and D-SNP**
- For Mississippi-specific D-SNP information, go to **UHCprovider.com/health-plans-by-state/MS/medicare-plans/dual-complete-snp-plans.html**

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Referrals	1-877-743-8734
Prior Authorization	UHCprovider.com/paan	1-877-743-8734
Pharmacy (Gainwell Technologies)	medicaid.ms.gov/pharmacy	1-833-660-2402
Dental	UHCproviders.com	1-800-508-4862
Healthy First Steps	uhchealthyfirststeps.com	1-800-599-5985

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 healthcare delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.

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

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain.

Without immediate attention, the affected person could suffer major:

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

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

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

Non-emergent ambulance transportation

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

Non-emergent stretcher/ambulance transportation must be requested at least 3 business days in advance. Call **1-844-525-3085**.

Schedule nonemergent ambulance or stretcher rides up to 30 days in advance.

Non-emergent stretcher/ambulance requests are accepted between:

- 7:30 a.m.–5:30 p.m. CT Monday–Friday
- 7:30 a.m.–8 p.m. CT on Wednesday
- 8 a.m.–5 p.m. CT the first Saturday and Sunday of each month

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 a prior authorization if performed in the following places of service:

- Emergency room
- 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: 1-866-889-8054 from 7 a.m.-7 p.m., Monday through Friday.

Make sure the medical record is available.

For the most current list 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.

Case management

We use retrospective and prospective methods to help ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for disease and care management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini-health risk assessment. In addition, we also review authorization requests, hospital and ER use, pharmacy data and referrals from you, members and their family/caregivers and our clinical staff. Identified individuals for possible care management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate DM or CM program based on the outcome of that scoring.

Prospective Identification — UnitedHealthcare Community Plan uses numerous data sources to identify members with a diagnosis for which we have a DM program as well as those whose utilization reflect high-risk and/or complex conditions (level 3). These data sources include but are not limited to:

- Short health risk assessments conducted during new member welcome calls
- Member reported health needs in calls to our Member Services department
- Pharmacy and lab data indicating a specific condition (e.g., insulin or inhalers)
- Emergency room reports, authorization requests and transitional care coordination requests
- Physician referrals
- Referrals from health departments, rural health clinics and FQHCs
- UnitedHealthcare Community Plan clinical staff referrals

Risk Stratification — All identified members complete a health risk assessment that scores them into risk categories. Based on the actionable population and aid categories of each health plan and state program, we determine the specific threshold for each case and disease management level. As previously mentioned, members are stratified into 1 of 3 levels and are assigned to the appropriately qualified staff. You can refer any member to care management.

For questions and more information about Case Management, contact **Member Services**.

Dental services

Covered

A dental provider manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for children and adults ages 21 and older with prior authorization.

Facility services require a prior authorization.

The following services are covered for children younger than 21 years:

- Diagnostic
- Preventive
- Restorative
- Orthodontia
- Emergency pain relief

The following services are covered for adults 21 years and older:

- Diagnostic
- Emergency pain relief

Dental care providers should arrange appointments for:

- **Urgent appointment -** within 48 hours
- **Routine appointment** - within 45 calendar days

Noncovered

UnitedHealthcare Community Plan does not cover routine dental services for anyone 21 years and older. Prior authorization or other limitations may apply for some dental services such as crowns, periodontal or specific oral surgery procedures, and orthodontic treatment. Prior authorization may apply or be required for accidental injury benefits, and procedures for diagnosis and treatment of TMJ syndrome. Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims.

For more details, go to **UHCprovider.com**, or contact Dental Provider Services at 1-800-508-4862.
To find a dental provider, go to **UHCprovider.com** > Our Network > Find a Provider > Dental Providers by State, Network or Location.

Disease management

Our Disease Management (DM) programs are part of our innovative Care Management Program. Our DM program is guided by the UnitedHealthcare Community Plan Care Management model principles. We developed the Whole Person Care Model to address the needs of medically under-served and low income populations. The model places emphasis on the individual as a whole, to include the environment, social determinants, background and culture.

Identifications and stratification

A Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying members for disease management programs.

HRA

The HRA is an initial assessment tool used for new and existing members, to identify a member's health risks. Based upon the member's response to a series of question, the tool will assign a score that corresponds to a level. These levels are as follows:

- **Level 1** - Low-risk members who are typically healthy, stable or only have 1 medical condition that is well managed.
- **Level 2** - Moderate-risk members who may have a severe single condition, or multiple conditions issues across multiple domains of care of DM.
- **Level 3** - High-risk members who are medically fragile, have multiple co-morbidities and need complex care management.

Identification of "rising" is a flag for intervention if a member is progressing into a higher risk category.

Stratification

Our multi-dimensional, episode-based predictive modeling tool, compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

On a monthly basis, the system uses algorithms to identify members for disease management and stratify them into risk levels by severity of disease and associated co-morbidities. The algorithm takes into consideration inpatient and emergency room (ER) use. An "Overall Future Risk Score" is assigned to each member and represents the degree to which the DM program has the opportunity to impact members' health status and clinical outcomes. This assists care managers in identifying members who are most likely to benefit from interventions.

Outreach and other identification processes

While HRAs and retrospective data are the first line of identification of new members in our DM programs, we have developed an extensive outreach program that supports real-time identification and referral for our DM services. Through community partnerships and relationships, our staff encourages and educates care providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of DM interventions when the situation requires it.

We supplement the HRA and the stratification tool identification process through several other methods. One of these approaches is an extensive outreach program that supports real-time identification and referral for our DM services. Our staff encourages and educates care providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of DM interventions when the situation requires it. We also rely on partnering programs and agencies to identify those members most in need. Our DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities to identify members. In addition to claims and pharmacy data, we integrate authorization and pre-certification information into the DM software system. This data provides real-time identification of members experiencing health care barriers and self-care deficits.

DM interventions

After a member has been identified, the care manager contacts the member's parent or caregiver by telephone and sends program and health education materials targeted to the member's specific care opportunities. The accompanying letter informs the member's parent or caregiver on how the member became eligible to participate in the program, how to use the DM services, and how to opt out if they do not wish to participate.

Because our DM program provides benefits and quality of life improvements that impact overall costs in care, our enrollment staff makes every attempt to enroll members in the DM program. We employ a number of strategies to locate and contact the member's parents or caregivers, including after-hours calls, searching for updated member information by contacting the PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to help ensure that all options have been exhausted prior to reporting failure to contact.

Once a member agrees to enroll in the DM program, the care manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of members. We also institute disease specific assessments to augment the HRA when the caretaker is contacted.

We have developed evidence-based interventions for our DM program. The following general interventions have been structured to improve members' health status.

- Health risk assessment
- Health review phone calls
- Provide assigned care manager's phone number to the member/family
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program website
- Episodic educational interventions, as needed
- Post-hospitalization and emergency room assessment

- Educational materials are sent to member
- Additional and/or specific interventions are also conducted to individualize the plan of care

Pharmacy

Our pharmacy disease management is integrated with our other DM programs into our Care Management program. Like the other DM program, it is based on our Personal Care Model (PCM), which emphasizes the whole individual, including environment, background and culture.

We provide pharmacy disease management through Optum Rx, a United Health Group (UHG) company. Optum Rx administers Disease Therapy Management (DTM) programs that are clinical, patient-focused programs offered as part of Specialty Pharmacy Care Management services. The objective of our DTM programs is to improve patient quality of care through education and communication.

