IA Health Link Training for Behavioral Health Providers
UnitedHealthcare Community Plan
Our United Culture

Our mission is to help people live healthier lives.
Our role is to make health care work for everyone.

Integrity.
Compassion.
Relationships.
Innovation.
Performance.

Honor commitments
Never compromise ethics

Walk in the shoes of people we serve
and those with whom we work

Build trust through collaboration

Invent the future, learn from the past

Demonstrate excellence
in everything we do
Behavioral Health Services
1. Moving from a disease-centric model to a Member-Driven, Medical-Behavioral-Social Health Model by operating with a collaborative team approach to deliver care using a standardized protocol

2. Treating Members in a holistic manner by using a single Member driven treatment plan, including helping the Member access their natural community supports based on their strengths and preferences

3. Use of clinical systems and claims platforms that allow for a seamless coordination across inter-disciplinary care teams of the Member's needs

4. Focused on multimorbidities in patients with chronic clinical conditions to improve health outcomes and affordability

5. Improved screening and treatment of Mental Health and Substance Use Disorder diagnoses

6. Treating Members at the point of care where they are comfortable
Behavioral and Medical Integration

**Our Goal:** Increase medical and behavioral health care integration for all members.
- Providers are asked to refer members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment.

**Our Goal:** Increase integration of treatment for mental health and substance use disorder conditions.
- Our care management program assists members with complex medical and/or behavioral health needs in the coordination of their care.
- All members are expected to be treated from a holistic standpoint, this is especially true for high-risk, high-service utilizers and other high-cost members with complex needs.
# Recovery and Resiliency

## Definition of Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

## Definition of Resilience

The ability to recover quickly from disruptive change, illness, or misfortune without being overwhelmed or acting in dysfunctional ways.

## Guiding Principles of Recovery

- Recovery emerges from hope
- Recovery is *person-driven*
- Recovery occurs via *many pathways*
- Recovery is holistic
- Recovery is *supported by peers and allies*
  - Recovery is supported through relationship and social networks
- Recovery is culturally-based and influenced
- Recovery is supported by addressing trauma
- Recovery involves *individual, family, and community strengths and responsibility*
- Recovery is based on respect
Role of the Recovery & Resiliency Team

• Our R& R team consist of 2 certified adult peers and 2 family peers support specialist.
  • They have completed dynamic trainings, have lived experience and have many years of experience working with high needs members and families.
  • They are here to work with individuals and families to develop wellness, whole-health and recovery action plans of care and make community/social connection:
    • Their lived experiences contribute to the support of the individuals and families
    • This collegial service augments clinical services
    • Family Peers/Peers empowers members and families to make decisions in a person-centered model
    • Family Peers/Peers act as conduits to Recovery & Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities, community connection, treatment options…)
    • Other services as appropriate (legal, shelter, basic needs, etc.)
• Members of the Recovery & Resiliency team provide a consultancy role to other physical and mental health providers
Role of the Field Care Advocate

• The Field Care Advocate is there to help members with complex behavioral health conditions connect with needed services and resources.
• Field Care Advocates work intensely with individuals in the development of a comprehensive plan of care which coordinates the following:
  • Therapeutic services (therapy, medication management)
  • Community case management
  • Community and Psychosocial supports (education/support regarding illness, coordination with support system, other supportive services)
  • Coordination of care between medical and behavioral physicians and clinicians
  • Recovery and Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities)
  • Other services as appropriate (legal, shelter, basic needs, etc.)
• It is very important of notify a member’s Field Care Advocate, as expeditiously as warranted by the member’s circumstances, of any significant changes in the member’s condition or care, hospitalizations, or recommendations for additional services.
Providers in our Behavioral Health Network

• Psychiatrists
• Addictionologists
• Psychologists
• Master Level Clinicians
• Advanced Practice Registered Nurses (APRN)
• Behavioral Health Intervention Specialists (BHIS)
• Physician Assistants

