



2026 Care Provider Manual

Physician, Care Provider, Facility and
Ancillary Care: Long-Term Care and Managed
Medical Assistance

Florida

Welcome

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

If you have questions about the information or material in this manual, or about any of our policies or procedures, for Managed Medical Assistance (MMA) connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** or Long-Term Care (LTC) **Provider Services** at **1-800-791-9233**.

Click the following links to access different care provider manuals:

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

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



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

Long Term Care and Managed Medical Assistance

All content within this manual applies to both Long-Term Care (LTC) and Managed Medical Assistance (MMA) unless otherwise noted.

Using this care provider 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

Terms and definitions as used in this care provider manual:

- “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- “You,” “your” or “care provider” refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- “Community Plan” refers to the UnitedHealthcare Medicaid plan
- “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with us
- “Us,” “we” or “our” refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this care provider manual
- Any reference to “ID card” includes a physical or digital card

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

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal . For chat options and contact information, visit UHCprovider.com/contactus	1-800-791-9233 LTC
Training	UHCprovider.com/training For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC
UnitedHealthcare Provider Portal	UHCprovider.com , then Sign In using your One Healthcare ID or go to UHCprovider.com/portal New users: UHCprovider.com/access	1-800-791-9233 LTC
CommunityCare Provider Portal Training	UnitedHealthcare CommunityCare Provider Portal User Guide	

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

- Children
- Children's parents and caretakers/relatives
- Pregnant women
- Aged or disabled individuals, regardless of receipt of Supplemental Security Income (SSI)

Only members who meet eligibility requirements and are living in a region with authorized managed care plans may enroll and receive services.

UnitedHealthcare Community Plan serves members in the following regions:

Region B: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union, Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia

Region D: Hardee, Highlands, Hillsborough, Manatee, and Polk

Region I: Miami-Dade and Monroe

The UnitedHealthcare Community Plan offers the following services:

- Long Term Care (LTC)
- Managed Medical Assistance (MMA)

The Agency for Health Care Administration (AHCA) administers Medicaid services in Florida. Either the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients) determines member eligibility. If you have questions about the information in this manual or about our policies, go to [UHCprovider.com](#) or call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#).

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at [UHCprovider.com/join](#). There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information. For LTC Home & Community Based providers, submit an email to **FL LTC Network** or call the LTC Provider phone line at 1-407-659-7241.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at [UHCprovider.com/attestation](https://uhcprovider.com/attestation).

Approach to health care

Care Model

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

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

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs

- Education and support with complex conditions
- Tools for helping members engage with providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The goals of the Care Model program are to:

- Avoid Potentially Preventable Events (PPEs), such as inpatient (IP) admission, re-admission and unnecessary emergency room (ER) visits
- 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 UnitedHealthcare Community Plan member to Care Model, call **1-888-716-8787**.

Contact after hours or weekends: Nurse Line: **1-877-678-8624** or uhc_fl_fbhrcm@optum.com.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan® has developed a Cultural Competency Program. Cultural competency is vital to closing gaps in the health care delivery system, particularly important during an individual's care planning process. Health services that are respectful of and responsive to the needs of diverse individuals and populations help us achieve positive outcomes. You must support our Cultural Competency Program. For more information, go to [UHCprovider.com/resourcelibrary](https://uhcprovider.com/resourcelibrary) > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education:** Free continuing medical education (CME) and non-CME courses are available on our [Cultural Competency page](#) as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our [data attestation process](#).
- **Translation/interpretation/auxiliary aide and services:** You must provide language services and auxiliary aide and services, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services. If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member. Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record. Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability. If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.
- **Care for members who are deaf or hard of hearing:** You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

We are committed to eliminating health disparities, or unfair differences, in how members receive health care. We give members the care and support they need to achieve optimal health.

Health disparities can be based on a person's:

- Race
- Ethnicity
- Age
- Language
- Income
- Disability
- Location
- Gender identity

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:**
 - We provide interpreter services Monday-Friday, 8 a.m.-8 p.m. ET
 - To arrange for interpreter services, please call **1-877-842-3210, TTY 711**
- **I Speak language assistance card:** This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English, Spanish or Haitian Creole. We also provide materials for visually impaired members. For more information go to [UHC.com > Language Assistance](#).

Helping our members who are hearing or speech impaired

We use the **711** TRS/TTY line to communicate with hearing impaired members. We also print the contact information on all member mailings and marketing materials. Member advocates receive training on handling calls from Communication Assistants. When the office is closed, the Communication Assistant can leave a message on the system requesting a call back. We answer those messages by the next business day using TRS via **711**. We will also accept calls from any relay service that a member uses.

Assistance for members with cognitive impairments

For those members with cognitive deficits related to either disease (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our member advocates are trained to assist the member and, if necessary, get assistance from a care coordinator as necessary for in-person member assistance.

Linking homeless members with community resources

We recognize certain members have significant social and emotional challenges, including homelessness. We employ community health workers (CHWs) from local neighborhoods to help determine a member's barrier to accessing care.

For more information, go to [UHC.com/legal](https://www.uhc.com/legal) > nondiscrimination-and-language-assistance-notice

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

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

Application Programming Interface

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

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit [UHCprovider.com/api](https://www.uhc.com/api).

Electronic Data Interchange

Electronic data interchange (EDI) is a self-service 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), and
 - Electronic remittance advice (ERA/835).

Visit [UHCprovider.com/EDI](https://www.uhc.com/EDI) for more information. Learn how to optimize your use of EDI at [UHCprovider.com/optimizeedi](https://www.uhc.com/optimizeedi).

Getting started

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

Read our [Clearinghouse Options](#) page for more information.

Point of Care Assist

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

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the [UnitedHealthcare Provider Portal](#). You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

See [UnitedHealthcare Provider Portal](#) for access and to create ID or sign in using a One Healthcare ID.

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

Here are the most frequently used tools on the [UnitedHealthcare Provider Portal](#):

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to [UHCprovider.com/eligibility](#).

- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to [UHCprovider.com/claims](#).
- **Prior authorization and notifications** – Submit notification and prior authorization requests. For more information, go to [UHCprovider.com/priorauth](#).
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare Provider Portal. You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile** – View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to [UHCprovider.com/mpp](#).
- **Document Library** – Access correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to [UHCprovider.com/documentlibrary](#).

See [UnitedHealthcare Provider Portal](#) to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

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

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

All users will access Direct Connect using [UnitedHealthcare Provider Portal](#). Email directconnectsupport@optum.com to get started with Direct Connect.

Privileges

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

Provider Services

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



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

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

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer and/or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Protection Act (TCPA) Opt Out form**. The Provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and it will be processed within 10 business days and your phone number will be removed from the do not call registry.

For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit UHCprovider.com/contactus.

How to contact us

*We no longer use fax numbers.

Topic	MMA	LTC	Contact	Information
Behavioral, mental health & substance abuse	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	Optum® providerexpress.com	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	UHCprovider.com/benefits	Confirm a member's benefits and/or prior authorization.
Care model (care management/disease management)	1-888-716-8787 Contact after hours or weekends: Nurse Line: 1-877-678-8624		Additional case management resources: Medical referrals uhc_fl_fbhrcm@optum.com Behavioral referrals carecoordination@optum.com Opioid Use Disorders (OUD)/ Substance Use Disorders (SUD) uhc_fl_fbhrcm@optum.com	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	myoptumhealthphysicalhealth.com	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	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	UHCprovider.com/claims UnitedHealthcare Community Plan P.O. Box 5290 Kingston, NY 12402-5290 For Fed-Ex (large packages/ more than 500 pages) UnitedHealthcare Community Plan 709 Grant Avenue, North Lobby Lake Katrine, NY 12449	Verify a claim status or get information about proper completion or submission of claims.

Topic	MMA	LTC	Contact	Information
Claim Overpayments			<p>Sign in to UHCprovider.com/claims to access the UnitedHealthcare Provider Portal.</p> <p>Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</p>	<p>Ask about claim overpayments.</p> <p>See the Overpayment section for requirements before sending your request</p>
Dental			<p>DentaQuest of Florida 11100 W Liberty Drive Milwaukee, WI. 53224 DentaQuest.com/Florida 1-888-468-5509</p> <p>Liberty Dental Plan of Florida 7870 Woodland Center Blvd. Tampa, FL. 33614 libertydentalplan.com/FLMedicaid 1-833-276-0850</p>	<p>The state offers dental services through the listed providers. They are not offered through UnitedHealthcare Community Plan.</p>
Electronic Data Intake (EDI) issues			<p>EDI Transaction Support Form UHCprovider.com/edi ac_edi_ops@uhc.com 1-800-210-8315</p>	<p>Contact EDI Support for issues or questions.</p>
Eligibility	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	UHCprovider.com/eligibility.	Confirm member eligibility.
Enterprise Voice Portal			<p>Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal</p>	<p>The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.</p>

Topic	MMA	LTC	Contact	Information
Fraud, waste, and abuse (payment integrity)			<p>Payment Integrity Information: UHCprovider.com/flcommunityplan > Integrity of Claims, Reports, and Representations to the Government</p> <p>Reporting: uhc.com/fraud 1-844-359-7736 or 1-877-401-9430</p> <p>State Consumer Hotline: 1-888-419-3456 or</p> <p>Florida Attorney General's Office: 1-866-966-7226</p>	<p>Learn about our payment integrity policies.</p> <p>Report suspected FWA by an care provider or member by phone or online.</p>
Healthy behaviors			<p>UnitedHealthcare Community Plan member programs</p> <p>1-800-825-8792</p> <p>HealthyBehaviorsProgram_DL@ds.uhc.com</p>	<p>Member incentive programs for weight loss, tobacco cessation and substance use cessation.</p>
Housing program			<p>Housing program:</p> <p>We have a dedicated Housing Navigator who works with our members. The role of the Housing Navigator is to:</p> <ul style="list-style-type: none"> • Help when members have a housing crisis • Help members find and maintain housing • Help members with public assistance programs or housing applications • Help members access services through a network of community housing providers <p>If you are experiencing housing instability and/or have questions, please contact our Housing Navigator at FLhousingreferral@uhc.com</p>	<p>Housing assistance and support for members according to their needs.</p>
Laboratory services			<p>UHCprovider.com/findprovider > Preferred Lab Network</p>	<p>The Preferred Lab Network webpage provides a full listing of eligible labs.</p>

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Topic	MMA	LTC	Contact	Information
Medicaid			<p>Medicaid.gov 1-866-762-2237</p> <p>Provider Enrollment: Enrollment Florida Medicaid Web Portal (flmmis.com)</p> <p>Complaints: Florida Medicaid Providers - How to File a Complaint (myflorida.com)</p> <p>General AHCA website: The Agency For Health Care Administration (myflorida.com)</p> <p>Florida Department of Children and Families (FL DCF)</p>	<p>Contact Medicaid directly.</p> <p>Provider enrollment, covered services, complaints, issues, etc.</p> <p>Member eligibility.</p>
Medical claim, reconsideration and appeal	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	<p>UHCprovider.com/claims</p> <p>Most care providers in your state must submit reconsideration/appeal requests electronically.</p> <p>For further information on reconsiderations and appeals, see the Reconsiderations and Appeals interactive guide.</p>	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	1-888-716-8787	1-800-791-9233	<p>myuhc.com®</p> <p>1-877-542-9239 / TTY 711 for help accessing member account</p>	Assist members with issues or concerns. Available Monday-Friday, 7 a.m. – 7 p.m.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	TDD 711	Available Monday-Friday, 8 a.m. – 5 p.m., except state designated holidays.
National Plan and Provider Enumeration System (NPPES)			<p>nppes.cms.hhs.gov</p> <p>1-800-465-3203</p>	Apply for a National Provider Identifier (NPI).
Network management	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233		A team of provider relation advocates. Ask about contracting and care provider services.