Optum Rx Specialty Pharmacy offers DTM programs for the following disease states/conditions:

- Rheumatoid arthritis
- Growth disorders
- Hemophilia
- Risk of respiratory syncytial virus due to prematurity

Additional programs available to Mississippi CHIP members include:

- Hepatitis C
- Multiple sclerosis
- Anemia related to chemotherapy

Our DM program is supported by our integrated clinical system. It includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

Our DM (Medication Management) program is supported by UnitedHealthcare Community Plan's integrated clinical system, which includes basic and comprehensive supplemental assessments, facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools.

For questions and more information about Disease Management, contact **Provider Services**.

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

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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

removal

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

Emergency room care

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

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

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call 1-800-955-7615. The treating care provider may continue with care until the health plan's medical care provider is reached, or when 1 of these guidelines is met:

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

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

Urgent care (nonemergent)

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. In accordance with the provisions of 42 C.F.R. § 422.133-c, post-stabilization services are covered and provided without the need of prior authorization if the services are medically necessary and resulting from the emergency medical condition.

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

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

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

The criteria are available in writing upon request or by calling **Provider Services**.

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

If a member meets an acute inpatient level of stay, admission starts at the time you write the order. Inpatient admissions resulting from emergency services require notification to UnitedHealthcare Community Plan within 24 hours from admission.

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 devices
- Contraceptive counseling
- Laboratory services

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

Noncovered items include:

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

Parenting/child birth education programs

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DOM Regulations for more information on sterilization.

Facility admission notification requirements

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

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

Care coordination/ health education

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

The program goals are to:

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

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

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

Hearing services

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

Hospice

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

Home hospice

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

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

Laboratory

LabCorp and Quest Diagnostics are the preferred lab providers. Contact **LabCorp** and/or **Quest Diagnostics** directly.

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

For more information on our in-network labs, go to **UHCprovider.com**.

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 1-800-599-598 or fax the notification form to 1-877-353-6913.

Healthy First Steps strives to:

- Increase early identification of expectant members and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for nonemergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the parent's support system including referrals to community resources and pregnancy support programs

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

Pregnancy/maternity

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

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

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-800-557-9933 for CHIP or 1-877-743-8734 for MississippiCAN** or go to or go to **UHCprovider.com/paan**. For more information about prior authorization requirements, go to UHCprovider.com/MScommunityplan > **prior authorization and notification**.

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

1. The pregnant member was in the second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. If they have an established relationship with a nonparticipating obstetrician.

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

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

Maternity admissions

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

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or by calling 1-800-557-9933 for CHIP or 1-877-743-8734 for MississippiCAN.

Fax HFS an America College of Gynecology (ACOG) or any initial prenatal visit form at **1-877-365-5960**. Provide the following information within 1 business day of the admission:

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

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

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

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

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

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

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

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

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the parent and the newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for 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 county of all deliveries, including UnitedHealthcare Community Plan members.

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

Home care and all prior authorization services

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

Hysterectomies

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

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

Find the form on the Mississippi DOM website at medicaid.ms.gov.

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

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

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

Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the member's life. In this case, follow the Mississippi 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 Mississippi Department of Social Services Medical Assistance Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

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

You may also find the form on the Mississippi DOM website at medicaid.ms.gov.

Have 3 copies of the consent form:

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

NICU case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > Clinical Guidelines.

Oncology

Prior authorization

To help ensure our member benefit coverage is medically appropriate, we regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence, published clinical guidelines and specialty society guidance.

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

Pharmacy

Pharmacy PDL

Gainwell Technologies administers the prescription drug coverage for all fee-for-service and managed care members. The Universal Preferred Drug List (PDL) applies to all Mississippi CHIP and MississippiCAN members. The PDL applies to prescription medications dispensed by contracted pharmacies to outpatient members. It does not apply to inpatient medications.

If a member requires a nonpreferred medication, call the Gainwell Prior Authorization Unit at 1-833-660-2402, submit the request through the Gainwell provider portal, or fax a Pharmacy Prior Authorization Request form to 1-866-644-6147.

Find the PDL and Pharmacy Prior Authorization Request forms at **medicaid.ms.gov/pharmacy-prior-authorization**.

DUR programs

UnitedHealthcare Community Plan provides retrospective Drug Utilization Review (rDUR) programs, including the Safety Management Program (drug-drug interaction, drug-disease interaction, drug-age interaction, dose per day and average daily dose interaction, therapeutic duplication, overutilization, concurrent use), Opioid Risk Management program, Gaps In Care Program, and the Meds On Track Medication Adherence Program.

Pharmacy prior authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start without delay and prior authorization is not available. The rules apply to nonpreferred drugs on the PDL, and to any drug affected by a clinical prior authorization edit.

To request pharmacy prior authorization, please call Gainwell at 1-833-660-2402 or fax your authorization request to 1-866-644-6147.

Prior authorization requests are reviewed, and notification is sent within 24 hours.

Prescription limitations- MississippiCAN

Medicaid beneficiaries are limited to 6 prescription drugs per month, with no more than 2 of the 6 being brand-name, nonpreferred drugs. Preferred brands do not count toward the monthly brand service limit, but do count towards the drug service limit of 6 per month.

Children younger than 21 can receive more than the monthly prescription limits with a medical necessity prior authorization. Prescribers should make these exception requests either in writing and faxed to Gainwell at 1-866-644-6147 or Gainwell Prior Authorization Unit at1-833-660-2402. Prior authorization request forms are available at **medicaid.ms.gov/pharmacy-prior-authorization.**

Preventive health care standards

Our goal is to partner with you to help ensure members receive preventive care. We endorse and monitor the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive health care standards and guidelines are available at **UHCprovider.com**. Standards such as well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening and cervical and breast cancer screening are included on the website.

Education about preventive health services is provided to both you and members. Members are offered assistance with gaining access to these services if needed. Members may self-refer to all public health agency facilities for medical conditions treated by those agencies.

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:

- Emergency room
- 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** - **1-866-889-8054** from 8 a.m.-5 p.m. Central Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

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.

SBIRT services

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

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

What is included in 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 already are. 3 of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.**

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

- The billing and servicing providers 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 the limit of 4 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
- Emergency room – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – free standing facility

- Tribal 638 free standing facility
- Homeless shelter

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

Medication-assisted treatment

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

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 Mississippi:

1. Go to UHCprovider.com
2. Select "Our Network" then "Find a Provider"
3. Select the care provider information
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"

If you have questions about MAT, please call Provider Services, enter your Tax Identification Number (TIN) then say 'Representative', and 'Representative' a second time, then 'Something Else' to speak to a representative.

TB screening and treatment

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

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the local health department. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

Routine vision, including a comprehensive eye exam and glasses or contacts, is provided through our third-party vendor, MARCH® Vision Care. The MARCH Vision network of ODs and MDs provide primary eye care services. The vision plan provides supplemental coverage for nonsurgical medical eye care through a MARCH Vision doctor.

Examples of covered services include diagnosis and tests for loss of vision, treatment for conditions such as conjunctivitis (pink eye), and management of glaucoma and diabetic retinopathy. MARCH Vision doctors may provide services, if covered, up to the optometry scope of licensure in the state of Mississippi in accordance with the covered benefits.

Members do not need a referral before the initial visit with their selected MARCH Vision doctor. Members may call for an appointment or be seen immediately if you determine urgent care is necessary. Call MARCH Vision at 1-844-606-2724 or visit MarchVisionCare.com.