Network providers also include:
• Community Mental Health Centers
• Rural Health Clinics
• Federally Qualified Health Centers
• Substance Use Disorder Agencies
• Inpatient Facilities
• Psychiatric Medical Institutions for Children (PMIC)
Covered Behavioral Services – Traditional Medicaid

- Crisis Services
- Inpatient Hospitalization
- Psychiatric Medical Institutions for Children (PMIC)
- Residential substance use disorder treatment, including detoxification
- Partial Hospital/Day Treatment/Intensive Outpatient Treatment (IOP)
- Individual, group and/or family therapy (in-home and office setting)
- Intensive Psychiatric Rehabilitation

- Outpatient substance use disorder treatment services including:
  - Assessment, Detoxification Services, Counseling, Medication Assisted Treatment
  - Evaluation and medication management
  - Behavioral Health Intervention Services for child and family
  - Applied Behavioral Analysis for children with Autism
  - Children’s Mental Health (CMH) waiver program
  - Habilitation waiver program
  - Integrated Health Homes
  - Peer support and counseling

* Covered services vary by Plan type
Covered Behavioral Services – Iowa Wellness Plan (ABP)

- Inpatient Hospitalization (MH/SUD)
- Partial Hospital / Day Treatment / Intensive Outpatient Treatment (IOP)
- Individual, group and/or family therapy
- Outpatient Substance-Use Disorder (SUD) treatment services including:
  - Assessment, Detoxification Services, Counseling, Medication Assisted Treatment
- Evaluation and medication management
Behavioral Services – *hawk-i*

- Inpatient Hospitalization
- Residential substance use disorder treatment, including detoxification
- Partial Hospital / Day Treatment / Intensive Outpatient Treatment (IOP)
- Individual, group and/or family therapy
- Outpatient Substance-Use Disorder treatment services including:
  - Assessment, Detoxification Services, Counseling, Medication Assisted Treatment
- Evaluation and medication management
1915(c) Children’s Mental Health Waiver

• Members are assessed based on eligibility criteria and must be authorized to be involved in the waiver services utilizing the current state approved assessment tool.

• A referral for the CMH waiver program may be received by:
  • Self referral
  • Provider referral
  • Hospital admission notification
  • Ongoing review of claims data

• The child may be placed on a waiting list and if this occurs, the MCO shall ensure that members are receiving additional non-waiver supports and services while on the waiting list.

• Once a slot becomes available, the member will be enrolled in an Integrated Health Home (IHH) (if not already enrolled) and CMH waiver services will begin.

• If a member opts-out of an IHH, the member will be dis-enrolled from the CMH waiver.
1915(i) Habilitation Waiver Services

- Members are assessed based on eligibility criteria and must be authorized to be involved in the waiver services utilizing the current state approved assessment tool.
- A referral for the Habilitation waiver program may be received by:
  - Self referral
  - Provider referral
  - Hospital admission notification
  - Ongoing review of claims data
- In order to receive Habilitation waiver services, the member will be (if not already) enrolled in an Integrated Health Home (IHH).
- If a member opts-out of an IHH, the member will be dis-enrolled from the habilitation waiver services.
Discharge Planning

• Effective discharge planning addresses how a member’s needs will be met during transition from one level of care to another or to a different treating clinician.

• Planning begins with the onset of care and should be documented and reviewed over the course of care.

• Discharge treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care.

• Discharge instructions should be specific, clearly documented and provided to the member prior to discharge. For discharge from an acute inpatient program, the member’s follow-up appointment will be scheduled prior to discharge and within seven days of the date of discharge.

• Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care.