Topic	MMA	LTC	Contact	Information
Network management support			Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	Self-service functionality to update or check credentialing information.
NurseLine			1-877-552-8105	Available 24 hours a day, 7 days a week.
Obstetrics/ pregnancy and baby care			<p>Healthy First Steps®: 1-800-599-5985</p> <p>Pregnancy Notification Form at UHCprovider.com, then sign into the UnitedHealthcare Provider Portal.</p> <p>1-800-599-5985 uhhealthyfirststeps.com</p>	<p>Experienced OB case managers provide education regarding medical and emotional aspects of pregnancy, how to recognize and report complications and assistance with transportation and other community-based services. Compliance with appointments and provider treatment plans are always discussed during telephone calls.</p> <p>For pregnant members, contact Healthy First Steps by calling, filling out the online Pregnancy Notification Form or faxing the OB Needs Assessment Form.</p> <p>Obstetrical Risk Assessment Form (OBRAF) - Provider incentives are available.</p> <p>Refer members to uhhealthyfirststeps.com to sign up for Healthy First Steps Rewards.</p>
Oncology prior authorization			<p>UHCprovider.com/oncology 1-888-397-8129 Monday -Friday, 7am - 7pm CT</p>	For current list of CPT codes that require prior authorization for oncology.
One Healthcare support center			<p>Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at UHCprovider.com/chat</p> <p>1-855-819-5909</p>	Contact if you have issues with your ID. Available Monday-Friday, 7 a.m. - 9 p.m., Saturday, 6 a.m. - 6 p.m. and Sunday, 9 a.m. - 6 p.m.

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Topic	MMA	LTC	Contact	Information
Pharmacy services			professionals.optumrx.com 1-877-305-8952 OptumRx®	OptumRx oversees and manages our network pharmacies.
Physical, occupational and speech therapy	(managed by Optum) 1-800-873-4575	1-800-791-9233	UHCprovider.com/findprovider Optum provider credentialing/ contracting questions: myoptumhealthphysicalhealth.com .	Request prior authorization.
Prior authorization/ notification for pharmacy			UHCprovider.com/pharmacy 1-800-310-6826	Request authorization for medications as required. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred Check coverage and price, including lower-cost alternatives.
Prior authorization requests & advanced notification			To notify us or request a medical prior authorization: Online Tool: UHCprovider.com/priorauth EDI: Transactions 278 and 278N Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." 1-877-651-6677	Use the Prior Authorization and Notification Tool online to: <ul style="list-style-type: none"> • 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/FLcommunityplan > Prior Authorization and Notification

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Topic	MMA	LTC	Contact	Information
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	UHCprovider.com/flcommunityplan	Available Monday-Friday, 7 a.m. – 5 p.m.
Radiology prior authorization			UHCprovider.com/radiology > Sign In 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233	UHCprovider.com/referrals	Submit new referral requests and check the status of referral submissions.
Reimbursement policy			UHCprovider.com/FLcommunityplan > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support			For chat options and contact information, visit UHCprovider.com/contactus 1-866-209-9320 for Optum support	Call if you have issues logging in the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line			1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	Reservations 1-888-777-6528 Ride Assist 1-888-777-6528 Hospital Discharge Facility line: 1-888-778-5113	Reservations 1-888-777-6528 Ride Assist 1-888-777-6528	MTM	To arrange non-emergent transportation, please contact MTM at least 3 business days in advance.

Topic	MMA	LTC	Contact	Information
Utilization management	<p>1-888-716-8787 TTY 711</p> <p>For after hours or weekend inpatient admissions: 1-866-547-0649</p> <p>For hours of operations: 1-866-815-5334</p>	<p>1-800-791-9233 TTY 711</p>	Provider Services	<p>UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines.</p> <p>For UM policies and protocols, go to UHCprovider.com/protocols.</p> <p>Request a copy of our UM guidelines or information about the program.</p>
Vision services	<p>1-888-716-8787 TTY 711</p>		<p>March Vision Care marchvisioncare.com 1-844-386-2724</p>	<p>Prior authorization is required for all routine eye exams and hardware.</p>
Website for FL Community Plan			UHCprovider.com/flcommunityplan	<p>Access your state-specific CommunityPlan information on this website.</p>

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
General care provider assistance	Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	
Eligibility	UHCprovider.com/eligibility For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
Referrals	UHCprovider.com/referrals For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
Provider Directory	UHCprovider.com/findprovider For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC

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 disability, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

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

This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

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:

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

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

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal** is available to help you and our members with the transition.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers. For a current list of care providers see UHCprovider.com/findprovider.

Administrative terminations for inactivity

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

- 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.

- 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.

Changing an existing TIN or adding a care provider

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

Updating your practice or facility information

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

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

After-hours care

After hours or weekends: Nurse Line: **1-877-678-8624**.

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.

If the member is in a life-threatening situation, refer them to the ER.

MMA

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.

LTC

The managed care plan provides members with home and community based services (HCBS) based on their needs. HCBS is available on a daily basis or for extended hours. When an unexpected gap in in-home HCBS occurs, the plan helps provide in-home HCBS services within 3 hours of the reported gap.

Home and Community-Based Services requirements

Home and community-based services (HCBS) assisted living facilities and adult family care home providers support the member's community inclusion and integration. They work with the case manager and member to help achieve the member's personal goals and community activities.

Members living in assisted living facilities and adult family care home may use the following services unless medical, physical, or cognitive impairments prevent members from using them:

- Private or semi-private rooms, as available
- Roommate for semi-private rooms
- Locking door to living unit
- Unlimited access and use of phone
- Eating schedule
- Activities schedule
- Participation in facility and community activities

Members may have unrestricted visitation and snacks as desired. In addition, they may prepare snacks as desired and maintain personal sleeping schedule.

Adult day care providers support the member's community inclusion and integration. They work with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

Members using adult day health services have the following options unless medical, physical, or cognitive impairments limit these options:

- Daily activities
- Physical environment
- Interaction
- Unlimited access and use of phone
- Eating schedule
- Activities schedule
- Participation in facility and community activities

They may have their:

- Right to privacy
- Right to dignity and respect
- Freedom from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Self-expression opportunities through individual initiative, autonomy, and independence

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. See UHCprovider.com/protocols.

Office hours

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

Protect confidentiality of member data

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

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

Follow medical record standards

Please reference **Chapter 9** for Medical Record Standards.

Inform members of advance directives

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

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 Handbook by calling **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.

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

Mutual obligations- UnitedHealthcare and provider professional conduct

Professional conduct

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

- **Collaborate for member outcomes:** Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism:** At all times, treat other providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.

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

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

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

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

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

Education

You must supply a copy of your own code of conduct, which must be consistent with these requirements, or if you do not have a code of conduct, comply with the above and provide the UnitedHealth Group Code of Conduct at unitedhealthgroup.com > Suppliers > Compliance Program > Code of Conduct to your employees. You must provide the materials annually to your employees and within 90 days of hire for new employees.

We may request documentation to verify compliance.

Appointment standards (Agency for Health Care Administration access and availability standards)

Agency for Health Care Administration (AHCA) complies with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 48 hours if no prior authorization is required, and within 96 hours if prior authorization is required
- Routine care appointment: within 30 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days

Specialty care

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

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

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

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

Provider directory

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

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

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

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

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

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

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

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

Care provider attestation

Confirm your provider data every quarter through the [UnitedHealthcare Provider Portal](#) or by calling **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#). If you have received the upgraded My Practice Profile and have editing rights, access the [UnitedHealthcare Provider Portal](#) to make many of the updates required in this section.

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

Prior authorization request

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

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

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

- Verify eligibility using the Provider Portal at UHCprovider.com/eligibility or by calling **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#).
- Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
 1. To access the Prior Authorization app, go to UHCprovider.com, then click Sign In.
 2. Select the **Prior Authorization and Notification app**.
 3. View notification requirements.
- Identify and bill other insurance carriers when appropriate.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

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

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

Specialists include internal medicine, pediatrics, or obstetrics/gynecology

PCPs are an important partner in the delivery of care, and Florida Medicaid members may seek services from any participating care provider. The Florida Medicaid program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a “medical home.”

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

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

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

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

Members may change their assigned PCP by contacting Member Services.

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

PCP changes may only be made effective the 1st of the current month if the member has not seen a PCP/ PCP group the current month, or if the member has only seen the PCP/PCP group they are requesting. Otherwise, the change must be made effective the 1st of the following month. We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

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

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

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

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

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

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

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

- Complying with the FL Medicaid
- Access and Availability standards for scheduling emergency, urgent care and routine visits
Appointment Standards are covered in **Chapter 2** of this manual

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

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

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) as their PCP.

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

- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

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

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

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

Ancillary care provider responsibilities

Ancillary care providers include:

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

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

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

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required.
- Visit **[UHCprovider.com/priorauth](https://uhcprovider.com/priorauth)**.
- Identify and bill other insurance carriers when appropriate

Interacting with capitated/delegated groups

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

What is capitation?

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

What is delegation?

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

We may delegate:

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

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

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

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

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

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

Key principles:

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

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	UHCCommunityPlan.com/FL For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC
Member handbook	UHCCommunityplan.com/FL > Plan Details > Member Resources > View Available Resources	
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC
Prior authorization	UHCprovider.com/priorauth For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC
D-SNP	UHCCommunityplan.com/FL > Medicare > Dual Complete Special Needs Plan For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC

Benefits



Go to UHCCommunityplan.com/fl or uhcprovider.com/eligibility for more information.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at UHCprovider.com then Sign In. Each month, we monitor PCP panel sizes via PCP-to-member ratio reports. When a PCP's panel nears the max limit, we remove it from auto-assignment.

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

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

You may also use [Report Center](#) for member contact information in a PDF at the individual practitioner level.

View the [Report Center Interactive User Guide](#) to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change if the member has only seen the PCP/PCP Group they are requesting. Otherwise, the change must be made effective the first of the following month.

Deductibles/copayments

There are no deductibles and copayments for services covered by the UnitedHealthcare Community Plan of Florida.

Medically necessary services

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

The medical or allied care, goods or services given or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Provide specific treatment to the patient consistent with symptoms or confirmed diagnosis of the illness or injury
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational
- Be aware of the level of service that can be safely given and for which no equally effective or less costly treatment is available statewide
- Be given in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the care provider

Just because a care provider has prescribed or approved medical care or services does not make the care or services medically necessary or qualify it to be a covered service. Inpatient hospital services are only medically necessary if the services must be furnished in a hospital, and they could not be delivered effectively on an outpatient basis.

Member assignment

Assignment to UnitedHealthcare Community Plan

The Agency for Health Care Administration (AHCA) assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. The Department of Children and Families (DCF) 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/fl. Go to Plan Details, then Member Resources, View Available Resource.