Please see the Reference Guide for information such as compliance, electronic payment information, safety resources and training or call 1-844-516-2724.

Medical eye care beyond the scope of primary eye care services, to include surgical care, is provided through UnitedHealthcare Community Plan's contracted ophthalmologists as listed in the UnitedHealthcare Community Plan Provider Directory. Please refer patients

to a participating ophthalmologist if medical eye care is needed.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering health care professional name and TIN/NPI
- Rendering health care professional and TIN/NPI
- ICD Clinical Modification (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

For behavioral health and substance use disorder authorizations, please contact United Behavioral Health at **1-877-743-8731**.

If you have questions, go to your state's prior authorization page at **UHCprovider.com/MScommunityplan** > 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
Nonurgent Pre-service	Within 3 calendar days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 24 hours of request receipt	Within 24 hours of the request	Within 24 hours of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective Review	Within 20 business days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 3 business days

Concurrent review guidelines

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

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

Concurrent review details

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

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

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

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

Retrospective review

A retrospective review is conducted after services are provided to a member. We perform these reviews for retro eligibility or for extenuating circumstances related to the member:

1. The member is unconscious upon presentation, and the care provider has not previously submitted a claim for the member; or
2. Acts of nature impairing the facility's ability to verify a member's coverage/ eligibility status.

The request for retrospective review must include a reason and be submitted within 60 days of the service date. Not providing a reason for the retrospective review request will result in a denial.

For a retrospective review request:

- **Call** - 1-800-557-9933 for CHIP or 1-877-743-8734 for MississippiCAN, Monday-Friday, 8 a.m.–5 p.m. Central Time. Emergency calls are accepted after hours.
- **Fax** - 1-888-310-6858

We do not conduct retrospective reviews for:

- Elective ambulatory or inpatient services on the UnitedHealthcare Community Plan advance notification list, found at **UHCprovider.com/MSCommunityPlan > Prior Authorization and Notification,** for which prior approval did not occur before providing the services
- Emergency inpatient services on the advance notification list that did not meet notification requirements. Notification of inpatient admission is required within 1 business day of the admission date.
- Services not requiring prior approval
- Reconsideration and/or review of an adverse benefit determination
- Previously submitted claim

You may request retrospective reviews when you could not determine a member's coverage status. In reasonable incidents, we will not deny payment for medically necessary services for lack of authorization.

For retrospective reviews you launch, we will not deny a claim because you did not file within a specified time period after the date of service when you could not have reasonably known the member's eligibility status during the timely filing period.

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

The services provided, as well as the type of care provider and setting, must reflect the level of services safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the member and not solely for the convenience of the member or care provider. The services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

In the case of pediatric members, the standard of medical necessity will include the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for other members, are:

1. Appropriate for the age and health status of the individual; and
2. Will aid the overall physical and mental growth and development of the individual, and the service will assist in achieving or maintaining functional capacity.

Services not covered under the plan as described in the medical policies will be denied as unproven, experimental in nature, cosmetic or not medically necessary. The member must be held harmless in accordance with the terms of your Agreement.

Determination process

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

Evidence-based clinical guidelines

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

Clinical criteria are available in writing, by request, to:

UnitedHealthcare Community Plan of Mississippi
c/o Medical Director
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Medical and drug policies and coverage determination guidelines

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

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

Only in-network care providers can initiate prior authorizations. Authorization for out-of-network services should be initiated by the in-network PCP or specialist who intends to seek other services. The in-network provider should appropriately indicate the provider who is performing the service through the provider portal.

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**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Mississippi 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
- Noncovered services
- Services provided to members not enrolled on the date(s) of service

Reimbursement policies are available online at: UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan. Reimbursement policies may be referred to in your agreement with UnitedHealthcare Community Plan as "payment policies."

UnitedHealthcare Community Plan may revise, update or add to these policies. As a participating care provider, you agree to abide by these policies. UnitedHealthcare Community Plan is committed to notifying affected care providers of policy changes.

Policies do not cover all issues related to reimbursement for services rendered to UnitedHealthcare Community Plan members as legislative mandates, the physician or other care provider contract documents, the member's benefit coverage documents, and the care provider manual all may supplement or in some cases supersede these policies.

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 Mississippi Division of Medicaid. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

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

Services not covered by UnitedHealthcare Community Plan

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

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care
  - Long-term care services in a nursing home
  - Nursing facility services
  - Intermediate care facilities for members with mental handicap
  - Home- and community-based waiver services
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services
- Any exclusion listed elsewhere in the UnitedHealthcare Community Plan of Mississippi Care Provider Manual, bulletins, or other Mississippi Medicaid publications. This includes:
  - Drugs that are investigational or approved for investigational purposes
  - Drugs used for off-label indications not found in official CMS-approved compendia or generally accepted in peer-reviewed literature

Services requiring prior authorization

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

Seek prior authorization within the following time frames

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

UM 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.

UM appeals

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

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

Key contacts

Topic	Link	Phone Number
EPSDT Enrollment	medicaid.ms.gov > programs > early-and-periodic-screening-diagnosis-and-treatment-epsdt	601-359-6150 1-800-421-2408
Vaccines for Children Enrollment	lmsdh.ms.gov	601-576-7751 1-800-634-9258

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members. EPSDT Services can only be performed by a care provider certified by the Mississippi Division of Medicaid. Services include:

- A comprehensive unclothed physical exam
- Comprehensive family/medical/developmental history
- Immunization status, any shots that are needed
- Lead assessment and testing
- Necessary blood and urine screening
- Tuberculosis (TB) skin test
- Developmental assessment
- Nutritional assessment/counseling
- Adolescent counseling
- Vision testing/screening
- Hearing testing/screening
- Dental referral services

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

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

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

Continuity of Care – The regional center determines the most appropriate setting for eligible home and community-based services (HCBS) and coordinates these services for the member in collaboration with the PCP and health plan coordinator. The care coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

First Steps

Early Intervention Central Referral Unit:
Find the referral form at msdh.ms.gov.
Phone - 601-576-7427 or 1-800-451-3903
Mail -
Mississippi State Department of Health
Early Intervention
O-204, P.O. Box 1700
Jackson, MS 39215-1700
Fax - 601–576-7540

The First Steps Program is handled by the state of MS 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 First Step 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.

Provide information requested to complete the referral process.

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

Full screening

Perform a full screen. Include:

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

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

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded Healthy Children and Youth Program (HCY) services. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

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

Lead screening/treatment

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

TCM

Targeted Case Management (TCM) consists of case management services for specified targeted groups to access medical, social, educational, and other services

provided by a regional center or local governmental health program as appropriate.

Identification – The 5 target populations include:

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

Referral – Refer eligible members to a regional center or local governmental health program, as appropriate, for TCM services. To refer, contact your local CMHC. If you're not sure who your local CMHC is, call BH Member Services at 1-877-743-8731 (MississippiCAN) or 1-800-992-9940 (CHIP).

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

VFC

The Vaccines for Children (VFC) program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC program, but we reimburse for administering the vaccine. To administer a vaccine, you must agree to participate in the State's Immunization Registry. We provide administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. Vaccines may be administered by network care providers, including school-based nurses, by a nonparticipating provider to whom UnitedHealthcare Community Plan has referred the member or by the Mississippi State Department of Health. We cannot reimburse for private stock vaccines when they are available through VFC.

