The quarterly newsletter for Indiana health care professionals

This quarterly newsletter has information to help you do business with us and covers a range of topics, including the benefits of digital tools, manual overviews, Indiana Department of Health guidance and more.

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Questions?
Check out our **UnitedHealthcare Community Plan of Indiana homepage.**

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Continuity of care extension for home and community-based services

UnitedHealthcare is pleased to announce an extension of the continuity of care (COC) period for Home and Community-Based Services (HCBS) under the Indiana PathWays for Aging program. This extension is effective through Feb. 28, 2025, and helps ensure ongoing support and stability for our Medicaid members receiving these essential services.

Providers will receive Notices of Action (NOA) through the **UnitedHealthcare Provider Portal** and via fax. As members transition to new service plans, any updates to the NOA will reflect these changes. The most current service plan and NOA should be adhered to. Please check the UnitedHealthcare Provider Portal regularly to verify the entry of extended NOAs. To ensure the correct extended NOA is displayed, select future service dates when reviewing portal entries. The NOAs reflecting the COC extension will clearly indicate the Feb. 28, 2025, expiration date.

Continuity of care extension

- The extension applies only to HCBS under the PathWays for Aging program
- New assessments will continue to be conducted based on annual review or when triggered by specific events, such as hospitalizations, falls, changes in caregiver support or transitions back to waiver services from Nursing Facility Level of Care (NFLOC)
- This notice serves as official communication regarding the COC extension for UnitedHealthcare HCBS-waiver members under the Indiana PathWays for Aging program

This extension demonstrates our commitment to ensuring seamless, uninterrupted care for our members as we continue to collaborate with providers to deliver high-quality, person-centered services. Providers can refer to IHCP Bulletin BT2024152 for additional details or contact UnitedHealthcare through the **Provider Portal** for further clarification.

By maintaining this continuity, UnitedHealthcare aims to support members' health and independence while minimizing disruptions in their care plans, particularly for those relying on HCBS-waiver services.

Fraud, waste and abuse prevention in Medicaid programs

Ensuring the integrity of Medicaid programs is a top priority for UnitedHealthcare and the Indiana Family and Social Services Administration (FSSA). Fraud, waste and abuse (FWA) can undermine the effectiveness of the health care system, inflate costs and erode trust. As such, UnitedHealthcare is committed to rigorous compliance measures to detect, prevent and report instances of FWA in Medicaid services.

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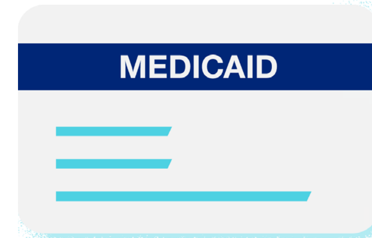
What is fraud, waste and abuse?

- Fraud involves intentional deception or misrepresentation made by a person with the knowledge that it could result in unauthorized benefits, such as billing for services not provided
- Waste refers to the overuse or inefficient use of resources, often due to poor management, resulting in unnecessary costs to the Medicaid program
- Abuse involves actions that are inconsistent with sound medical, business or fiscal practices, such as charging for services that are not medically necessary



Compliance requirements

All providers participating in Medicaid must be vigilant in their efforts to comply with federal and state regulations designed to combat FWA. UnitedHealthcare enforces strict guidelines to ensure that all claims submitted are accurate, legitimate and supported by proper documentation.

How providers can help

1. **Accurate documentation:** Ensure all claims are accurately documented, including proper coding for services rendered. Incorrect coding, whether intentional or not, can lead to improper payments and compliance violations.
2. **Medical necessity:** Only bill for services that are medically necessary and supported by patient records. Any attempt to bill for unnecessary procedures or services could be seen as fraudulent.
3. **Education and training:** Providers and their staff should stay updated on the latest FWA training and resources. Regular training helps identify potential red flags and ensures compliance with Medicaid regulations.
4. **Timely reporting:** If you suspect any instances of FWA, it is critical to report them immediately. Providers can contact the Indiana Medicaid Fraud Control Unit (MFCU) at 800-382-1039 or the UnitedHealthcare Fraud Hotline at 844-359-7736. Additionally, providers can report online through the secure **UnitedHealthcare Fraud Reporting page.**

Consequences of FWA

Non-compliance with FWA regulations can result in severe penalties, including:

- Fines and financial penalties
- Loss of Medicaid participation status
- Civil or criminal prosecution
- Reputational damage

Our role

UnitedHealthcare works closely with the Indiana FSSA and other regulatory bodies to monitor Medicaid claims for signs of fraud, waste and abuse. Through audits, data analysis and provider reviews, we can detect and prevent improper billing practices. Additionally, UnitedHealthcare offers ongoing education and resources to providers to help maintain compliance.