Immediate enrollment changes

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



Get eligibility information by calling **Provider Services at 1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.

Unborn enrollment changes

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



Members may call FL Medicaid.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

Primary care provider selection

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 in Florida's Medicaid program.

The FL DCF determines program eligibility. An individual who becomes eligible for the FL Medicaid either chooses or is assigned to 1 of the FL Medicaid (SMMC)-contracted health plans.

Member ID card

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



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

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**. 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.

Primary care provider-initiated transfers

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

To transfer the member, mail documentation including 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

Attn: Enrollee Services

7901 SW 6th Street, Suite 400

Plantation, FL 33324

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 Provider Portal through UHCprovider.com/eligibility
- **Provider Services** at **1-800-791-9233** for LTC and **1-877-842-3210** for MMA is available Monday-Friday, 7 a.m. - 5 p.m.
- FL Medicaid Eligibility System (MES)

UnitedHealthcare Dual Complete

UnitedHealthcare Dual Complete (DSNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.


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

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP at UHCprovider.com/guides.

For FL specific DSNP information, go to UHCprovider.com/FL > Medicare > [dual-complete-snp-plans.html](https://UHCprovider.com/FL/Medicare/dual-complete-snp-plans.html).


Sample health member ID cards

LTC ID card


 Health Plan (80840) 911-87726-04
 Member ID: 99999910711 Group Number: FLLTC
 Member: NEW ENGLISH Payer ID: 87726
 Effective Date: 06/01/2017
 DOI-0501 Underwritten by UnitedHealthcare of Florida, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 09/26/25
 This card does not guarantee coverage. For coordination of care, call your case manager. To verify benefits or to find a provider, visit the website www.uhcommunityplan.com or call.
 For Members: 800-791-9233 TTY 711
 AHCA: 888-419-3456
 Behavioral Health: 800-791-9233
 NurseLine: 877-552-8105
 For Providers: UHCprovider.com 877-842-3210
 Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
 Health Plan: 7901 SW 6th Street, Suite 400 Plantation, FL 33324


MMA and LTC ID card


 Health Plan (80840) 911-87726-04
 Member ID: 999999913 Group Number: FLMMMA
 Member: NEW R ENGLISH Payer ID: 87726
 PCP Name: DOUGLAS GETWELL
 PCP Phone: (610)863-5378
 Effective Date: 06/01/2017
 Copay: OFFICE/SPEC/ER/UrgCare \$0/\$0/\$0/\$0
 PCP referral required for specific specialty services Comprehensive MMA & LTC
 DOI-0501 Underwritten by UnitedHealthcare of Florida, Inc.

Optum Rx[®]
 Rx Bin: 610494
 Rx Grp: ACUFL
 Rx PCN: 4300

In an emergency go to nearest emergency room or call 911. Printed: 09/26/25
 This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhcommunityplan.com or call.
 For Members: 888-716-8787 TTY 711
 AHCA: 888-419-3456
 Behavioral Health: 888-716-8787
 NurseLine: 877-552-8105
 For Providers: UHCprovider.com 877-842-3210
 Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
 Health Plan: 7901 SW 6th Street, Suite 400 Plantation, FL 33324
 Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
 For Pharmacists: 844-567-6857 Rx Prior Auth: 800-310-6826

MMA ID card



 Health Plan (80840) 911-87726-04
 Member ID: 9999999921 Group Number: FLMMMA
 Member: NEW A ENGLISH Payer ID: 87726
 PCP Name: DOUGLAS GETWELL
 PCP Phone: (717)851-2521
 Effective Date: 06/01/2017
 Copay: OFFICE/SPEC/ER/UrgCare \$0/\$0/\$0/\$0
 PCP referral required for specific specialty services MMA
 DOI-0501 Underwritten by UnitedHealthcare of Florida, Inc.

Optum Rx[®]
 Rx Bin: 610494
 Rx Grp: ACUFL
 Rx PCN: 4300

In an emergency go to nearest emergency room or call 911. Printed: 09/26/25
 This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhcommunityplan.com or call.
 For Members: 888-716-8787 TTY 711
 AHCA: 888-419-3456
 Behavioral Health: 888-716-8787
 NurseLine: 877-552-8105
 For Providers: UHCprovider.com 877-842-3210
 Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
 Health Plan: 7901 SW 6th Street, Suite 400 Plantation, FL 33324
 Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
 For Pharmacists: 844-567-6857 Rx Prior Auth: 800-310-6826

Chapter 3: Care provider office procedures and member benefits

RAM MMA TANF/SSI & LTC ID card


Health Plan (80840) **911-87726-04**

Member ID: 9999999999 Group Number: **FLMMA**

Member:
NEW ENGLISH

PCP Name: DOUGLAS GETWELL
PCP Phone: (717)851-2521

Effective Date
06/01/2017

Copay: OFFICE/SPEC/ER/UrgCare
\$0/\$0/\$0/\$0

Limited Rx
DOI-0501

Payer ID: 87726

Optum Rx[®]

Rx Bin: 610494
Rx Grp: ACUFL
Rx PCN: 4300

Comprehensive MMA & LTC
Underwritten by UnitedHealthcare of Florida, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 09/26/25


This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhcommunityplan.com or call.

For Members: 888-716-8787 TTY 711
AHCA: 888-419-3456
Behavioral Health: 888-716-8787
NurseLine: 877-552-8105

For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan: 7901 SW 6th Street, Suite 400 Plantation, FL 33324

Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 844-567-6857 Rx Prior Auth: 800-310-6826

MMA TANF/SSI card


Health Plan (80840) **911-87726-04**

Member ID: 9999999917 Group Number: **FLMMA**

Member:
NEW A ENGLISH

PCP Name: DOUGLAS GETWELL
PCP Phone: (717)851-2521

Effective Date
06/01/2017

Copay: OFFICE/SPEC/ER/UrgCare
\$0/\$0/\$0/\$0

Limited Rx
DOI-0501

Payer ID: 87726

Optum Rx[®]

Rx Bin: 610494
Rx Grp: ACUFL
Rx PCN: 4300

MMA
Underwritten by UnitedHealthcare of Florida, Inc.

In an emergency go to nearest emergency room or call 911. Printed: 09/26/25

This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhcommunityplan.com or call.

For Members: 888-716-8787 TTY 711
AHCA: 888-419-3456
Behavioral Health: 888-716-8787
NurseLine: 877-552-8105

For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan: 7901 SW 6th Street, Suite 400 Plantation, FL 33324

Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 844-567-6857 Rx Prior Auth: 800-310-6826

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Healthy First Steps	uhhealthyfirststeps.com	1-800-599-5985
Referrals	UHCprovider.com/referrals For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
Prior authorization	UHCprovider.com/priorauth and for MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC
Pharmacy	professionals.optumrx.com For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC

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

Ambulance services

Air ambulance

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

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



Non-emergent air ambulance requires prior authorization. For authorization, go to uhcprovider.com/priorauth or call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#).

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.

Urgent transportation

MTM has specific trips considered urgent that do not require 3 day notice for scheduling. These are hospital discharge trips, normally scheduled the same day. Hospital discharge line is : 1-888-778-5113. MTM does not provide emergency transportation.

For MMA members: Dialysis, Chemotherapy, Wound Care are also among trips that are considered critical, but it is always suggested the member schedules the trip within the 3 day notice to secure transportation.

If the member needs an urgent ride for a critical care trip, the member can schedule the trip and explain it is urgent.

Non-emergent transportation

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

MTM covers:

- Livery (door to door, upon request)
- Ambulatory: Sedan, van, taxi, Transportation Network Companies (rideshare)
- Wheelchair lift-equipped vehicle
- Stretcher Van
- Mass Transit
- Advanced Life Support (ambulance)
- Basic Life Support (ambulance)



Request non-emergent transportation at least 3 business days in advance.

Schedule non-emergent transportation up to 30 days in advance. Call the reservation line to schedule.

MMA: 1-866-372-9891

LTC: 1-877-931-4751

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/policies](https://www.uhcprovider.com/policies) > For Community Plans > **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 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 it 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 one of these guidelines is met:

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

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

Urgent care (non-emergent)

Urgent care services are covered.



For a list of urgent care centers, contact **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.

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** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.



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

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

Facility admission notification requirements

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

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions

- Admissions following outpatient surgery
- Admissions following observation

Family planning

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

- Annual gynecological examination
- Annual pap smear or every 3 years if results were normal
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

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

Non-covered items include:

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

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 AHCA Regulations for more information on sterilization.

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
- Reduce potentially preventable events (PPEs)
- 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.

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

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.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver.

Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

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

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. Members who receive LTC or hospice services will receive a letter from DCF when the member becomes eligible or there are any eligibility changes.

Laboratory



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

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

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

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



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

Maternity/pregnancy/well-child care

MMA only

Pregnancy notification risk screening

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



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

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment by timely submission of the pregnancy notification forms (OBRAF)
- Care provider incentive is available if the OBRAF is submitted within 10 days of the initial office visit. The form can be submitted electronically. Assess the member’s risk level and provide member-specific needs that support the care provider’s plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member’s understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster an care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Smoking Cessation Healthy Behaviors Program
- Help identify and build the mother’s support system including referrals to community resources and pregnancy support programs

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

Pregnancy/Maternity

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

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



For prior authorization maternity care, including out-of-plan and continuity of care, call **1-877-842-3210** or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/flcommunityplan** > 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:

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

UnitedHealthcare Community Plan will continue to pay for services provided by a pregnant woman’s current provider for the entire course of her pregnancy, including the completion of her postpartum care (6 weeks after birth), regardless of whether the provider is in the network.

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

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

Maternity admissions

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



Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**.

Provide the following information within 1 business day of the admission:

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

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

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

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

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

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

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



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

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn if ordered by the attending care provider.

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.

Newborn circumcision is covered for infant males up to 28 days old at no cost. No prior authorization is required. Member may not be balance billed.

Bright Futures assessment

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

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

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.

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

Home care and all prior authorization services

The discharge planner ordering home care should call **Provider Services** at **1-800-791-9233** for LTC and **1-877-842-3210** for MMA to arrange for home care.

Hysterectomies

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

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



Find the form on the Florida Department of Children and Families myflfamilies.com.

See “Sterilization consent form” section for more information. Exception: Florida Medicaid does not require informed consent if:

- As the physician performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
- 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 MMA hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member’s ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Pregnancy termination services

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

Allowable pregnancy termination services do not require a referral from the member’s PCP. 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 MMA Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the MMA 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 Florida Department of Social Services MMA Consent Form for sterilization is properly filled out. Other consent forms do not replace the MMA Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.**
Complete all applicable sections of the consent form before submitting it with the billing form. The Florida MMA 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 Consent for Sterilization: Form HHS-687 on the Florida Department of Social Services website: myflorida.com

Have 3 copies of the consent form:

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

Neonatal Intensive Care Unit case management

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

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

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

Inhaled nitric oxide

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com/policies > For Community Plans. Search for "Inhaled Nitric Oxide Therapy."

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/or chemotherapy guidelines, requirements and resources, go to UHCprovider.com/oncology or call Optum at **1-888-397-8129** Monday-Friday, 8 a.m. – 8 p.m. ET.