• Members MUST have a discharge appointment and prescriptions at the time of discharge
# Prior Authorization Requirements

<table>
<thead>
<tr>
<th>No Authorization Required</th>
<th>Authorization Required (Request Online or by Phone)</th>
</tr>
</thead>
</table>
| • Members shall be able to access all behavioral health outpatient services (mental health and substance use) without a referral. | • Inpatient Mental Health and Substance Use Services (includes detoxification and residential treatment)  
• Psychiatric Medical Institutions for Children (PMIC)  
• Partial Hospitalization  
• Day Treatment  
• Intensive Outpatient  
• Peer Support Services  
• Autism / ABA Services |
## Authorization

### Non-emergent situations

- Prior authorization can be obtained by a member, family member, or a provider. When calling UHC, be prepared to provide demographic information and a brief description of the presenting problem. UHC will explain the services available under their benefit plan.

### Emergent situations

- A medical professional, a member, or a lay person in an emergency situation can identify the need for behavioral health services. Conditions that warrant an emergency admission are situations in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance abuse.
- UHC must be contacted for a prior authorization of additional care.

**Authorization phone number:** 888-650-3462
Eligibility and Benefit Review Process

When a request for services is received, United will:

- review member benefit eligibility
- gather required clinical information
- reference the appropriate criteria set
- determine whether the requested care meets medical necessity criteria

United may certify levels of care and treatment services that are specified as available under the specific benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient)
Utilization Management Statement

Utilization Management decision-making is based only on the appropriateness of care as defined by

- Level of Care Guidelines
- Psychological and Neuropsychological Testing Guidelines
- Coverage Determination Guidelines
- American Society of Addiction Medicine Criteria

United does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service
### Outpatient Management

<table>
<thead>
<tr>
<th>Reduced administrative burden</th>
<th>Management strategy</th>
<th>In scope services</th>
</tr>
</thead>
</table>
| • We have removed precertification requirements for in scope services | • Algorithms for Effective Reporting and Treatment (ALERT)  
• Practice Management | • Individual/Group/Family Outpatient Therapy  
• Outpatient Addiction Services (ASAM level 1)  
• Integrated Health Home services and supports  
• BHIS  
• Habilitation |
<table>
<thead>
<tr>
<th>Member identification</th>
<th>Licensed care advocate reach out telephonically to treating provider to:</th>
<th>Potential outcome of review:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Claims data</td>
<td>• Review eligibility for the service(s)</td>
<td>• Close case (member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)</td>
</tr>
<tr>
<td>• Service combinations</td>
<td>• Review the treatment plan/plan of care</td>
<td>• Modification to plan (e.g., current care is not evidence based but there is agreement to correct)</td>
</tr>
<tr>
<td>• Frequency and/or duration that is higher than expected</td>
<td>• Review the case against applicable medical necessity guidelines</td>
<td>• Referral to Peer Review (e.g., member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)</td>
</tr>
</tbody>
</table>
Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our practice management program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arose from the claims analysis
- Potential outcomes from discussion
  - No additional action necessary
  - Program audit including record review
  - Corrective Action Plan (CAP)
  - Targeted precertification as part of CAP
Appeals and Complaints
## Appeals

### Non Urgent (Standard)

Must be requested within 30 days from receipt of the notice of action letter.

Pre-Service: is an appeal of a service that has not yet been received by a member. When a pre-service appeal is requested, we will make an appeal determination and notify the provider, facility, member or authorized member representative in writing within fourteen (14) calendar days of the request.

Post-Service: is an appeal of a service after it has been received by a member. When a post service appeal is requested, we will make the appeal determination and notify the provider, facility, member or authorized member representative in writing within fourteen (14) calendar days of the request.

### Urgent ( Expedited)

Must be requested as soon as possible after the Adverse Determination.

United will make a reasonable effort to contact you prior to making a determination on the appeal. If United is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to United at that time.

Notification will occur as expeditiously as the member’s health condition requires, within three (3) business days, unless the appeal is pertaining to an appeal relating to an ongoing emergency or denial of continued hospitalization, which we will complete investigation and resolution of not later than one (1) business day after receiving the request.

Appeal requests can be made orally or in writing.
Services While In Appeal

You may continue to provide service following an adverse determination, but the member should also be informed of the adverse determination.

The member or the member representative should be informed that the care will become the financial responsibility of the member from the date of the adverse determination forward.