UnitedHealthcare Community Plan must reimburse you on a fee-for-service basis for the cost of administering any immunizations you provide to members. Other nonroutine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, will be covered as any other covered service.

Contact **VFC** if you have questions.
Phone - 601-576-7751 or 1-800-634-9258
Fax - 573-526-5220

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

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

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)
Healthy First Steps Rewards	UHChealthyfirststeps.com	1-800-599-5985
Value Add Services	UHCcommunityplan.com/MS > View plan details	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)

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 **1-800-557-9933** unless otherwise noted.

Chronic condition management

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

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

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

Referral – PCPs may make referrals to support practice-based interventions by contacting the Health Services team at **1-866-270-5785**.

Early Intervention program

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

Healthy First Steps rewards

Mississippi CHIP

Healthy First Steps™ (HFS) 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 Neonatal Intensive Care Unit (NICU) admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Members self-enroll on a smartphone or computer. They can go to UHChealthyfirststeps.com and click on "Register" or call 1-800-599-5985.

How it works

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

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

How you can help

- Identify UnitedHealthcare Community Plan members during prenatal visits
- Share the information with the member to talk about the program
- Encourage the member to enroll at Healthy First Steps Rewards

Mobile apps

Apps are available at no charge to our members. They include **Health4Me**, an app that enables users to review health benefits, access claims information and locate in-network providers.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **1-866-351-6827** to reach a nurse. Mississippi CHIP members can call NurseLine at 1-877-410-0184. MississippiCAN members can call NurseLine at 1-877-370-4009, Health Information Library Pin Number: 466.

On My Way

This online program helps young adults who are either transitioning from foster care or from their parents'/guardians' home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

Quit for Life®

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

SUD recovery coaching

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

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

UHC Doctor Chat— virtual visits

Members will have access to UHC Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for nonemergent care. A board-certified emergency medicine physician 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.

WIC

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

For more information about WIC, call 601-991-6000 or 1-800-545-6747 or go to **msdh.ms.gov/msdhsite/_static/41,0,128.html**.

Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	1-800-888-2998
Provider Services	UHCprovider.com	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)

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

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

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Covered services

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

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

For member resources, go to providerexpress.com > 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 issues.

Members have statewide access for outpatient behavioral health and SUD services. Out-of-state services are limited to specific emergency services.

For information on referring patients for behavioral health and SUD services, call:

- **MississippiCAN**
  - Member Services: 1-877-743-8731
  - Provider Services: 1-877-743-8731
- **Mississippi CHIP**
  - Member Services: 1-800-992-9940
  - Provider Services: 1-800-557-9933

Members should also be referred to this number for assistance in finding a behavioral health care provider.

Benefits include:

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

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the 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 program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering nonemergent services. Get prior authorization by going to UHCprovider.com/priorauth, calling **1-800-557-9933 for CHIP** or **1-877-743-8734 for MississippiCAN**, or faxing 1-888-310-6858.

Collaboration with other care providers

Coordination of care

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

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

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

Portal access

Medical website: UHCprovider.com

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services, on this site. Use online services to verify eligibility, review electronic claim submission, view claim status, and submit notifications/ prior authorizations.

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services to verify eligibility and benefit information (available 7:30 a.m.-5:30 p.m. Central Time, Monday through Friday).

Behavioral health website: providerexpress.com

Update your practice information, review guidelines and policies, and view the national Optum Network Manual.

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.

Addressing the opioid epidemic

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

Brief summary of framework

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

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/ OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at UHCprovider.com > Resources > **Drug Lists and Pharmacy**. Click “Opioid Programs and Resources - Community Plan” to find a list of tools and education.

Prescribing opioids

Go to our **Universal Preferred Drug List** to learn more about which opioids require prior authorization and if there are prescription limits.

Pharmacy lock-In

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

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

Expanding MAT access & capacity

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

To find a behavioral health MAT provider in Mississippi:

1. Go to **UHCprovider.com**
2. Select “Our Network,” then “Find a Provider”
3. Click on “Search for a Behavioral Health Provider”
4. Enter “(city)” and “(state)” for options
5. 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.

Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCcommunityplan.com/MS	1-800-992-9940 (CHIP) 1-877-743-8731 (MississippiCAN)
Member Handbook	CHIP: UHCcommunityplan.com/ms/chip/chip MississippiCAN: UHCcommunityplan.com/ms/medicaid/mississippican	1-800-992-9940 (CHIP) 1-877-743-8731 (MississippiCAN)

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 PHI

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 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

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

Right to request restrictions

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

Right to request confidential communications

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

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCCommunityPlan.com/MS > MS CHIP or MississippiCAN > **Member Handbook**.

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 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
- Be told where, when and how to get the services needed
- Be told by the doctor what is wrong, what can be done, and what the result may be in language understood by the member
- Refuse treatment directly or through an advance directive. Say no to treatment, services, or PCPs, and be told what may happen if they refuse the treatment. They can continue to get Medicaid and medical care even if they refuse treatment.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- 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. Ask for a list of people who have been given a copy of their medical records.
- 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, at no cost to them. If a UnitedHealthcare Community Plan care provider is not available, we will help them get a second opinion from a non-participating provider at no cost to them.
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply
- Get covered benefits or services regardless of gender, race, ethnicity, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay or ability to speak English.
- Not have their medical records shown to others without their approval, unless allowed by law
- Ask for materials to be presented in a manner or language that they understand, at no cost to them

Member responsibilities

Members should:

- Find out how the health care system works
- 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
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Tell UnitedHealthcare Community Plan of any problems with any health care staff
- Get any approvals needed before receiving treatment
- Use the emergency room only during a serious threat to life or health
- Go back to the doctor or ask for a second opinion if health does not improve
- Call the doctor when medical care is needed - even after office hours
- Notify us of any change in address or family status
- Give you and us information that could help improve their health
- Members must pay for unapproved health care received from nonparticipating care providers and have the right to know how to obtain approval for these services

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

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

Chapter 9: Medical Records

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 could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner • Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel

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

Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - 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 1 free copy of their Medical Record. Additional copies may be available at member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame.(i.e., immunization and tuberculosis records required for lifetime).

Medical record review

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

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

Member hospitalization records should include, as appropriate:

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

Medical record documentation EPSDT/well baby/well child tool sample

EPSDT/Well Child/Well Baby Medical Record Review
Past History (REQUIRED)
Family History (REQUIRED)
Interval History (REQUIRED)
Developmental/Behavioral Assessment (REQUIRED)
Nutritional Assessment (Recommended)
Dyslipidemia Screening (Recommended, begin at 2 years)
Lead Screening Assessment (Recommended, 6–72 months)

II. COMPREHENSIVE PHYSICAL
Exam Performed (REQUIRED)
Weight (Recommended)
Height (Recommended)
Body Mass Index (BMI)
Blood Pressure (Recommended)
Head Circumference (Recommended)
Pelvic Exam (Provider discretion, recommended if indicated)

III. LAB TESTS (REQUIRED if age appropriate)
Newborn Blood Screening
Hemoglobin or Hematocrit
Lead Blood Level Screening
Dyslipidemia Screening
Tuberculosis Test
STI Screening

IV. HEALTH EDUCATION (REQUIRED)
Age-appropriate topic/information documented

V. VISION (REQUIRED)
Ocular Alignment (REQUIRED) – between 2 & 6 years, Visual Assessment at 3, 4, 5, 6, 8, 10, 12, 15, 18 years or in-between years through 21 if not done at specified years