Pharmacy

Pharmacy preferred drug list

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

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

If a member requires a non-preferred medication, call Pharmacy Prior Authorization or use the online Prior Authorization and Notification tool on the [UnitedHealthcare Provider Portal](#).

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

Pharmacy prior authorization

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

To request pharmacy prior authorization, call Pharmacy Prior Authorization at 1-800-310-6826. We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

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

- Used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases

- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled



Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to [uhcprovider.com/priorauth](#).

Radiology

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

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

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

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

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

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

Request prior authorization online or by phone at:

Online - [UHCprovider.com/radiology](#) > Sign In

Phone - **1-866-889-8054** Monday-Friday, 7 a.m. - 7 p.m. local time. Make sure the medical record is available.



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

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

SBIRT reimbursement provides the opportunity for early intervention with at-risk adolescent and adults before more severe consequences occur:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care

SBIRT codes have been added to the Medicaid Practitioner Fee Schedule and are retroactively effective to date of service January 1, 2021. The codes are applicable to FFS and managed care. At this time, only physicians and physician extenders can render SBIRT services. This includes the following provider types:

- 25 – M.D.
- 26 – D.O.
- 29 – PA
- 30 – APRN

Procedure codes

Code	Description
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes

H0049 can be used once per day, as medically necessary, and is not limited by age. H0050 is allowed for 0-4 units per day, as medically necessary, and is not limited by age.

The place of service is open for office visits, all hospital settings and clinics and ambulatory surgical centers.

The new SBIRT codes are intended to be used in primary care and other medical settings. These services may be performed and billed in addition to an Evaluation and Management (E/M) service when provided during the same visit.

The Agency refers to procedure code definitions when it comes to services provided. H0050 is defined as alcohol and/or drug services, brief intervention, per 15 minutes. H0049 does not include a time specification but should be clinically appropriate.

For more information on how to implement SBIRT in your office refer to the following links:

- [Training and Videos - SBIRT for Substance Abuse](#)
- [AHCA: Guide to Utilizing the Screening, Brief Intervention and Referral to Treatment Model for Medicaid Practitioners \(myflorida.com\)](#)
- [Behavioral Health Toolkit for Medical Providers \(providerexpress.com\)](#)



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

Medication-assisted treatment

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

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

As a 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](https://www.liveandworkwell.com).

To find a medical MAT provider in Florida:

- Go to UHCprovider.com/findprovider.
- Click on "Medical Care Directory."
- Click on "Medicaid Plans."
- Click on applicable state.
- Select applicable plan.
- Type "Medication Assisted Treatment" in the search bar and click "search."



If you have questions about MAT, please call **Provider Services** at **1-800-791-9233** for LTC and for MMA - connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**, enter your Tax Identification Number (TIN) then say "Representative," and "Representative" a second time, then "Something Else" to speak to a representative.

Tuberculosis screening and treatment; Direct observation therapy

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

Responsibilities

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

Vision

Vision services are covered by March Vision Care. Please visit marchvisioncare.com or call 1-844-386-2724.

Waiver programs

Human immunodeficiency virus/acquired immune deficiency syndrome waiver services program

The human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in-home waiver services program is available to members who would otherwise require long-term institutional services.

Identification - Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral - If the member agrees to participation, provide the waiver agency with supportive documentation including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of Care - The HIV/AIDS waiver program will coordinate in-home HCBS services in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS services. These members are referred to the Long Term Care Division/HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid Program.



For behavioral health and substance use disorder authorizations, please call **1-800-582-8220**.



If you have questions, go to your state's prior authorization page at **UHCprovider.com/FLcommunityplan > Prior Authorization and Notification Resources** or call **Provider Services**.

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

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 7 days of receipt of request.	Within 7 days of receipt of request.	Within 7 days of receipt of request.
Urgent/expedited pre-service	Within 2 days of request receipt.	Within 2 days of the request.	Within 2 days of the request.
Concurrent review	Within 24 hours or next business day following.	Notified within 24 hours of determination.	Notified within 24 hours of determination and member notification within 2 business days.
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information.	Within 24 hours of determination.	Within 24 hours of determination and member notification within 2 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 EMR, phone or record review.

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

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

UnitedHealthcare Community Plan uses InterQual (formally MCG Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings.

This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

Determination process

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

Medical necessity for members younger than 21 years

UnitedHealthcare Community Plan provides all medically necessary services for members younger than age 21, even if the service is not a covered benefit or has a limit. As long as a service is medically necessary, services are not bound by coverage, monetary, or time limits. Request prior authorization using the stated guidelines for medically necessary, non-Medicaid covered services.

Long-Term Support Services only

Long-Term Support Services (LTSS) is an alternative to out-of-home care (such as nursing homes). It helps pay for services provided to members so they can remain safely in their own home. The types of services authorized through LTSS are:

- Housecleaning
- Meal preparation
- Laundry
- Companion care services
- Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

LTSS allows members to self-direct care through selection, hiring, supervising, training and terminating caregivers.

More information about LTC benefits is available on UHCCommunityPlan.com/FI.

Eligibility – Members must be 18 years or older, disabled or blind. Additional eligibility requirements:

- Florida resident
- Meet Medicaid recipient eligibility criteria
- Reside in own home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered “own home”)
- Submit a completed Health Care Certification form completed by a licensed health care professional indicating the member is: Unable to perform more than 1 activity of daily living independently, and is at risk of out-of-home care placement without LTSS

Evidence-based clinical guidelines

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

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com/policies > For Community Plans.

Referral guidelines

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

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact Provider Services.
- 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 network (except emergency treatment or as part of continuity of care for new members)

- Any care covered by Medicaid but not through managed care:
 - Intermediate care facilities for members with mental handicap
 - All outpatient Dental services, except for services provided by a non-dentist. For example Fluoride varnish provided by a pediatrician.
 - UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medically necessary. Prior authorization is required.
 - Residential inpatient hospice 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
- Hemophilia Factor, which is covered directly through Florida Medicaid

Services requiring prior authorization



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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

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

Utilization management guidelines

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

Utilization management appeals

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



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

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

Key contacts

Topic	Link	Phone number
EPSDT	aap.org	1-800-433-9016
Vaccines for Children	www.floridahealth.gov/ email: Immunization@FLHealth.gov	1-877-888-7468
Medicaid well child visits	ahca.myflorida.com	

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. **This benefit only applies to MMA members.**

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

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to brightfutures.aap.org.

The EPSDT program requires each health plan to complete an annual reporting form: the CMS-416. Completion of this form measures UnitedHealthcare Community Plan's efforts to ensure that eligible children receive the services provided through EPSDT. CMS and the state of Florida established a goal of an 80% enrollee participant ratio and screening ratio for health plans. The screening ratio is the actual number of initial and periodic screening services received by eligible members compared to the expected number. A screening ratio with a high percentage means most of the eligible children are being screened. Therefore, if problems are detected, the children can be referred to the appropriate treatment. The participation ratio is the actual number of eligible members receiving initial and periodic screening services during the year based on the number of eligible members who should be receiving screening services.

Developmental 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 will determine the most appropriate setting for eligible HCBS services and will coordinate 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.

Full screening

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

- A comprehensive health and developmental history, including physical, nutritional, and mental health development assessments
- Unclothed physical examination
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Lead risk assessment
- Developmental/psychosocial/behavioral/ and substance abuse assessment/screening as appropriate
- Hearing
- Vision
- Dental
- An oral health assessment and referral for dental care for children 1 year of age and older

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. 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

Based on CMS standards, all children enrolled in Medicaid must receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one.

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. Report levels over 10ug/dL to the county health department where the member lives.

Vaccines for children program

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

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



Contact VFC if you have questions.
Phone: 1-877-888-7468

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 only receive vaccinations from a FQHC or RHC. They cannot receive vaccinations from a private care provider using a VFC-supplied vaccine. UnitedHealthcare Community Plan will pay for vaccine serum and administration for Members in MediKids [CHIP for ages 1-5] as they do not qualify for VFC.)

Chapter 6: Expanded/ value-added services

Key contacts

Topic	Link	Phone number
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
Healthy First Steps	UHChealthyfirststeps.com	1-800-599-5985
Value-added services	UHCCommunityplan.com/fl > View plan details For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services unless otherwise noted.

Expanded benefits - Medical and long-term care

Expanded benefits are extra goods or services we provide to our members at no cost.

Service	Description	Coverage/limitations	Prior authorization
Over-the-counter (OTC) medications and supplies	Allowance to purchase OTG products	The Managed Care Plan shall provide a monthly OTG benefit limit of \$65.00 per household.	No
Adult visual aid services	Contact lens, frame, eye exam.	Contact lens - 6 months' supply with prescription, Frame, eye exam - 1 per year. For members ages 21 and older.	No
Adult additional primary care services	Primary care provider visits.	Unlimited. For members ages 21 and older.	No

Service	Description	Coverage/limitations	Prior authorization
Prenatal services	Hospital grade breast pump; breast pump; antepartum management; postpartum care.	Max of 1 per year (rental, PA is required); 1 per 2 years (rental, no PA required); 14 visits for low- risk pregnancies and 18 visits for high-risk pregnancies; 3 visits within 90 days following delivery, and 1 well-woman visit between 90 days and 12 months following delivery in preparation to transition back to the primary care medical home. For members ages 21 and older.	No
Durable medical equipment services and supplies	Automatic blood pressure monitor.	For members ages 21 and older.	No
Physical therapy for adults	Physical therapy evaluation; physical therapy re-evaluation; physical therapy treatment visit; application of casting or strapping; wheelchair evaluation and fitting by a physical therapist.	One evaluation per year, up to 7 therapy treatment units per week. For members age 21 and older.	Yes
Newborn circumcision	Circumcision neonate.	One per lifetime. Your male baby is covered up to 28 days old.	No
Hearing services for adults	Occupational therapy evaluation low to high complexity; occupational therapy re evaluation; occupational therapy treatment visit; application of casting or strapping; wheelchair evaluation and fitting by an occupational therapist.	One evaluation per year, up to 7 therapy treatment units per week. For members ages 21 and older.	Yes

Expanded benefits - Maternal health – prenatal through postpartum

Service	Description	Coverage/limitations	Prior authorization
Wellhop virtual support group	Group video conversations.	Group video conversations with a trained facilitator and members at the same stage in pregnancy. Evidence-based information on pregnancy and postpartum, educational articles, videos, podcasts and more. For members ages 13 and older.	No
Peer support doula program	Certified behavioral health and substance use disorder peer supports.	Access to certified BH and SUD peer supports who are trained and certified maternity peer doulas who support their pregnant peers living with SUD and SMI throughout the prenatal and postpartum processes to enhance health and well-being. For members ages 13 and older.	Yes
Doula program	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring. Home visit for postnatal assessment and follow-up care. Home visit for newborn care and assessment. Unlisted home visit service or procedure.	Doulas are nonclinical support professionals providing emotional, informational and physical support before, during and after labor. They assist with relaxation techniques, breathing exercises, massages, positioning suggestions and other comfort measures, while providing education on childbirth options and pain management. Support provided before, during, and after pregnancy. For members ages 13 and older.	Yes
Babyscripts and Healthy First Steps® Rewards	Member rewards for healthy baby milestones.	The program ends at 15 months post-delivery. Enrollees receive rewards at specific milestones, including reward cards and baby-related items ranging in value from \$10 to \$30. For members ages 13 and older.	No
Diaper starter pack	Diaper assistance.	New mothers during the first 12 months, post-delivery. Maximum \$50 for diapers, one time per child. For members ages 13 and older.	No

Expanded benefits - Children and adolescents with a serious mental illness and/or substance use disorder

Service	Description	Coverage/limitations	Prior authorization
Condition-specific durable medical equipment	Durable medical equipment.	Durable medical equipment and other supplies to help children manage their symptoms, like additional weighted blankets or enuresis alarms. Limited to \$100 annually. For members up to age 18.	No
Sensory toys for children living with attention deficit hyperactivity disorder (ADHD)	Sensory toys.	Sensory toys can help children living with ADHD with their focus, relaxation and overall development. For members ages 6 to 14.	No
Transitional age youth flex fund (TAE)	Incidentals such as cash assistance for rental deposit(s), rent, utilities, moving expenses, etc.	Provides a maximum of \$250 per year to support the completion of necessary, required health care services through virtual connectivity, with the criteria that the enrollee must be in an emerging health risk level or higher, and the support must help strengthen their natural system of care. For members ages 14 to 25.	Yes

Expanded benefits - Children with complex medical needs currently living in a skilled nursing facility

Nursing facility transition assistance benefit

UnitedHealthcare Community Plan offers a nursing facility transition benefit to help families of children living in a nursing facility to bring their child home. The benefit will provide assistance to the children and their families to help overcome barriers preventing the child from living at home with their family.