The member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the United contracted fee for such services, although a lower fee may be charged.

If, subsequent to the adverse benefit determination and in advance of receiving continued services, the member does not consent in writing to continue to receive such care and we uphold the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the member pursuant the terms of your Agreement.
Complaints

We strive for the best customer service, but if you have a complaint please contact us:

Call 888-650-3462 and a Customer Service representative will assist with the complaint process

Or send a written complaint to:

United Healthcare Community Plan of Iowa
Appeals Department
PO Box 31364
Salt Lake City, UT 84131
Treatment Record Documentation
General Documentation Standard

The following must be clearly documented in the members chart:
- Complete biopsychosocial assessment
- Substance abuse screening for consumers over the age of 11
- Treatment plan with specific long term and short term goals
- Ongoing risk assessments

More information about documentation standards can be found in the Provider Manual.
Release of Information

We release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law.

Members must sign and date a Release of Information for each party that the individual grants permission to access their PHI, specifying what information may be disclosed, to whom, and during what period of time.

The member may decline to sign a Release of Information which must be noted in the Treatment Record; the decline of the release of information should be honored to the extent allowable by law.

PHI may be exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations.
Integration of Physical and Behavioral Health

• It is essential to integrate physical and behavioral health services
• We require that coordination of care occur on a routine basis
• At the beginning of treatment, appropriate releases of information should be obtained to support coordination of care activities
• Coordination of care is completed (and documented) with Primary Care Physicians
• Coordination of care is completed (and documented) with other treating providers
• If the member refuses to allow coordination to occur, that is clearly documented in the treatment record
  • The member needs to be educated regarding how coordination of care is beneficial to their overall treatment
Billing and Claims
Claims Submission

Required Claim Forms
1500 Claim Form
Inpatient Hospital providers, use UB-04

Claims/Customer Service #: 888-650-3462

Electronic Claims Payer ID: 87726

Paper Claims:
When submitting behavioral Claims by paper, please mail claims to:
United Healthcare
PO Box 5220
Kingston, NY 12402-5220
Claims Submission

- Providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding including, but not limited to, ICD-10, CPT, and HCPCS coding
- UnitedHealthcare Community Plan requires that you initially submit your claim within 180 days of the date of service
- When a provider is contracted as a group, the payment is made to the group, not to an individual
- All claim submissions must include:
  - Member name, Medicaid identification number and date of birth
  - Provider’s Federal Tax I.D. number
  - National Provider Identifier (NPI) (unique NPI’s for rostered clinicians)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov
Entry through www.unitedhealthcareonline.com:

• Secure HIPAA-compliant transaction features streamline the claim submission process
• Performs well on all connection speeds
• Submitting claims closely mirrors the process of manually completing a CMS-1500 form
• Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function:

• To obtain a user ID, call toll-free (866) 842-3278
Claims Submission option 2 – EDI/Electronically

• Electronic Data Interchange (EDI) is an exchange of information
• Performing claim submission electronically offers distinct benefits:
  • It's fast - eliminates mail and paper processing delays
  • It's convenient - easy set-up and intuitive process, even for those new to computers
  • It's secure - data security is higher than with paper-based claims
  • It's efficient - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
  • It's complete - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
  • It's cost-efficient - you eliminate mailing costs, the solutions are free or low-cost
You may use any clearinghouse vendor to submit claims.
Payer ID for submitting claims is 87726.
Additional information regarding EDI is available on:


and

www.unitedhealthcareonline.com
Claims Submission option 3 – Hardcopy

Use the 1500 claim form:

Claim elements include but are not limited to diagnosis **DSM-5**
Member name, Member date of birth, Member identification number, dates of service, type and duration of service, name of clinician (e.g., individual who actually provided the service), provider credentials, tax ID and NPI numbers

Paper claims submitted via U.S. Postal Service should be mailed to:

United Healthcare
PO Box 5220
Kingston, NY 12402-5220

Use DSM-5 for assessment and the associated ICD-10 coding for billing
With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

• Lessens administrative costs and simplifies bookkeeping
• Reduces reimbursement turnaround time
• Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com. Here’s what you’ll need:

• Bank account information for direct deposit
• Either a voided check or a bank letter to verify bank account information
• A copy of your practice’s W-9 form

If you’re already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.