VI. HEARING (REQUIRED)
ABR/OAE prior to 1 month, objective at newborn, 4, 5, 6, 8, 10, 12, 15 & 18 years or in-between years through 18 if not done at specified years; subjective at all other visits

VII. ORAL ASSESSMENT or DENTAL REFERRAL
Oral Assessment or Dental Referral (Recommended)

VIII. IMMUNIZATIONS Up-to-Date
Diphtheria, Tetanus, Pertussis 5 doses + booster at 2, 4, 6, 15–18 months and 4–6 years, booster at 11–12 years if completed series.
Haemophilus Influenza Type B (HIB) 3–4 doses at 2, 4, 6 & 12–15 months; 6-month dose not required if Pedvax or ComVax given.
Hepatitis A 2 doses at 12–23 months with doses 6 months apart.
Hepatitis B 3–4 doses at birth, 1–2, 4 & 6–18 months. 4-month dose not required if monovalent vaccine given.
Human Papillomavirus (HPV) 3 doses at 11–12 years, 2nd dose 2 months after 1st, 3rd dose 6 months after 1st; at 13–20 years if not previously vaccinated.
Influenza Annually for 6 months–20 years.
Inactivated Poliovirus (IPV) 4 doses at 2, 4, 6–18 months & 4–6 years.
Measles, Mumps, Rubella (MMR) 2 doses at 12–15 months & 4–6 years).
Meningococcal 1 dose at 11–12 years; 2nd dose (booster) at 16 years. If 1st dose is after 16 years, booster not needed.
Pneumococcal Conjugate 4 doses at 2, 4, 6 & 12–15 months
Rotavirus 3 doses at 2, 4 and 6 months. 6-month dose not required if Rotarix was given at ages 2 and 4 months.
Varicella 2 doses at 12–5 months and 4–6 years.

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 Mississippi Division of Medicaid (DOM): medicaid.ms.gov Gainwell: gainwelltechnologies.com	1-877-842-3210 1-800-421-2408 (MS DOM) 1-800-884-3222 (Gainwell)
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	1-800-455-4521

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

We require your cooperation and compliance to:

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

Care provider satisfaction

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

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

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

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

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

We also distribute clinical practice guidelines upon your request and provide training for you and your staff on how best to integrate practice guidelines into everyday practice. When you demonstrate a pattern of noncompliance with clinical practice guidelines, the medical director may contact you by phone or in person to review the guideline and identify any barriers that can be resolved.

Credentialing standards

Mississippi Medicaid is mandated by the Mississippi Legislature to implement uniform credentialing for providers effective July 1, 2022. UnitedHealthcare Community Plan follows MS Medicaid's credentialing committee decision as it pertains to the MSCAN and CHIP products. Care providers must be approved through the MS DOM credentialing committee to participate as a network provider.

Credentialing and recredentialing process

All MississippiCAN and CHIP providers must be credentialed through the Mississippi Division of Medicaid's **Medicaid Enterprise System (MESA)** provider portal.

Once your credentialing is complete with the Mississippi Division of Medicaid and you have an active MS Medicaid ID number, submit your practice's letter of intent or request for participation by email to **hpdemo@uhc.com**. Once the Mississippi Division of Medicaid's credentialing process is complete, contact UnitedHealthcare to request a participation agreement to join our network. You should receive a reference number (starts with PR) for your request within an hour. If you have not received a PR number within 24 business hours, please double-check your spam or junk folders before resubmitting. Please do not copy anyone on your participation request, as this can cause a submission error that prevents your letter from being received.

As part of your application, please include a statement that the practice is requesting a new medical group agreement, along with the specific medical group specialty, practice roster and copies of Form W-9. The average turnaround time for demographic loading is 30 days, with an additional 30–45 days for completion of the contract process. Please be aware that credentialing approval does not imply or guarantee participation with our health plans. Approved and signed physician contracts are required for participation.

Care provider responsibilities

Immediately notify us, in writing, if your ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, an investigation is initiated by any authorized city, state or federal agency. You will tell us of any new or pending malpractice actions, or of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable

credentialing and licensure requirements, as required by the MS Division of Medicaid and their fiscal agent.

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

Or call us at 866-574-6088.

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

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

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

Arbitration proceedings are held at the location described in your Agreement with us, or if a location is not specified in your Agreement, then at a location as described in the arbitration counties by location section.

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

HIPAA compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

NPI

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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

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

Ethics and integrity

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

Compliance program

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

- Oversight of the Ethics and Integrity program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by educating employees
- Assessing compliance by monitoring and auditing
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management 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 facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud, Waste and Abuse line or go to uhc.com/fraud.

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

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

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

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Mississippi 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 Mississippi Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Mississippi CHIP and MississippiCAN program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

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

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

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

Delegating and subcontracting

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

Office site quality

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

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

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

Criteria for site visits

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

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	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	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 11: Billing and Submission

Key contacts

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

Looking for something else?

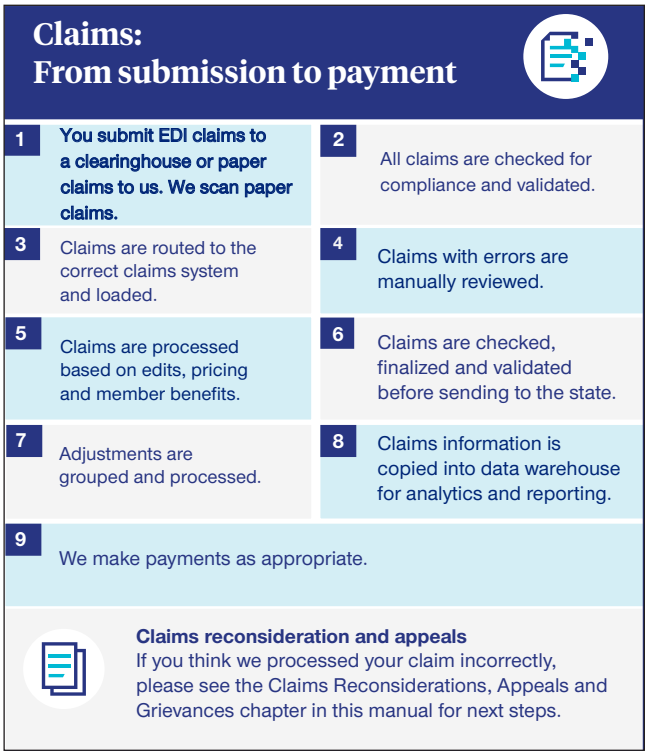
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the “what can we help you find?” search bar

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. Under “Administrative Guide for Commercial, Medicare Advantage and D-SNP”, select “View Guide.” Refer to the Claims Process chapter.



NPI

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

Once you have your NPI, call our Network Account Management team at 1-866-574-6088. You may also email SWProviderservices@uhc.com.

You can also fax NPI information to 1-866-455-4068 or 414-721-9006.

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 by calling Provider Services.

The following NPIs always require validation* on the CMS 1500 claim form:

- Rendering provider
- Billing provider

Rendering NPI are billed in Box 24J. Billing NPI and taxonomy are billed in box 33a and 33b.

***Validation** is a system validation - the system will validate the NPI / taxonomy against the state file we receive daily. If it does not match, the claim will error out instead of deny and will not make it into our platform for processing.

When submitting a taxonomy code, please be sure to include the qualifier ZZ on CMS 1500 (HCFA) forms.