This benefit is available for individuals currently residing in a nursing facility and are either under 21 years old or under 30 years of age and have been living in a nursing facility before turning 21 years old.

The nursing facility transition benefit may include the following:

- Home renovations
- Purchase of a generator to provide power medical equipment during outages
- Home additions to give the child space for all necessary medical equipment and care needs
- Addition of an accessible bathroom
- Adaptations to or purchase of a vehicle equipped to meet the child’s transportation needs
- Deposits to help with the transition (like rental security deposits or move-in fees)

- Home repairs or services to ensure a healthy living space
- Funding to help with moving costs

Eligible members may receive up to \$75,000 to assist with the transition home. This benefit is a once in a lifetime.

The member should talk to their case manager if they think this benefit can help. If they need assistance with contacting their case manager, they can call Member Services at **1-888-716-8787**, TTY **711**, from 8 a.m. to 7 p.m. ET, Monday through Friday.

Expanded benefits - Enrollees in a home and community-based (HCBS) setting, such as people with developmental disabilities, familial dysautonomia, or people in long-term care settings

Service	Description	Coverage/limitations	Prior authorization
Assisted living facility/adult family care home - Bed hold days	Up to 30-day bed hold.	This benefit allows enrollees who are temporarily absent from their rehabilitation facility, assisted living facility or adult family care home to hold their bed for up to 30 days so the enrollee does not lose their placement in the facility. For members ages 18 and older.	Yes
Individual therapy for caregivers	Behavioral health therapy.	Up to 2 therapeutic behavioral services sessions per calendar year. For members ages 18 and older.	No
Nursing facility to community setting transition assistance	Transition assistance.	We support enrollees transitioning to a community setting by providing home essentials like furniture, safety equipment or assistance to secure housing. Up to a maximum of \$5,000 per enrollee per lifetime. For members ages 18 and older.	Yes
Caregiver transportation	Transportation.	Caregivers of enrollees in an HGBS setting can access 4 one-way trips to visit an enrollee residing in an assisted living or nursing facility. For members ages 18 and older.	Yes

Service	Description	Coverage/limitations	Prior authorization
Careforth for caregivers	Caregiver support.	<p>Careforth coaches design a person-centered program for each enrollee after completing an assessment that evaluates the knowledge, skills and needs of the caregiver and the enrollee’s health risks and behavioral challenges. Caregivers of enrollees in an HGBS setting have access to clinical recommendations and caregiver support services and coaching.</p> <p>For members ages 18 and older.</p>	No
Massage therapy	Massage therapy to enhance health and well-being.	<p>Hot and cold pack therapy. Neuromuscular therapy.</p> <p>15-minute massage, including mobilization, manipulation, manual lymphatic drainage, manual traction, 1 or more regions, 15-minute massage, including effleurage, petrissage and tapotement.</p> <p>For members ages 21 and older.</p>	Yes
Nutritional counseling	Visits with a dietitian to help with a nutrition plan and healthy eating habits.	<p>A comprehensive approach to medical nutrition therapy (MNT) services, provided by registered dietitians or other qualified health care professionals. This program evaluates an enrollee’s nutritional status and develops personalized nutrition plans while educating them on healthy eating habits.</p> <p>Three MNT visits per year, no more than 1 unit per day.</p> <p>For members ages 21 and older.</p>	Yes
Acupuncture	A non-traditional pain management alternative.	<p>One or more needles, without electrical stimulation, initial 15 minutes of personal one-on- one contact with the patient.</p> <p>Additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles. One or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.</p> <p>For members ages 21 and older.</p>	Yes

Expanded benefits - General expanded benefits

Service	Description	Coverage/limitations	Prior authorization
Waived copayments	No copays for certain services.	For members ages 21 and older, no copays for chiropractor services, community behavioral health services, home health services, hospital outpatient services, federally qualified health center visits, independent laboratory services, non-emergency transportation services, nurse practitioner services, optometrist services, physician and physician assistant services, podiatrist services, portable X-ray services, rural health clinic visits and use of the hospital emergency department for non-emergency service.	N/A
Chiropractic services	A non-traditional pain management alternative involving spine manipulation.	Unlimited with prior authorization. For members ages 21 and older.	Yes
Outpatient hospital services	No limits for: PET scan, pharmacy services, professional, PT/OT therapy, radiology services, routine dental services, sleep studies, speech therapy, sterilization services, supplies – med surg, therapeutic radiology, therapeutic, transplant, treatment/OBS room services, and urgent care services.	Unlimited with prior authorization. For members ages 21 and older.	Yes
Cellular phone services	No-cost smartphone and service packages are provided in partnership with Assurance Wireless through the federal Lifeline program.	New, low-cost cellphone. Or bring their own phone. Unlimited talk and text; 10 GB of data. For members ages 18 and older.	Yes
Targeted case management	Targeted case management.	Unlimited. For members ages 21 and older.	No
Assessment/evaluation services – behavioral	Various assessment, evaluation and testing codes.	Unlimited. For members ages 21 and older.	No

Chapter 6: Expanded/value-added services

Service	Description	Coverage/limitations	Prior authorization
Behavioral health day services/day treatment	Behavioral health day services/day treatment, day care services, adult: per diem.	Unlimited. For members ages 21 and older.	Yes
Behavioral health medical services (drug screening)	Behavioral health medical services (alcohol and other drug screening specimen collection).	Unlimited. For members ages 21 and older.	No
Behavioral health medical services (medication management)	Medication management.	Unlimited. For members ages 21 and older.	No
Behavioral health medical services (verbal interaction)	Behavioral health medical services (verbal interaction), mental health/ substance abuse.	Unlimited. For members ages 21 and older.	No
Behavioral health screening services	Behavioral health screening services.	Unlimited. For members ages 21 and older.	No
Medication-assisted treatment services	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).	Unlimited. For members ages 21 and older.	No
Psychosocial rehabilitation	Psychosocial rehabilitation services.	Unlimited. For members ages 21 and older.	No
Speech therapy	Various assessment, evaluation and testing codes.	One evaluation per year, up to 7 therapy treatment units per week. One evaluation per year, up to 4 - 30-minute AAG fitting adjustment and training sessions per year. For members ages 21 and older.	No
Therapy/ psychotherapy (group)	Group therapy, brief group medical therapy.	Unlimited. For members ages 21 and older.	No

Chapter 6: Expanded/value-added services

Service	Description	Coverage/limitations	Prior authorization
Therapy/ psychotherapy (individual/ family)	Individual and family therapy, brief individual psychotherapy, training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).	Unlimited. For members ages 21 and older.	No
PDN – Careforth, transportation and community setting transitions	Transition assistance.	<p>We support enrollees transitioning to a community setting by providing home essentials like furniture, safety equipment or assistance to secure housing, up to a maximum of \$10,000 per enrollee per lifetime. Requires prior authorization. Caregivers of enrollees in an HGBS setting can access 4 one-way trips to visit an enrollee residing in an assisted living or nursing facility.</p> <p>Careforth coaches design a person-centered program for each enrollee after completing an assessment that evaluates the knowledge, skills and needs of the caregiver and the enrollee's health risks and behavioral challenges. Caregivers of enrollees in an HGBS setting have access to clinical recommendations and caregiver support services and coaching.</p> <p>For members ages 18 and older.</p>	Yes
Home visit by a clinical social worker	Various.	One additional visit per day. For members ages 21 and older.	No

Service	Description	Coverage/limitations	Prior authorization
Waived copayments	No copays for certain services	For members age 21 and older. No copays for: <ul style="list-style-type: none"> • Chiropractor services • Community behavioral health services • Home health services • Hospital outpatient services • Federally qualified health center visits • Independent laboratory services • Non-emergency transportation services • Nurse practitioner services • Optometrist services • Physician and physician assistant services • Podiatrist services • Portable X-ray services • Rural health clinic visits • Use of the hospital emergency department for non-emergency service 	No

LTC expanded benefits

Expanded benefits are extra services we provide to at no cost.

Expanded benefits	Benefit description	Coverage/limitations	Prior authorization
Assisted living facility/adult family care home – bed hold days	Up to a 30-day bed hold	A bed will be saved for up to 30 days each time you leave an assisted living facility (ALF) or adult family care home (AFCH) for a minimum of 30 days between episodes. Resident must intend to return to the facility and continue to make any room, board and patient responsibility payments.	Yes
Transition assistance – nursing facility to community setting	Community transition waiver	Up to a maximum of \$5,000 per enrollee per lifetime. This money assists with deposits for housing or utilities, household items (e.g., furniture, microwave), health and safety items and moving expenses.	Yes
Individual therapy sessions for caregivers	Therapeutic behavioral services	Up to 2 sessions per year.	No

Expanded benefits - Pathways to prosperity

Service	Description	Coverage/limitations	Prior authorization
Housing assistance	Services that support a member in the preparation for and transition into housing.	Assistance to all enrollees seeking safe and stable housing.	No
Housing assistance	Peer support promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist.	Peer support to promote skills to support coping and managing housing needs.	No
Housing assistance	Incidentals such as cash assistance for rental deposit(s), rent, utilities, moving expenses, etc.	Governing one-time incidentals like shut-off notices, moving expenses, rental deposits, utilities, etc.	No
Food assistance	Medical nutrition group meals per diem; not otherwise specified.	Enrollees diagnosed with SMI who are discharged from a hospital or facility, access to 14 home-delivered meals per year.	No
Food assistance	Medical nutrition group meals per diem; not otherwise specified.	New mothers returning home after giving birth to a newborn. Access to 14 home-delivered meals per year.	No
Food assistance	Medical nutrition group meals per diem; not otherwise specified.	Enrollees with a primary diagnosis of congestive heart failure (GHF), diabetes, chronic obstructive pulmonary disease (COPD), cancer and recently discharged from a hospital stay. Access to 14 home-delivered meals per year.	No