Note: For more information, please call (866) 842-3278, option 5, or go to UnitedHealthcareOnline.com > Quick Links > Electronic Payments and Statements.
• **Box 24J:** Independently licensed clinicians who render services enter their **NPI number** in the non-shaded portion.

• **Box 24J:** Non-independently licensed clinicians who render services do not need to enter an NPI number in Box 24J.
• **Box 31:** Independently licensed clinicians who render services enter their name and licensure in Box 31.

• **Box 31:** Non-independently licensed clinicians who render services enter the name of the agency in Box 31.

• Only independently licensed clinicians should appear in Box 31.
**Box 33**: Agency name, address, and phone number

**Box 33a**: Agency NPI number
When billing UnitedHealthcare for telemental health services as the originating site, providers must use the Q3014 code with the GT modifier.

Some providers may have previously billed originating site services using the T2016 code.

UnitedHealthcare requires the use of the Q3014 with the GT modifier as this is the industry standard for billing these services.
To ensure clean claims remember:
- An NPI # is always required on all claims
- A complete diagnosis is also required on all claims

Claims filing deadline
- Providers should refer to their contract with United to identify the timely filing deadline that applies.

Claims Processing
- Clean claims, including adjustments, will be adjudicated within 14 days of receipt.

Balance Billing
- The member cannot be balance billed for behavioral services covered under the contractual agreement.
Claim Tips

Member Eligibility
Provider is responsible to verify member eligibility through DHS website

Coding Issues
Coding issues including incomplete or missing diagnosis
Invalid or missing HCPC/CPT examples:
  Submitting claims with codes that are not covered services
  Required data elements missing, (i.e., number of units)

Provider information missing/incorrect
Example: provider information has not been completely entered on the claim form or place of service

Prior Authorization Required
No authorization received for those services for which an authorization is required
Units exceeded, example: authorization was given for 10 days, facility has billed for 11 inpatient days
Member Information
Member ID Card

• Will be sent directly to the member
• The member’s ID number will be their Medicaid number
• All relevant contact information will be on the back of the card for both medical and behavioral customer service

Please note this image is for illustrative purposes only.
Member Rights and Responsibilities

• Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system.

• Members have the right to disability related access per the Americans with Disabilities Act.

• You will find a complete copy of Member Rights and Responsibilities in the Network Manual.

• These can also be found on the website: providerexpress.com

• These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting.

• We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the members.
unitedhealthcareonline.com

Secure transactions for Medicaid include:

• Check eligibility and authorization or notification of benefits requirements
• Submit professional claims and view claim status
• Make claim adjustment requests
• Register for Electronic Payments and Statements (EPS)
• To request a user ID to the secure transactions on the unitedhealthcareonline.com, select New User from the Home Page; you may obtain additional information through the Help Desk at (866) 842-3278

For member eligibility, claim status, and reference materials, go to > Tools and Resources > UnitedHealthcare Community Plan Resources

Customer Service for website support: 888-650-3462
Provider Responsibilities
# Access to Care – Standards