The following NPIs always require validation on the CMS 1450 claim (UB) form:

- Billing provider
- Attending provider
- Operating provider

Billing NPI is billed in Box 56. Billing taxonomy is billed in box 81. Attending and operating are billed in boxes 76 and 77. When submitting a taxonomy code, include the qualifier B3 on CMS 1450 (UB04) form.

You must provide the NPI that aligns with your MS Medicaid ID. Failure to do so may impact claims payment.

General billing guidelines

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

Fee schedule

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

Modifier codes

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

Member ID card for billing

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

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

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

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

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

Please do not send claims on paper or with attachments unless requested by the health plan.

Paper claim specific rules include:

- Submit corrected claims electronically; however, the words "corrected claim" must be in the notes field. Your software vendor can instruct you on correct placement of all notes. You can also do this through the Provider Portal, our online provider portal, by choosing the reconsideration process.
- Submit unlisted procedure codes with a sufficient description in the notes field. Your software vendor can instruct you on correct placement of all notes. If sufficient information cannot be submitted in the notes field, paper must be submitted. X-ray, lab and drug claims with unlisted procedure codes should be submitted with notes.

OT/ST/PT/Dialysis/MHSA claims require the date of service by line item. We do not accept span dates for these types of claims.

Care provider coding

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

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit UHCprovider.com and view the **Social Determinants of Health ICD-10 Coding Protocol**.

Electronic claims submission and billing

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

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

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

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 EDI 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 > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options**.

Correcting errors

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and corrections are not received by the health plan within 180 days from date of service or EOB from primary carrier, the **claim will be considered late billed** and denied as not allowed for timely filing.

e-Business support

Call Provider Services at 800-210-8315 for help with online billing, claims, Electronic Remittance Advices (ERAs), Electronic Funds Transfers (EFTs).

In addition, our interactive voice response (IVR) telephone system is available to members 24 hours a day, 7 days a week. Our nurse triage hotline is available through our IVR for health-related issues.

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** > Resources > then Resource Library to find Electronic Data Interchange menu.

Important EDI payer information

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP

Electronic payment solutions: OptumPay™

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

Why choose ACH/direct deposit?

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

What does this mean to you?

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

Completing the CMS 1500 claim form

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

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

Completing the UB-04 form

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

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

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending 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
- Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

Subrogation and COB

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. At the time of service, please submit all claims to us for processing. Through recovery efforts, we will work to recoup funds related to subrogation and workers' compensation. In addition, if your office receives a third-party payment, notify Customer Service so the overpayment can be recouped.
- **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.

Effective date/termination date

Member coverage will be effective on the date the member is effective with the health plan, as assigned by the Division of Medicaid. Member coverage will terminate on the date the member's benefit plan terminates with the health plan. If a portion of the services or confinement take place before the effective date, or after the termination date, an itemized split bill will be required.

Please be aware effective dates for MississippiCAN and Mississippi CHIP members are frequently revised, as individual members re-verify with the Division of Medicaid. Verify eligibility at each visit to assure coverage for services.

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 > Resources > Plans, Policies, Protocols and Guides > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan.

CCI

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

Comprehensive and component codes

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

- **Separate procedures -** Only report these codes when performed independently
- **Most extensive procedures -** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services -** Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards -** Services part of a larger procedure are bundled
- **Laboratory panels -** Don't report individual components of panels or multichannel tests separately
- **Sequential procedures -** When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported

Mutually exclusive codes

Mutually exclusive code edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same care provider.

CCI guidelines will edit your claims before submission. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technology Information Service, or NTIS, and can be reached at 1-800-363-2068, or online at **ntis.gov**.

CLIA

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, nonexperimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

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

Ambulance claims (emergency)

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

NDC

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.

POS Codes

Go to CMS.gov for Place of Service (POS) 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 45 days to solve your concern. Limit phone calls to 5 issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the Provider Portal by signing in 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 Provider Portal 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, paperwork and faxes

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

Find Provider Portal training on UHCprovider.com/training.

Provider Portal training course is available using the CommunityCare Provider Portal User Guide.

Resolving claim issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

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

For paper claims

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

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

Timely filing

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

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

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

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

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

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

Timely filing limits are generally 180 days from date of services, but can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to the Division of Medicaid website at **medicaid.ms.gov**.

Please see Chapter 12 of this manual for procedures and time frames involving complaints, grievances, appeals and independent reviews.

Balance billing

Do not balance bill members if:

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

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

If you don't know who your provider advocate is, email **southeastprteam@uhc.com**.

Care provider/member cost sharing responsibilities

MississippiCAN

No copayments, deductibles or other cost sharing is allowed for MississippiCAN members. You also may not charge members for missed appointments.

Mississippi CHIP

Mississippi CHIP members are only responsible for the costs allowed under the State of Mississippi's Children's Health Insurance Program Rules and Regulations as valid cost sharing responsibilities. You cannot refuse to provide medically necessary services for a member's failure to pay copayments.

You will collect from the member any applicable Mississippi CHIP copayments, and payments for non covered services. Reasonable efforts to collect should include referral to a collection agency and, where appropriate, court action. Documentation of the collection efforts must be maintained and made available to us upon request.

Cost sharing

No premiums are charged to members for coverage under CHIP. For children in families with annual income at or below 150% of the FPL, there are no cost sharing requirements in the plan of benefits. Likewise, there are no cost sharing requirements in the plan of benefits for children of Native Alaskan or Native American descent, regardless of the poverty level. We pay for covered expenses at 100%.

For members in families with annual income greater than 150% up to 200% of the FPL, cost sharing requirements are imposed in the form of copayments up to an out-of-pocket maximum.

The out-of-pocket maximums are as follows:

- MPC01-$0
- MPC02-$800
- MPC03-$950

There are no cost sharing requirements for routine well baby and well child care visits, including administration of immunizations, vision and hearing examinations, eyeglasses, hearing aids and preventive and diagnostic dental care and routine dental fillings. Also, under federal law, the total amount of copayments for all covered members cannot exceed 5% of the family income in any benefit period. The out-of-pocket maximums have been designed to comply with the federal limits on cost sharing.

Third-party resources

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

Chapter 12: Claim Reconsiderations, Appeals and Grievances

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 Agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

Appeals and grievances related to pharmacy services provided by Mississippi Division of Medicaid through Gainwell should be directed to Gainwell at 1-833-660-2402.

For claims, billing and payment questions, go to **UHCprovider.com**. Please use our online options or phone number.