Service	Description	Coverage/limitations	Prior authorization
Non-medical transportation	Non-medical transportation assistance.	<p>In support of job search activity, provides transportation assistance beyond required non-emergency services for adults 18 and older.</p> <p>Trips must be approved and within a 30-mile radius of the enrollee's home; 20 one-way or 10 round trips per year.</p>	No
Non-medical transportation	Public transportation pass after employment.	60-day bus pass stipend after job is secured, once per year for adults 18 and older.	No
Non-medical transportation	Gas reward card - No public transportation after employment.	<p>Gas reward card (\$50) after job secured in geographies where public transportation is unavailable.</p> <p>For adults 18 and older.</p>	No
Tutoring, vocational training, and/or job readiness	GED Program.	<p>GEDWorks:</p> <p>GED testing, education advisors, study frameworks and exam preparation.</p> <p>For members ages 18 and older. Study materials and testing available in Spanish.</p>	No
Tutoring, vocational training, and/or job readiness	Goodwill.	<p>Goodwill:</p> <p>Employment advisory services, technical assistance and support to job seekers in finding employment or advancing enrollee careers. Access to career navigators, connecting enrollees to employers in their community.</p> <p>For members ages 18 and older.</p>	No
Tutoring, vocational training, and/or job readiness	My Secure Advantage.	<p>Secure Advantage:</p> <p>Enrollees can receive guidance and support from a money coach who provides objective information and clear action steps to help them make informed decisions about their finances.</p> <p>For members ages 18 and older.</p>	No

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	providerexpress.com	1-877-614-0484
Provider Services	For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC

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

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

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

You must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan. To request an ID number, go to the Department of Social Services website at nppes.cms.hhs.gov > go to the section titled "Apply to be a Medicaid Provider."



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

Covered services

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



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

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Statewide inpatient psychiatric program
- Outpatient assessment and treatment:
 - Day treatment
 - Psychiatric evaluation and 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)
 - Electroconvulsive therapy
 - Telehealth
 - Behavior Analysis
- Community support and rehabilitation services
- Targeted case management
- Day treatment/intensive outpatient

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility 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 non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth.

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

You can use the [UnitedHealthcare Provider Portal](https://UHCprovider.com) for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

View the Prior Authorization list, find forms and access the care provider manual. Provider Services for MMA - connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](https://UHCprovider.com) or **1-800-791-9233** for LTC to verify eligibility and benefit information available Monday-Friday, 8 a.m. - 5 p.m. CT.

Website: providerexpress.com

Update your practice information, review guidelines and policies, and view the national Optum Network Manual. Or call **Provider Services** at **1-866-815-5334**.

Training resources and materials

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

- [Behavioral health toolkits](#)
- [Provider training materials](#)
- [Network provider manuals](#)

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 before they occur through pharmacy management, provider practices, and education
- Treatment:
 - Access and reduce barriers to evidence-based and integrated treatment
- Recovery:
 - Support case management and referral to person-centered recovery resources
- Harm Reduction:
 - Access to Naloxone and facilitating safe use, storage, and disposal of opioids

- Strategic community relationships and approaches:
 - Tailor solutions to local needs
- Enhanced solutions for pregnant mom and child:
 - Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics:
 - Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (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/pharmacy. Click “Opioid Programs and Resources-Community Plan” to find a list of tools and education.

Prescribing opioids

Go to our [Drug Lists and Pharmacy page](#) to learn more about which opioids require prior authorization 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). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Expanding medication assisted treatment access and capacity

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

To find a behavioral health MAT provider in Florida:

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

We contract with licensed opioid treatment programs in addition to private physicians licensed to prescribe MAT. This helps ensure access to MAT services in the member’s community. See the MAT section in [Chapter 4](#).

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	UHCommunityPlan.com/fl	1-800-791-9233 LTC
Member handbook	UHCommunityplan.com/fl > Community Plan > Member benefits For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	TTY 711 for help accessing member account

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 of member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information

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

Amendment of protected health information

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

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their protected health information (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 Resources tab:

UHCCommunityplan.com/fl > Medicaid Plans.

Native American access to care

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

Member rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed

- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers to not keep from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the emergency room only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

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

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

Chapter 9: Medical records

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. Authorized state and federal agencies, and their authorized representatives, may audit or examine your records. You must allow access to all FL Medicaid recipient records and any other information that cannot be separated from FL Medicaid-related records. You must send, at your expense, legible paper copies (unless otherwise authorized) of all FL Medicaid-related information to the authorized agencies or their authorized representatives upon their request regardless of the format in which you retain them.

The member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at member cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandates a longer time frame (i.e., immunization and tuberculosis records are required for lifetime). 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: <ul style="list-style-type: none">• Privacy of the member medical record• Initial and periodic training of office staff about medical record privacy• Release of information• Record retention• Availability of medical record if housed in a different office location• Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern• Coordination of care between medical and behavioral care teams
Record organization and documentation	<ul style="list-style-type: none">• 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

***Critical element**

Topic	Contact
Procedural elements	<p>Medical records are readable*</p> <ul style="list-style-type: none"> • 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	<p>An initial history (for members seen 3 or more times) and physical is performed. It should include:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

***Critical element**

Topic	Contact
<p>Problem evaluation and management</p>	<p>Documentation for each visit includes:</p> <ul style="list-style-type: none"> • Appropriate vital signs (Measurement of height, weight, and BMI annually) <ul style="list-style-type: none"> - Problem List* - Allergies* - History* - Diagnoses* - Treatment Plan* - Appropriate Treatment* • 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: <ul style="list-style-type: none"> - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs and 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**

Chapter 10: Quality management program and compliance information

Key contacts

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

What is the quality improvement program?

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

The program consists of:

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

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

The Provider Advisory Committee (PAC) is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, and utilization of the medical care rendered within the network. Network primary care and sub-specialty providers are encouraged to join PAC.

Cooperation with quality-improvement activities

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

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

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)
- Collaborate on performance improvement projects federal and state legislatures identify, such as Potentially Preventable Events (PPE), inappropriate ER use, and readmissions within 30 days and hospitalizations. We also expect you to help us improve birth outcomes across areas like c-sections, pre-term births and neonatal abstinence syndrome (NAS).

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 independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

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

Clinical practice guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines and resources for quality and health management programs. Visit UHCprovider.com/cpg to view these guidelines, which are essential for clinical decision-making.

Credentialing standards

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

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

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

American Health Care Act and UnitedHealthcare Community Plan standards

You must successfully meet Agency for Health Care Administration (AHCA) and UnitedHealthcare Community Plan standards for network participation.

Requirements include all of the following:

- NPI number
- Completed care provider application
- W-9
- Current provider agreement with AHCA

For physicians, the following is also required:

- Good standing of privileges at the hospital designated as the primary admitting facility by the physician or, if the physician does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage
- Valid Drug Enforcement Administration certificates, where applicable
- Confirmation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare and commercial coverage) is no more than 3,000 patients per primary care physician. An active patient is one that is seen by the provider a minimum of 2 times per year.
- A good standing report on a site visit survey, which includes the following:
 - Review of care provider's facilities using the UnitedHealthcare's organizational standards;
 - The care provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities and proper fire and safety procedures are in place; and
 - The care provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards
- Attestation to the correctness/completeness of the care provider's application
- Statement regarding any history of loss or limitation of privileges or disciplinary activity

- A statement from each care provider applicant regarding the following:
 - Any physical or behavioral health problems that may affect the provider’s ability to provide health care; and
 - Any history of chemical dependency/substance abuse
- Current curriculum vitae or completed credentialing application, which includes at least 5 years of work history
- Proof of the provider’s medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, if applicable.
- Evidence of specialty board certification, if applicable

Long Term Care credentialing/recredentialing requirements



For LTC Home & Community Based providers, obtain credentialing/re-credentialing assistance via email or call the LTC Provider phone line at 1-407-659-7241.

Requirements include the following:

- Credentialing/recredentialing application along with required documents such as W-9, current business/occupational license, active Medicaid ID number (limited or full enrollment with the state) and active NPI number
- Complete applicable training and include some additional information as required for Long Term Care providers per the State of Florida, AHCA and SMMC

LTC credentialing/recredentialing is managed at the local health plan level, which provides immediate resources to assist providers when needed.

If you have a valid limited enrolled or fully enrolled agreement with AHCA, you must meet the following requirements for credentialing and recredentialing:

- A copy of your current license for medical care providers, or occupational or facility license as applicable to care provider type or authority to do business

- No revocation, moratorium or suspension of your state license by AHCA or the Department of Health, if applicable
- No sanctions imposed on the care provider by Medicare or Medicaid (validated through AHCA, DHHS OIG and SAM database)
- A satisfactory Level 2 background check for all treating care providers not currently enrolled in Medicaid’s fee-for-service program
- Disclosure related to ownership and management, business transactions and conviction of crimes

As defined by UnitedHealthcare Community Plan, you will need to submit a roster listing of all staff who qualify as direct care providers (face-to-face contact and have access to member information) as it relates to UnitedHealthcare LTC Medicaid Managed Care plan members. The roster will be used to confirm staff compliance by accessing the AHCA background screening portal. Requirements include all of the following:

- W-9 with Tax ID number
- AHCA business license
- Occupational license or business tax receipt
- Level 2 background screening results
- Attestation to background screening
- Liability insurance declaration page
- Workers’ compensation declaration
 - If you have 3 or less employees, provide a printed notice on letterhead stating you don’t require worker’s compensation.
- Compliance attestation form
- Attestation to abuse/neglect/exploitation training
- Proof of Medicaid ID number
 - Per AHCA, Medicaid numbers must be enrolled. You will need to apply for a new number if you have a registered Medicaid number
- Emergency contingency plan (How will you help ensure UnitedHealthcare Community Plan members can access care or treatment in an emergency, like a disaster, care provider is ill, etc.?)

Credentialing and contracting policies and procedures

Credentialing and recredentialing policies and procedures include the following:

- All direct service care providers must complete abuse, neglect and exploitation training

- Approval of new care providers and imposition of sanctions, termination, suspension and restrictions on existing care providers
- Identification of quality deficiencies that result in UnitedHealthcare Community Plan's restriction, suspension, termination or sanctioning of a care provider

Care providers not currently enrolled in Medicaid's fee-for-service program must submit fingerprints electronically following the process described on the AHCA's background screening website. Medicaid eligibility is verified through this background screening system. We will not contract with any care provider who has a record of illegal conduct, i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s.435.04, F.S.

Individuals already screened as Medicaid care providers, or screened within the past 12 months by another Florida agency or department using the same criteria as the agency, are not required to submit fingerprints electronically but shall document the results of the previous screening.

Individuals listed in s.409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on AHCA's background screening website.

Care provider credentialing rights

Care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application
- To correct information
- To be told the status of your credentialing or recredentialing application, upon request

Subcontractor responsibilities

We enter into subcontractor arrangements, as appropriate. We agree to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations.