<table>
<thead>
<tr>
<th>Routine Outpatient</th>
<th>Members shall be seen by an appropriate provider within 3 weeks of the request for an appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent</strong></td>
<td>Shall be seen within 24 hours of telephone contact</td>
</tr>
<tr>
<td>If not addressed in a timely way could escalate to an emergency situation</td>
<td></td>
</tr>
<tr>
<td><strong>Life threatening emergencies</strong></td>
<td>Referral is Immediate</td>
</tr>
<tr>
<td>Imminent risk of harm or death to self or others due to a medical or psychiatric condition</td>
<td></td>
</tr>
<tr>
<td><strong>Post Inpatient Discharge</strong></td>
<td>All members must be seen within 7 days post discharge</td>
</tr>
<tr>
<td>If you are unable to see the member during this time – refer to another in-network provider to satisfy this deadline</td>
<td></td>
</tr>
<tr>
<td><strong>Missed an Appointment</strong></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>The Care Advocate for behavioral services will contact members who have missed a post-discharge appointment to reschedule that appointment</td>
<td></td>
</tr>
<tr>
<td><strong>Special Health Care Needs:</strong></td>
<td>Within 48 hours of initial contact</td>
</tr>
<tr>
<td>Members who are pregnant women in need of routine substance abuse services</td>
<td></td>
</tr>
<tr>
<td><strong>Special Health Care Needs:</strong></td>
<td>Within 14 calendar days of initial contact</td>
</tr>
<tr>
<td>IV drug users identified as having used drugs within the last 6 months, will need to be seen for treatment</td>
<td></td>
</tr>
</tbody>
</table>
Critical Incident Definition

Critical Incidents impacts providers who have personal contact with Medicaid members under the home-and-community-based habilitation services, ill and handicapped waiver, elderly waiver, AIDS/HIV waiver, intellectual disability (formally mental retardation) waiver, brain injury waiver, physical disability waiver, and children’s mental health waiver.

The Critical incidents are divided into two categories:

- Major Incident
- Minor Incident
Definition of a Major Incident

Major incident means an occurrence involving a member enrolled in a waiver services that:

1. Incident resulting in the death of any person,
2. Requires emergency mental health treatment for the member,
3. Incident resulting in physical injury to or by the member that requires a physician’s treatment or admission to a hospital.
4. Requires the intervention of law enforcement,
5. Requires a report of child abuse pursuant to Iowa Code, section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3,
6. Constitutes a prescription medication error or a pattern of medication errors that lead to any outcomes stated above.
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.
Definition of a Minor Incident

**Minor Incident** means an occurrence involving a member enrolled in waiver services that is not a **Major Incident** and that:

1. *Results in the application of basic first aid,*
2. *Results in bruising,*
3. *Results in seizure activity,*
4. *Results in injury to self, to others or to property,* or
5. *Constitutes a prescription medication error.*
Critical Incident – Reporting Goals

Review of Critical Incident Reports are intended to accomplish the following goals:

- Ensure that Critical Incidents are appropriately reported, reviewed and monitored as part of an overall patient safety program;
- Identify provider, facility and practitioner performance improvement areas;
- Improve the overall quality of care provided to members;
- Reduce the probability of a Critical Incident in the future; and
- Compliance with Iowa Administrative code.
Critical Incidents –
Information to Report & When

What information will be reported?
- The name of the member involved.
- The date and time the incident occurred.
- A description of the incident.
- The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident.
- The action taken to manage the incident.
- Any resolution or follow-up to the incident.

When should Critical Incidents be reported?
- Major Incidents – Are reported to the UnitedHealthcare by the end of the next calendar day from the date of the incident occurred or was discovered.

- Minor Incidents- Are reported to contracted providers supervisor within 72 hours of the incident occurring or being discovered.
Critical Incidents – Report Where & How

**Major Critical Incidents reporting:**
Major Critical Incidents are reported to UHC by fax or email

*UnitedHealthcare Iowa Community Plan*

*Email: critical_incidents@uhc.com*

*Fax: 855-371-7638*

**How should Major Critical Incidents be reported?**
- Fully Complete Critical Incident Report
- Forms can be found at
  [http://www.uhccommunityplan.com/health-professionals/ia/provider-forms.html](http://www.uhccommunityplan.com/health-professionals/ia/provider-forms.html)
Where should Minor Critical Incidents be reported?

 Contracted Providers should report Minor Incidents according to their company policy for reporting and tracking Critical Incidents.

 When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident.