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

Situation	Definition	Who may submit?	Submission address	Online form for fax or email	Contact information	Website for online submissions	Filing time frame	Response time frame
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care Provider	UnitedHealthcare Community Plan PO Box 5240 Kingston, NY 12402-5240	**UHCprovider.com/claims**	1-800-557-9933	Use the Claims Management or Claims on Provider Portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims	90 calendar days from the date of denial	30 business days
Care Provider Claim Reconsideration	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 5032 Kingston, NY 12402-5092		1-800 557-9933 Fax: 801-994-1224	Use the Claims Management or Claims on Provider Portal. Click Sign In on the top right corner of **UHCprovider.com,** then click Claims	Must receive within 90 business days	45 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
Situation	**Definition**	**Who may submit?**	**Submission address**	**Online form for fax or email**	**Contact information**	**Website for online submissions**	**Filing time frame**	**Response time frame**
Care Provider Complaint	An expression of dissatisfaction, received verbally or in writing, that is of a less serious or formal nature.	Care provider	UnitedHealthcare Community Plan P.O. Box 5032 Kingston, NY 12402-5032	**UHCprovider.com/claims**	1-877-743-8734		Within 30 calendar days of the date of the event causing the dissatisfaction	1 calendar day
Care Provider Grievance	An expression of dissatisfaction with operations, activities, behavior of the health plan or member or any matter other than an adverse benefit determination.	Care provider	UnitedHealthcare Community Plan P.O. Box 5032 Kingston, NY 12402-5032		1-800-557-9933 Fax: 801-994-1082	Click Sign In on top right corner of **UHCprovider.com,** then click Claims	Within 30 calendar days of the dissatisfying event	30 calendar days
Care Provider Appeal	A formal review of a processed claim that was partially paid or denied.	Care provider	UnitedHealthcare Community Plan P.O. Box 5032 Kingston, NY 12402-5032		1-800 557-9933 Fax: 801 994-1082	Use the Claims Management or Claims on Provider Portal. Click Sign In on top right corner of **UHCprovider.com,** then click Claims	Within 30 calendar days of UnitedHealthcare Community Plan's adverse benefit determination	30 calendar days
State Administrative Hearing (MississippiCAN)	A hearing conducted by the Division of Medicaid, or its subcontractor, after an appeal decision by UnitedHealthcare Community Plan.	Care provider	Mississippi Division of Medicaid Attn: Office of Appeals 550 High Street, Suite 1000 Jackson, MS 39201				Within 30 calendar days of UnitedHealthcare Community Plan's final determination	90 calendar days from date filed

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
Situation	**Definition**	**Who may submit?**	**Submission address**	**Online form for fax or email**	**Contact information**	**Website for online submissions**	**Filing time frame**	**Response time frame**
Member Appeal	A formal way to share dissatisfaction with an adverse benefit determination.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	**UHCprovider.com/claims** *AOR Consent Form on this site for member appeals	1-877-743-8731 Fax: 801-994-1082		Within 60 calendar days of the adverse benefit determination	Urgent appeals are resolved within 72 hours of receipt. Standard appeals - the CCO will respond within 30 calendar days.
Member Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364		1-877-743-8731 Fax: 801-994-1082		A member, or authorized representative, can file a grievance any time after the dissatisfying event has occurred	30 calendar days

The above 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.

UnitedHealthcare Community Plan maintains a timely and organized process using policies and procedures to help ensure prompt resolution of informal and formal complaints/grievances filed by you and our members. Our system includes an appeal process and grievance process for both you and the member.

Please refer to the member handbook for member-specific information about complaints, appeals, grievances, and external reviews, which you can find at UHCcommunityplan.com < State Information < Mississippi < **See Plans in Mississippi**.

Denial

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

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

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

Other top reasons for denial include:

- **Duplicate claim** – This is 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

Notice of adverse benefit determination

UnitedHealthcare Community Plan notifies the requesting care provider and provides written notice to members of adverse benefit determinations. An adverse benefit determination includes:

- The denial or limited authorization of a requested service
- Including determinations on the service type or level
- Medical necessity requirements
- Appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of a service payment
- A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter
- The failure to provide services in a timely manner, as defined by the Division
- The failure of the health plan to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- For residents in a rural area with only 1 MCO, the denial of a member's request to exercise their right, under 42 C.F.R. §438.52(b)(2)(ii)
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities
- Determinations by skilled nursing facilities and nursing facilities to transfer or discharge members and adverse determinations made by a state with regard to the pre-admission screening and annual member review requirements of Section 1919(e)(7) of the Act, if applicable

The written notice explains the action taken, the member's right to file an appeal with us and to request a State Fair Hearing (MSCAN) or an Independent External

Review (CHIP) procedure for exercising appeal rights, and information about requesting expedited resolutions and continuation of benefits pending appeal resolution.

UnitedHealthcare Community Plan provides the notice of action within the following time frames:

- For termination, suspension or reduction of previously authorized services, at least 3 calendar or 2 business days prior to the effective date of the intended adverse benefit determination.
- For expedited requests, no later than 72 hours following receipt of the request; and
- For denial of payment, at the time of the determination affecting the claim.
- For standard, noninpatient, hospital service authorizations, no later than 3 calendar days or 2 business days following receipt of all requested information. This may be extended up to 14 additional calendar days if formally requested and the extension is the best interest of the member.

If UnitedHealthcare Community Plan does not make a decision within the applicable time frames, a notice will be issued on the date the time frame expires.

Claim correction

What is it?

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

When to use:

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

How to use:

Use the claims reconsideration application on the Provider Portal. To access the 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 5240
Kingston, NY 12402-5240

Additional Information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common Reasons for Rejected Claims:

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

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

How to use:

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

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

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

- **For administrative denials** - In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.
- **For medical necessity denials** - In your request, please include any additional clinical information that may not have been reviewed with your original claim. Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

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

- **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 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 5032
  Kingston, NY 12402-5032

  Available at **UHCprovider.com/claims**.
- **Fax -** Send the Claim Reconsideration Request Form to **801-994-1224**

Tips for successful claims resolution

To help process claim reconsiderations:

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

Valid proof of timely filing documentation (reconsideration)

What is it?

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

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits

- Letter from another insurance carrier or employer group indicating
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

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

How to use:

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

- **Electronic claims -** Include the EDI acceptance report stating we received your claim
- **Mail or fax 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 are generally 180 days from date of services, but can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

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

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

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

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

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

Where to send:

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

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

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

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

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

Sample overpayment report

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

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	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

Care provider complaint

What is it?

A provider complaint is an expression of dissatisfaction, received orally or in writing, that is of a less serious or formal nature and resolved within 1 calendar day of receipt. A care provider complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation that may be promptly resolved by clearing up the misunderstanding or by providing accurate information.

When to file:

File a complaint within 30 calendar days of the date of the event causing the dissatisfaction. Any complaint not resolved within 1 calendar day is treated as a grievance.

How to use:

You may call or write a complaint.

- **Phone** - Provider Services 877-743-8734
- **Mail** - Send your name, contact information and complaint to:

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

Care provider grievance

What is it?

A provider grievance is an expression of dissatisfaction with operations, activities, behavior of the health plan or member or any matter other than an adverse benefit determination. A grievance is more serious in nature than a complaint that cannot be resolved within 1 business day.

When to use:

You may file a grievance within 30 calendar days of the date of the event causing the dissatisfaction.

How to file:

A provider may file verbally or in writing.

- **Phone -** Provider Services **877-743-8734**
- **Mail -** Send provider name, contact information and your grievance to:

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

We acknowledge receipt of a grievance within 5 calendar days. We will send notice of our decision within 30 calendar days of receipt.

We may extend the resolution by up to an additional 14 calendar days upon your request, or if we demonstrate the need for more information.

Care provider appeals

What is it?

An appeal is a review when a reconsideration claim results in an adverse benefit determination. It is a 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, use the appeal process to ask UnitedHealthcare Community Plan to review the adverse benefit determination.

You must file an appeal within 30 calendar days of the date of UnitedHealthcare Community Plan's notice of adverse benefit determination.

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, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronically -** Use the Claims Management or Claims on the Provider Portal. Click Sign in to the portal in the top right corner of UHCprovider.com, then click Claims. You may upload attachments.
- **Mail -** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 5032
  Kingston, NY 12402-5032
- **Fax** - Send the appeal to **801-994-1082**

UnitedHealthcare Community Plan will acknowledge receipt of your appeal within 10 calendar days and provide the expected resolution date. We will resolve your appeal within 3 days if urgent, or 30 calendar days if not urgent. If we need more time, we may write to tell you we're extending the resolution by up to 14 calendar days.