All model and executed subcontractors and amendments used by the UnitedHealthcare Community Plan under this contract shall meet the following requirements:

- Provide for inspections of any records pertinent to the contract by AHCA
- Care providers and subcontractors agree to comply with record retention requirements for practitioner or care provider licensure, require records be maintained for a period no less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete (prior approval for the disposition of records must be requested and approved by UnitedHealthcare Community Plan if the subcontract is continuous)
- Subcontractor agrees to provide assurance all licensed medical professionals are credentialed based on state credentialing requirements, credentialing activities have been delegated
- Additionally, subcontractors are required to secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this contract unless such employees are covered by the protection afforded by the managed care plan. Such insurance shall comply with Florida's Workers' Compensation Law

The subcontractor must help ensure ability for members to obtain services and provide monitoring of services provided to the members by the subcontractor.

Subcontractors are also subject to background checks.

Managed medical assistance credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

Health facilities

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

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

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

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



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



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

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

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

Adverse credentialing determination appeals

If UnitedHealthcare Community Plan makes an adverse determination regarding your participation, you are notified in writing and given an opportunity to initiate a formal appeal.

Peer review

Credentialing process

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

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website.

Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

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

Applicant rights and notification

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

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

Confidentiality

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

Resolving disputes

Contract concerns

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

South Florida

UnitedHealthcare Community Plan
7901 SW 6th Street, Suite 400
Plantation, FL 33324

North Florida

10151 Deerwood Park Blvd
Bldg. 100, Suite 420
Jacksonville, FL 32256

West Florida

Network Management
9009 Corporate Lakes Drive, Suite 200
Tampa, FL 33634

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

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

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

National provider identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations. Find additional information on HIPAA regulations at [cms.hhs.gov](https://www.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 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 AHCA contractual requirements and 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.



To report questionable incidents involving members or care providers
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.

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 Florida 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 the records under review or inspection. You agree to refund UnitedHealthcare or 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 Florida program standards.

You must cooperate with the state or any of its authorized representatives, AHCA, Florida Department of Health, the Florida Medicaid Fraud Control Unit, 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 care provider manual.

Critical and adverse incident reporting

In the event of a critical incident defined by the Agency for Health Care Administration (AHCA): “Critical events that negatively impact the health, safety, or welfare of enrollees.

Critical incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.”

This may result in, but is not limited to, the following:

- Death
- Abuse/neglect/exploitation
- Major medication incident
- Altercation requiring medical intervention
- Involvement with law enforcement
- Member elopement/missing
- Member major injury
- Member major illness

If the incident is related to the provision of covered Home and Community Based Services (HCBS), critical Incidents must be reported by both providers and vendors including:

- Care provider
- Any health care professional who administers care to members

This excludes:

- Assisted Living Facilities (ALF) and Skilled Nursing Facilities (SNF) vendor
- Any subcontracted entity who provides services to members

Care providers/vendors with direct patient care must report critical incidents to UnitedHealthcare Community Plan within 24 hours of the incident by calling **1-800-791-9233** and be prepared to provide the following:

- Member name
- Member date of birth
- Medicaid ID number
- Member address of residence
- Address where critical incident occurred, if different from member’s residence
- Member phone number
- What happened
- Date of incident
- A description of what happened
- Whether the event was associated with or resulted in injury or illness
- Information about the injury or illness
- What was the outcome: Did member receive care for this critical incident? Where did the member go to receive care?

- Name of person reporting, title and phone number
- Date of report

Care providers/vendors with direct patient care must use the AHCA Incident Reporting System (AIRS) to report serious patient injury. Information regarding AIS user registration and submission can be found at [AHCA’s Office of Risk Management and Patient Safety webpage](#).

Providers/vendors who do not have direct patient care may use their own critical incident report forms.

It is important to appreciate what the term “adverse incident” means to AHCA and how the Florida statute for reporting is conducted at UnitedHealthcare Community Plan.

There is 1 critical difference for health plans vs. hospital reporting. Hospitals have 15 days to report (hence, the term Code 15). Reporting for health plans is required by Florida Statute, Chapter 59A-12 of the Florida Administrative Code and shall require Home and Community Based (HCBS) providers to report critical incidents to the Managed Care Plans within 24 hours of the incident. The initial Code 15 report has to be filed within 24 hours of the occurrence of the event. According to the Adverse Incident Reporting Guide distributed by AHCA, the term “adverse incident” for Code 15 reporting means an event over which health care personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and results in one of the following injuries:

- Death
- Brain or spinal damage
- The performance of a surgical procedure on the wrong patient
- The performance of a wrong surgical procedure
- The performance of a wrong-site surgical procedure
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

Adverse/critical incident reports must be completed in their entirety.

For any incidents that occur on the weekends (after 5 p.m. Friday ET) and on holidays, care providers must also report the incident immediately to the member’s case manager. The member’s case manager can be determined by reviewing the member’s plan of care, the Authorized Service Order (ASO) sent to the provider, or contact information left by case manager with provider’s administration.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and services (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary practice 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.	Office facilities are dirty; smelly or otherwise in need of cleaning. Office exams rooms do not provide adequate privacy.	2 complaints in 6 months.
Other.	All other complaints concerning the office facilities.	3 complaints in 6 months.

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	UHCprovider.com/claims For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	UHCprovider.com/edi	1-866-633-4449

Our claims process



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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on UHCprovider.com/guides.

Claims process from submission to payment

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

National provider identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.



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

Your clean claims must include your NPI and federal TIN.

General billing guidelines

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

Fee schedule

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

Bill for HCBS services using the existing Healthcare Common Procedure Coding System (HCPCS) codes, modifiers and units listed in the Payment Appendix of your Agreement.

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 1500 and UB-04 claim forms.

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

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

Clean claims and submission requirements

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

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

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

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

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 HCFA 1500 and UB-04 forms

For more information see EDI claims section

Electronic data interchange companion documents

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

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

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements. The companion documents are located on [UHCprovider.com/edi](#) > **EDI transaction and code sets**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don’t confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties. For clearinghouse options, use [UHCprovider.com/edi](#) > **EDI Clearinghouse Options**.

e-Business Support

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

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

For further information about EDI online, go to UHCprovider.com/resourcelibrary to find electronic data interchange menu.

Important electronic data interchange payer information

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP
- ERA ID 04567 for dates of services before June 1, 2017 use previous ERA #87726

Electronic payment solution: Optum Pay

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

Why choose automated clearing house / direct deposit?

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

What does this mean to you?

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

Completing the CMS 1500 claim form



Companion documents for 837 transactions are on UHCprovider.com/resourcelibrary to find the **EDI** section.

Visit the [National Uniform Claim Committee](https://www.nucm.com) website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

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

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

Capitated services

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

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

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

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

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

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

Form reminders

- Note the attending 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

When an NPI number alone cannot identify your Medicaid provider ID number, the following must be included on your **claims**:

- A taxonomy code appropriate to the services provided
- A taxonomy code appropriate to your enrolled provider type and specialty

Subrogation and coordination of benefit

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

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

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

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 (NPFSS) Relative Value File to determine global days values.

To learn more about billing for global days and their values, read our global days policy on [UHCprovider.com/policies](#) > For Community Plans > [Reimbursement Policies for Community Plan](#) > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

Correct coding initiative

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

Comprehensive and component codes

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

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

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

Ambulance claims (emergency)

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

National drug code

Claims must include:

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

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

Medical necessity

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

Place of service codes

Go to [CMS.gov](https://www.cms.gov) for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the **UnitedHealthcare Provider Portal**.

UnitedHealthcare Provider Portal

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

Resolving claim issues

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

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

For paper claims

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

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

Timely filing

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

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

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

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

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

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

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

Balance billing

Do not balance bill members if:

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

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

Third-party resources

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

Chapter 12: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements. For claims, billing and payment questions, go to UHCproviders.com/claims. We no longer use fax numbers. Please use our online options or phone number.

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

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form For mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim 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.	<ul style="list-style-type: none"> Member Care provider on behalf of a member with member consent 		UHCprovider.com/claims For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or UHCprovider.com/claims .	Must receive within 45 business days.	30 business days.
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with..	<ul style="list-style-type: none"> Member Care provider on behalf of a member with member consent 		For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the Reconsiderations and Appeals interactive guide .	Must receive within 90 business days.	45 business days.
Care provider claim formal appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration..	Care provider		For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal .	1-800-791-9233 LTC	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . Most care providers in your state must submit reconsideration requests electronically. For further information on appeals, see the Reconsiderations and Appeals interactive guide .	90 days from the date of determination.	60 days from receipt.
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care provider	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364		1-877-842-3210 MMA 1-800-791-9233 LTC	Use the Claims Management or Claims on the Provider Portal. Click Sign in on the top right corner of UHCprovider.com , then click Claims.	45 days	90 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form For mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made.	<ul style="list-style-type: none"> Member Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent 	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	providerforms.uhc.com *AOR consent form located at this link.	1-800-895- 2017, TTY 711	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations.	Standard and urgent appeals: 60 calendar days.	Expedited appeals: We will respond within 48 hours. Standard appeals: 30 days.
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	<ul style="list-style-type: none"> Member Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent 	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364		1-800-895- 2017, TTY 711			

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

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

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

When to use:

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

How to use:

View the [appeals and grievances grid](#) for submission information.

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

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

View the [appeals and grievances grid](#) for submission information.

Warning! If your claim was denied and you resubmit it, you will receive a **duplicate claim denial**. 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 or learn about denial versus rejection at therabill.zendesk.com.

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 or mail.

View the [appeals and grievances grid](#) for submission information.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements

- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

View the [appeals and grievances grid](#) for submission information.

Submit a reconsideration request electronically by phone or mail with the following information.

- Correct member name
- Correct date of service
- Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within 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 are on [UHCprovider.com/claims](https://uhcprovider.com/claims).

Find the Overpayment form at:

uhcprovider.com/claims > **Overpayment-Refund-Form**

If you need help or have a question about an adjustment or how a claim was processed, please contact Provider Services.

If you received a letter from Optum about an overpayment, follow the instructions provided in the letter. The letter will tell you where and how to refund, or appeal the request.

Call **Optum Recovery services** at **1-800-727-6735**

Monday-Friday, 7:30 a.m. - 5 p.m. CT.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract. If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

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

Sample overpayment report

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

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
1111	01/01/24	14A0000000001	01/31/24	\$115.03	\$115.03	Double payment of claim.
22222	02/02/24	14A0000000002	03/15/24	\$77.29	\$27.29	Contract states \$50.00, claim paid \$77.29.
333333	03/03/24	14A0000000003	04/01/24	\$131.41	\$98.56	You paid 4 units, we billed only 1.
4444444	04/04/24	14A0000000004	05/02/24	\$412.26	\$412.26	Member has other insurance.
55555555	05/05/24	14A0000000005	06/15/24	\$332.63	\$332.63	Member terminated.

Appeals (step 2 of dispute)

What is it?

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

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

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

View the [appeals and grievances grid](#) for submission information.

Questions about your appeal or need a status update?

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

External claim dispute resolution

Based on Florida statute 408.7057 and Florida Administrative Rule 59A-12.030, AHCA is contracted with Capitol Bridge, an independent dispute resolution organization, to provide assistance to health care providers and health plans to resolve claim disputes. For details, visit the statewide provider and health plan You may only file a grievance on a member's behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures claim dispute resolution program page on AHCA's website at ahca.myflorida.com.