Staying proactive

Providers are encouraged to review the latest Medicaid FWA guidelines, participate in mandatory training and use the resources available through the **UnitedHealthcare Provider Portal.** By taking an active role in FWA prevention, providers can help protect the integrity of Medicaid services and ensure resources are directed where they are most needed.

For more information, providers can also consult Indiana's Hoosier Care Connect Program Integrity Plan for compliance measures and additional reporting guidelines. Together, we can safeguard the Medicaid program for the members who rely on it and ensure that health care dollars are spent responsibly and ethically.

Behavioral health coordination of care audits

UnitedHealthcare Community Plan is committed to improving the quality of care provided to its members through a robust system of checks and continuous improvements. As part of this effort, semi-annual behavioral health coordination of care audits will be conducted for in-network outpatient behavioral health providers. These audits aim to ensure effective collaboration and communication are maintained between behavioral health providers and primary medical providers (PMPs).

The audits will examine clinical documentation to assess the sharing of essential behavioral health treatment information between providers. This includes:

- Primary and secondary diagnoses to ensure a full understanding of the member's health status
- Findings from assessments, offering a comprehensive view of the member's behavioral health condition
- Prescribed medications, ensuring appropriate medication management and reducing the risk of conflicting treatments
- Psychotherapy treatments prescribed to the member
- Other relevant health information that supports holistic and coordinated care

Why conduct these audits?

The integration of behavioral and primary health care is vital to providing comprehensive and continuous care to our members. Coordinated care across behavioral and medical services experience can help improve health outcomes, reduce hospitalizations and improve adherence to treatment plans. For UnitedHealthcare, this initiative represents a proactive approach to health care that not only aligns with best practices but also fosters better patient experiences and long-term well-being.

The primary objectives of these audits are:

- **Enhancing communication:** Encouraging regular communication between behavioral health and primary medical providers helps ensure each provider is fully informed of the member's overall health, reducing gaps in care
- **Improving member health outcomes:** A coordinated care approach addresses both the physical and mental health needs of members, improving overall treatment effectiveness
- **Reducing duplication of services:** Sharing information between providers helps eliminate the unnecessary duplication of diagnostic tests, medications or therapies, which can reduce costs and enhance member safety
- **Fostering better treatment plans:** When providers collaborate, they can create more comprehensive and tailored treatment plans that address the full spectrum of a member's health, leading to higher satisfaction and better adherence to prescribed treatments

Provider participation

UnitedHealthcare's Provider Performance team will randomly select in-network behavioral health outpatient providers for the audit. Selected providers will be contacted and asked to submit clinical records and supporting documentation for the chosen members. The review process will evaluate the extent and quality of the communication between the behavioral health and medical providers, with a focus on improving care coordination.

Benefits to providers and members

For providers, participating in these audits can offer valuable insights into how to strengthen interdisciplinary collaboration, reduce administrative burdens and ensure compliance with best practices. For members, improved coordination of care translates to more effective treatments, a higher level of care continuity and better health outcomes.

The behavioral health coordination of care audits are designed to ensure members receive integrated and comprehensive care by promoting clear communication and collaboration between their behavioral health and primary medical providers. This initiative underscores our ongoing commitment to delivering high-quality, patient-centered health care solutions.

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The Individual Health Record

The Individual Health Record (IHR) is a technology platform that provides a robust digital record of a person's UnitedHealthcare health care history. IHR takes data from across systems and transforms it into a record that communicates each person's health history and current health status.

The platform delivers patient information across all patient encounters in the health care delivery system, including:

- Diverse data such as inpatient, outpatient, ambulatory, in-network, out-of-network and reported sources are combined into a single record
- Access to current and historical diagnoses, visits, medications and tests from physicians outside your practice care

The IHR provides a broader view of your patient's overall health care experience. It benefits care teams by helping you:

- Make the most of the patient's visit, potentially closing gaps in care
- Identify potential admission/readmission risks early, so you can take preventive measures

Coordination

The IHR reduces unnecessary or duplicated tests and appointments. All clinical teams work from the same patient information, helping you:

- Reduce administrative burden by automating the movement of data
- Decrease possible test duplication and increase the ability to monitor items, such as medication through near real-time data
- Get a broader understanding of your patients' overall health care

How do I request access to IHR?

- Go to **UHCprovider.com/newuser**
- Contact UnitedHealthcare Web Support at **providertechsupport@uhc.com**
- Call **866-842-3278**, option 1, 7 a.m.–9 p.m. CT, Monday–Friday

Questions?

Call the Dedicated Service Team at **888-761-0346,** 7 a.m.–7 p.m. CT, Monday–Friday. The Dedicated Service Team will research the issue and validate the information.

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