 The completed report shall be maintained in a centralized file with a notation in the member’s file.
Major Incident – Resolution & Follow-Up

- A UHC Critical Incident Nurse will review the report and will determine if the incident meets the states definition of a Major Critical Incident and oversee the investigation process.

- The process will be completed within 30 calendar days of notification including any indicated follow-up.

- As part of the investigation process, the Critical Incident Nurse may coordinate with the other UHG departments, such as Care Coordination staff for assistance with making sure the member’s needs are being addressed.
Critical Incidents – Who Reports?

Who reports a Critical Incident?

Notification can be completed by any referral source including but not limited to:

- Provider
- Provider Staff
- Case Managers
- Members/member representative
- UHC employees
- State Agency representative

If you have questions about a critical incident, contact Provider Services: 888-650-3462
Abuse and Neglect Training

Training For Mandatory Reporters in Iowa

• Licensed professionals are required to complete training that is required and approved by their respective licensing and examining boards or approved by the Iowa Abuse Education Review Panel.
• The Abuse Education Review Panel website can be used for abuse education resources and can be accessed at: http://www.idph.state.ia.us/bh/abuse ed review.asp
• Report of suspected child abuse and dependent abuse shall be made by calling the Abuse hotline 1-800-362-2178.

Mandatory reporters are required by law to complete two hours of training during their first six months of employment and two hours every five years thereafter.
Provider Responsibilities

• Check member’s eligibility prior to performing services by phone or online at unitedhealthcareonline.com

• Adhere to the authorization policies as outlined in the provider manual

• Adhere to appointment and accessibility standards as outlined in the provider manual

• Adhere to medical record keeping and chart review standards

• Provide services consistent with professional and ethical standards as set forth by national certification and state licensing boards, and applicable law or regulation regardless of a member’s Benefit Plan or terms of coverage
Provider Responsibilities

• Provide services to members in a non-discriminatory manner

• Determine if members have medical benefits through other insurance coverage

• Advocate for members as needed

• Notify us at providerexpress.com within ten (10) calendar days whenever you make changes to your office location, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire)

  ➡️ This includes roster management.
Network Participation
Joining Our Network

If you have received a letter inviting you to join the network, please complete the materials that were attached and return them per the instructions in the letter.

If you did not receive a letter but want to join the network, please contact United:
  by email at: bnsproviderupdates@optum.com
  or by phone at: 877-614-0484

Be sure to include the following information in your request:
  ✓ Your full name
  ✓ Your clinical license type
  ✓ Your date of birth
  ✓ Your CAQH Application ID Number
  ✓ Your email address
  ✓ Tax ID
  ✓ Name of Group or Agency
## Contact Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>United at 888-650-3462</td>
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</tbody>
</table>
| **Claims Paper Submission**      | Mail paper claims to: United Healthcare  
PO Box 5220  
Kingston, NY 12402-5220 |
| **Electronic Claim Submission**  | Through [unitedhealthcareonline.com](http://unitedhealthcareonline.com) or via EDI clearing house  
Payor ID 87726 |
| **Claims Status**                | Customer Service Center at 888-650-3462  
Web portal at [unitedhealthcareonline.com](http://unitedhealthcareonline.com) |
| **Claims Appeals Eligibility Verification Customer Service** | United Healthcare Community Plan of Iowa  
Appeals Department  
PO Box 31364  
Salt Lake City, UT 84131  
View eligibility online at [unitedhealthcareonline.com](http://unitedhealthcareonline.com) |
| **Provider Assistance**          | Iowa Network Director: Erica Bang  
National Provider Service Line at 1-877-614-0484 |
| **Update Practice Information**  | [providerexpress.com](http://providerexpress.com) or via 877-614-0484 |
Iowa Network Managers

East of I-35

Steve Inzerello
Phone: 952-703-7133
Email: steve.inzerello@uhc.com

West of I-35

Lori Moncherry
Phone: 763-283-2862
Email: lori.moncherry@uhc.com
Thank You.