Care provider grievance

What is it?

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

When to file:

You may file a grievance about:

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

How to file:

File verbally or in writing.

- **Phone:** Call **Provider Services** at
MMA: **1-877-842-3210**
LTC: **1-800-791-9233**
- **Mail:** Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan

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

You may also send a letter to:

South Florida

UnitedHealthcare Community Plan
7901 SW 6th Street, Suite 400
Plantation, FL 33324

Central Florida

UnitedHealthcare Community Plan
7901 SW 6th Street, Suite 400
Plantation, FL 33324

North Florida

10151 Deerwood Park Blvd
Building 100, Suite 420
Jacksonville, FL 32256

West Florida

Network Management
9009 Corporate Lakes Drive, Suite 200
Tampa, FL 33634

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

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

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

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

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 or mail the information within 60 calendar days from the date of the adverse benefit determination.

View the [appeals and grievances grid](#) for submission information.

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

How to use:

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

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.

- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if the Medicaid Fair Hearing upholds the plan's decision. 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 48 hours from when we receive it.

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

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

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal. A copy of the form is online at providerforms.uhc.com

Member grievance

What is it?

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

When to use:

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

Where to send:

View the [appeals and grievances grid](#) for submission information.

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires. We offer a 14-calendar-day extension if the member or UnitedHealthcare Community Plan requests additional time.

The member may also file a grievance in writing to the state of Florida within 30 calendar days of receipt of the first determination letter.

State fair hearings

What is it?

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

When to use:

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:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 7237
Tallahassee, FL 32314-7237

Phone: 1-877-254-1055

Fax: 1-239-338-2642

MedicaidHearingUnit@ahca.myflorida.com

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

Processes related to reversal of our initial decision

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

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

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

Title XXI MediKids members are ineligible for a Medicaid Fair Hearing.**

State Review Process (MediKids Members)

Upon the member's request, a state-appointed hearing officer will review the decision made during the Plan appeal. Members have up to 30 days from the date of the notice to request a state review. Please note the appeal process must be completed first.

To request a state review, members can contact the Agency for Health Care Administration by phone, mail, or email:

Mailing address:

Agency for Health Care Administration
P.O. Box 7237
Tallahassee, FL 32314-7237

Phone: 1-877-254-1055

Fax: 1-239-338-2642

MedicaidHearingUnit@ahca.myflorida.com

Once the request is received, the Agency will provide the member with a written confirmation.

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](https://www.uhc.com/fraud) to learn more or to report and track a concern. You can also make a report by calling the State Consumer Hotline at 1-888-419-3456 or the Florida Attorney General's office at 1-866-966-7226.

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.

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. Find out how we follow federal and state regulations around false claims at [UHCprovider.com/flcommunityplan](https://www.uhcprovider.com/flcommunityplan) > Integrity of Claims, Reports, and Representations to the Government

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

This manual 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

Federal False Claims Act

The False Claims Act (31 USC § 3279-33) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false claim to the U.S. government for payment.

“Knowingly” means a person, with respect to information, has actual knowledge of the falsity of information in the claim; acts in deliberate ignorance of the truth or falsity of the information in a claim; or acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud. Instead, people can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

Penalties can be up to 3 times the value of the false claim, plus from \$5,500 to \$11,000 in fines, per claim

Whistleblower provisions

To encourage people to report misconduct involving false claims, the act includes a whistleblower provision. This provision allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Those seeking whistleblower status must meet several criteria to prevail as outlined.

Original source

The whistleblower must be the original source of the information reported to the U.S. government. They must have direct and independent knowledge of the false claims activities and voluntarily provide this information to the government. The matter disclosed cannot already be the subject of a federal investigation.

Rights of parties to whistleblower actions

If the government decides the lawsuit has merit and decides to join, the lawsuit is directed by the U.S. Department of Justice. At this point, the government is the “plaintiff,” or party suing. If the government decides not to intervene, the whistleblower may continue with the lawsuit on their own.

Award to whistleblowers

If the lawsuit is successful (after being prosecuted by the government), the whistleblower may receive an award ranging from 15-30% of the amount the government recovers.

The whistleblower may also be entitled to reasonable expenses, including attorneys' fees and costs for bringing the lawsuit.

No retaliation protection for whistleblowers

In addition to a financial award, the act grants whistleblowers additional relief, including employment reinstatement, back pay, and other compensation arising from retaliatory conduct against them for filing an action under the act or committing other acts. This includes providing testimony of assisting in a False Claims Act action. Our employees are protected from retaliation (e.g., discharge, demotion, suspension, threat, harassment, discrimination) in the event any employee files a claim pursuant to the act or otherwise makes a good faith report alleging fraud, waste or abuse in a federal health care program, including the Medicare and Medicaid programs, to UnitedHealthcare Community Plan or the proper authorities, subject to the terms and conditions of UnitedHealthcare Community Plan's Compliance Plan.

State laws

States where UnitedHealthcare Community Plan does business have laws with civil or criminal penalties for false claims and statements in addition to the penalties provided in the act.

Exclusion checks

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

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

What you need to do for exclusion checks

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

Human trafficking

Human trafficking is the transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport for forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion.

Look for these warning signs when treating members:

- A scripted or inconsistent health history
- An unwillingness or hesitance to answer questions about an injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner or employer)
- Fearful or nervous behavior or avoids eye contact
- Resistance to help or shows hostile behavior
- Cannot provide their address
- Lack of awareness for their location, the date or time
- Does not have their identification documents
- Not in control of their own money
- Not being paid or wages are withheld

How to help

If you have information regarding suspected human trafficking of a child in Florida, contact the Florida Abuse Hotline at 1-800-962-2873.

If you have information regarding suspected human trafficking of an adult anywhere in the United States or of a child outside of Florida, please contact the National Human Trafficking Resource Center at 1-888-373-7888.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Care provider education	UHCprovider.com/resourcelibrary For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
News and bulletins	UHCprovider.com/news For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC
Care provider manuals	UHCprovider.com/guides For MMA - connect with us through chat 24/7 in the UnitedHealthcare Provider Portal	1-800-791-9233 LTC

Communication with care providers

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

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

- **Chat support available**
Have a question? Skip the phone and chat with a live service advocate when you sign in to the [UnitedHealthcare Provider Portal](#). Available Monday-Friday, 7 a.m.-7 p.m. CT, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

- **UnitedHealthcare Community Plan of Florida page:** UHCprovider.com/flcommunityplan has resources, guidance and rules specific to Florida. Be sure to check back frequently for updates.
- **Policies and protocols:** UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
 - Facebook
 - Instagram
 - LinkedIn
 - YouTube
 - X (Twitter)
- **FL health plans:** UHCprovider.com/fl is the fastest way to review all of the health plans UnitedHealthcare offers in Florida. To review information for another state, simply use the drop down menu at UHCprovider.com/plans. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.

- **UnitedHealthcare Provider Portal:** This secure portal 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 **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
Bookmark UHCprovider.com/networknews. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
 - Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

Care provider education and training

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

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

Email communication – required contact information

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

Submit your email address in one of the following ways:

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

Care provider office visits

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

Care provider manual

UnitedHealthcare Community Plan publishes this 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 websites and forms

Find the following forms on the state's website at flrules.org:

- [Consent for Sterilization Form](#)
- [State of Florida Hysterectomy Acknowledgment Form, HAF-5000](#)

Outreach and marketing guidelines for member materials

You may make available and/or distribute managed care plan marketing materials as long as you and/or the facility distributes or makes available marketing materials for all managed care plans with which you participate.

If you agree to make available and/or distribute managed care plan marketing materials, do so knowing you must accept future requests from other managed care plans with which you participate. You are also permitted to display posters or other materials in common areas such as the waiting room.

Additionally, LTC facilities may provide materials in admission packets announcing all managed care plan contractual relationships.

Through education, outreach and monitoring, we work with you to help ensure you are aware of and comply with these guidelines. For example, you may engage in discussions with recipients should a recipient seek advice. However, you must remain neutral when assisting with enrollment decisions.

You may not:

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in a managed care plan based on financial or any other interests that you may have
- Mail marketing materials on behalf of a managed care plan
- Offer anything of value to induce recipients/members to select them as their care provider
- Offer inducements to persuade recipients to enroll in a managed care plan
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from a managed care plan for marketing activities
- Distribute marketing materials within an exam room setting
- Furnish to managed care plans, lists of their Medicaid patients or the membership of any managed care plan

You may:

- Provide the names of the managed care plans with which you participate
- Make available and/or distribute managed care plan marketing materials
- Refer your patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid Area Office
- Share information with patients from the AHCA website or CMS website
- Announce new or continuing affiliations with a Managed Care Plan through general advertising (e.g., radio, television, websites)
- Make new affiliation announcements within the first 30 calendar days of the new care provider agreement
- Make one announcement to patients of a new affiliation that names only that managed care plan when such announcement is conveyed through direct mail, email, or phone

Additional direct mail and/or email communications from you to patients regarding affiliations must include a list of all managed care plans with which you contract.

Any affiliation communication materials that include managed care plan-specific information (e.g., benefits, formularies) must be prior approved by the agency.

You may distribute printed information provided by a managed care plan to patients comparing the benefits of all of the different managed care plans with which you contract. The managed care plans will help ensure that:

- Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information
- Such materials have the concurrence of all managed care plans involved in the comparison and are approved by the agency prior to distribution

The managed care plans identify a lead plan to coordinate submission of the materials.

Methods and media offering cultural competency information to care providers

In addition to our provider manual, we use a variety of educational and communication materials designed to support providers in their care of our member communities.

Care provider newsletter (Practice Matters) and service bulletins

Practice Matters, our quarterly provider newsletter, contains program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives and articles regarding health topics of importance to members. The newsletters also include changes in the law, regulations and subcontract requirements. We list these service bulletins on the provider portal and recap them in Practice Matters.

UnitedHealthcare Provider Portal

[UHCCommunityplan.com](https://www.uhccommunityplan.com) supports Florida Medicaid providers through many features and tools and integrates with our critical systems. The website enables providers to electronically determine member eligibility, submit claims and ascertain the status of claims.

The provider portal contains an online version of the care provider manual, the provider directory, clinical practice guidelines, quality and utilization requirements and educational materials such as cultural competency information, newsletters, recent bulletins and other provider information. Notifications regarding legal changes, regulations, bulletins and alerts are also posted.

Physician cultural education library

Our physician cultural education library is available on [UHCCommunityplan.com](https://www.uhccommunityplan.com). The library provides links to training tools/reference materials to help improve awareness of sociocultural influences on health beliefs and behaviors and to better understand population-specific disease prevalence and outcomes. Some of the resources available include cultural competency practices, educational decks, provider manuals and self-paced cultural competency training, including courses with continuing education credits (CEU) and continuing medical education (CME) requirements.

Town hall meetings and field-based care provider training

We schedule trainings and educational forums throughout the year and across the state. The provider advocate team holds monthly meetings with high-volume providers to present regular updates and refresher trainings. We hold joint operating committee meetings with key facilities to address operational issues, including training needs.

Webinars

We offer a full slate of interactive webinars, all conducted in real time. Webinar training encompasses all topics, including contract requirements; utilization management; fraud, waste and abuse; prior authorization; cultural competency; pharmacy and transportation.