Questions about your appeal or need a status update?

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

State administrative hearing

MississippiCAN

What is it?

A state administrative hearing lets you share why you think Mississippi Medicaid services should not have been denied, reduced or terminated.

When to use:

You may appeal directly to the Division of Medicaid (DOM) after exhausting UnitedHealthcare Community Plan's appeal process. You have 30 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use/file:

You may ask for a state administrative hearing by submitting a written request to:

Mississippi Division of Medicaid
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

- If DOM reverses a decision to deny, limit or delay services, and these services were not furnished while the appeal was pending, we will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires
- If DOM reverses a decision to deny, limit or delay services, and the member received the disputed services while the appeal was pending, we will pay for these services

Provider independent external (or third party) review

Mississippi CHIP

What is it?

A review of an UnitedHealthcare Community Plan adverse benefit determination conducted by an Independent External Review Organization.

When to use:

A CHIP provider may initiate this review after exhausting UnitedHealthcare Community Plan's member appeal process.

A provider must file a review request in writing within 30 days from the date on UnitedHealthcare Community Plan's final decision.

How to use:

Submit your written request for the independent external review. Send your information by mail or fax.

- **Mail -** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 5032
  Kingston, NY 12402-5032

- **Fax** - 801-994-1082

Member appeals and grievances procedures

In accordance with 42 CFR § 438.402(c)(ii), UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances. You may only file a grievance, appeal, request a state fair hearing (CAN) or Independent External Review (CHIP) on a member's behalf with the written consent of the member. See the member grievances procedure in the CHIP Member Handbook at **UHCCommunityPlan.com/MS > CHIP** or CAN Member Handbook at **UHCCommunityPlan.com/MS > Medicaid > MississippiCAN**.

Member appeals

What is it?

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

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

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

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call, mail or fax the information within 60 calendar days of the notice of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

Phone - **1-800-587-5187** (TTY **711**)

Fax -1-800-757-2617

How to use:

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

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should

not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

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

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

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

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

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

A copy of the form is online at UHCprovider.com. Click **here** for the form.

Member grievance

What is it?

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

When to use:

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

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 5032
Kingston, NY 12402-5032

Phone: **1-800-587-5187** (TTY **711**)

We will send an answer no later than 30 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

State fair hearings

Mississippi CAN

What is it?

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

When to use:

In accordance with 42 CFR § 438.402(c)(ii), members, or their authorized representative on behalf of a member, may appeal directly to the DOM after exhausting UnitedHealthcare Community Plan's appeal process. Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

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

Mississippi Division of Medicaid
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.
- If DOM reverses a decision to deny, limit or delay services, and these services were not furnished while the appeal was pending, we will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires
- If DOM reverses a decision to deny, limit or delay services, and the member received the disputed services while the appeal was pending, we will pay for these services

Continuation of benefits

A member is entitled to continuation of benefits while the appeal or hearing is pending, if all of the following are met:

1. The member timely files the appeal request in accordance with §438.402(c)(1)(ii) and (c)(2)(ii)
2. The appeal involves the termination, suspension, or reduction of previously authorized services
3. The services were ordered by an authorized care provider
4. The period covered by the original authorization has not expired
5. The member timely files for continuation of benefits

If, at the member's request, the health plan continues or reinstates the member's benefits while the appeal is pending, the benefits will continue until one of the following occurs:

1. The member withdraws the appeal or State Fair Hearing request
2. The member does not request a State Fair Hearing and continuation of benefits within 10 calendar days after the health plan sends the adverse resolution to the member's appeal notice under §438.408(d)(2)
3. The DOM issues a State Fair Hearing decision adverse to the member
4. The service limit of a previously authorized service has expired

If the DOM decision upholds our decision, we may initiate cost recovery for the provided service(s), pending the appeal outcome and State Fair Hearing decisions.

We will resolve within the outlined time frames or as quickly as the member's health condition requires (shorter of the 2 circumstances that meet criteria).

Member independent external (or third party) review

Mississippi CHIP

What is it?

A review for a Mississippi CHIP member of an UnitedHealthcare Community Plan adverse benefit determination conducted by an Independent External Review Organization.

When to use:

A CHIP member, or their authorized representative on behalf of a CHIP member, may initiate this review after exhausting UnitedHealthcare Community Plan's member appeal process.

A request must be filed in writing within 120 days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

Submit your written request for the independent external review. Send your information by mail or fax.

- **Mail -** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 5032
  Kingston, NY 12402-5032

- **Fax** - 801-994-1082.

Processes related to reversal of our initial decision

If the state fair hearing or the Independent External Reviewer reverses the outcome is to not deny, limit, or delay services while the member was waiting on an appeal, then we provide the services as quickly as the member's health condition requires but no later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

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

Fraud, waste and abuse

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

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps

identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

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

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

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

Call the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum at 1-866-242-7727 to make anonymous reports and offer tips about suspected fraud, waste or abuse.

If you suspect another care provider or member has committed fraud or abuse, you have a responsibility to report it. Call Monday-Friday, 8 a.m.-4:30 p.m. Central Time. After-hours calls have the option to leave a message and/or request a call back. This number is accessible to both you and members.

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

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

Exclusion checks

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

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

What you need to do for exclusion checks

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

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)
News and Bulletins	UHCprovider.com > Resources > News	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)
Provider Manuals	UHCprovider.com/guides	1-800-557-9933 (CHIP) 1-877-743-8734 (MississippiCAN)

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:

Communication with care providers

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

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

- UHCprovider.com – This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs:
- UHCprovider.com/mscommunityplan – The UnitedHealthcare Community Plan of Mississippi page has state-specific resources, guidance and rules
- **Policies and protocols** – UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans library includes UnitedHealthcare Community Plan policies and protocols
- **Mississippi Health plans**–UHCprovider.com/ms is the fastest way to review all of the health plans UnitedHealthcare offers in Mississippi. To review information for another state, use the drop-down menu at UHCprovider.com > Resources > Health Plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**–This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the portal in Chapter 1 of this manual or by visiting UHCprovider.com/portal. You can also access UHCprovider.com/training > Digital Solutions for many of the tools and tasks available in the portal.

- **UnitedHealthcare Network News–**Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at cloud.provideremail.uhc.com/subscribe. You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

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

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

Email communication – required contact information

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

Submit your email address in 1 of the following ways:

1. Sign up for a One Healthcare ID, which also gives you access to the UnitedHealthcare Provider Portal
2. Subscribe to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your email address and content preferences.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

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

Care provider manual

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

State website and forms

Find the following forms on the state's website at medicaid.ms.gov/resources/forms/:

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

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 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.

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. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter.

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 their 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.

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.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

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 member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members 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 a member in conjunction with the member, the member's representative and the member'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
PCPs, 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 2 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 Diagnosis 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 2 or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

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

Eligibility Determination
Deciding 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 by care providers registered with Medicaid to a 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 where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member 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
An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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 a 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 nonmedical 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.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant members, 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 1 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 used on all electronic transactions. It is a single unique provider identifier assigned to a care 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, physician administered 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 Mississippi DOM.

Specialist
A care provider licensed in the state of Mississippi 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 nonphysician 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.