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Introduction to UCare

UCare was founded in 1984 by the Department of Family Practice and Community Health at the University of Minnesota Medical School. Today, we are an independent, nonprofit, state-certified health maintenance organization (HMO) that is recognized as one of Minnesota's leading health plans.

UCare serves more than 400,000 members throughout the state of Minnesota.

Working with health care providers, community organizations and others throughout Minnesota, we create innovative health coverage plans for:

- Individuals and families choosing health coverage through MNsure, Minnesota’s insurance marketplace
- Medicare-eligible individuals
- Individuals and families enrolled in Minnesota Health Care Programs, such as MinnesotaCare and Medical Assistance
- Adults with disabilities

UCare’s Mission

Mission statement: “UCare will improve the health of our members through innovative services and partnerships across communities.”

To fulfill this mission, we provide comprehensive health care coverage to selected populations through a community-based, holistic approach.

We support family practice education and research so that this philosophy of care can be carried into the future.

We are committed to serving our members, our communities, our business partners and our employees from a foundation built on these values:

**Integrity:** UCare stands on its reputation. We are what we say we are; we do what we say we will do.

**Community:** UCare works with communities to support our members and give back to the communities through UCare grants and employee volunteer efforts.

**Quality:** UCare strives to continually improve our products and operations to ensure the highest quality of care for our members. Learn more.

**Flexibility:** UCare seeks to understand the needs of our members, providers and purchasers over time and to develop programs and services to meet those needs.

**Respect:** UCare respects its members by providing quality care and services that recognize their unique needs. UCare respects its employees by providing a supportive work culture that encourages their development and embraces their diversity.
UCare Provider Portal

The UCare Provider Portal is a secure website that allows registered users of UCare’s provider network to access electronic transactions such as:

- View explanation of payments
- Claim status inquiry
- Eligibility inquiry
- Primary Care Clinic enrollment roster
- Authorization status checks

To gain access to the UCare Provider Portal, please contact the UCare Provider Portal administrator within your organization. The administrator has access rights to add, update and remove users within your organization.

If there is no designated administrator account established for your organization, you may request one on the Provider Portal Registration page.

Requesters will receive a response within three to five business days.

- If the request is approved, the administrator must activate the administrator account prior to adding other users within your organization.
- If the request is denied, UCare’s response will explain why.

If you have any questions or need assistance with the UCare Provider Portal, please call the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free, Monday through Friday, 8 a.m. – 5 p.m.

UCare Provider Assistance Center

When providers have questions or issues that cannot be answered by using the self-service features of Provider Portal, they may contact UCare’s Provider Assistance Center (PAC). A PAC representative can be reached at 612-676-3300 or 1-888-531-1493 toll free, Monday through Friday, 8 a.m. – 5 p.m.

OTHER UCARE KEY CONTACTS

Authorizations – Medical
UCare Clinical Services
612-676-6705
1-877-447-4384 toll free
Fax: 612-884-2499

Authorizations – Mental Health & Chemical Dependency
UCare Behavioral Health
612-676-3300 or 1-888-531-1493 (follow the prompts)
Fax: 612-884-2033 or 1-855-260-9710

**Fraud Waste and Abuse**
UCare Special Investigations Unit
1-877-826-6847
[compliance@UCare.org](mailto:compliance@UCare.org)

**Questions Regarding Contracts with UCare**
[prccontractadmin@UCare.org](mailto:prccontractadmin@UCare.org)

**For On-site Provider Training and Education**
UCare Provider Field Representatives – See [Territory Map](mailto:Territory Map)

Kathy Campeau
1-612-246-0505

Dee Kochevar
1-612-246-0487

Kara O’Neil
1-612-219-4090
Working with UCare’s Delegated Business Services

UCare works with organizations to whom we have delegated the responsibility for providing pharmacy benefit management, dental and chiropractic services through their own provider networks on UCare’s behalf.

Pharmacy Services

EXPRESS SCRIPTS, INC.

Express Scripts, Inc. (ESI) has been the pharmacy benefit manager for UCare beneficiaries since 2010. All covered new and refill prescriptions, including mail-order, should be processed through ESI.

Pharmacy Network

ESI is a full-service Pharmacy Benefits Manager with offices in Minnesota. They have an extensive retail pharmacy network with more than 60,000 participating pharmacies across the country. Many of the retail pharmacies also participate in the 90-day extended day supply program for applicable benefit plans.

In 2019, UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, and EssentiaCare members will have access to a preferred pharmacy network. Costs for some drugs may be less at pharmacies in this network. An online pharmacy directory is available at UCare.org. Express-Scripts Mail Order Pharmacy is included in the preferred cost sharing pharmacy network.

Contact information for Express-Scripts Mail Order Pharmacy

<table>
<thead>
<tr>
<th>ePrescribing</th>
<th>Select Express Home Delivery Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NCPDP: 2623735</td>
</tr>
<tr>
<td></td>
<td>NPI: 1558443911</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Express-Scripts Mail Order Pharmacy (by mail):</th>
<th>Express-Scripts Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home Delivery Services</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 66564</td>
</tr>
<tr>
<td></td>
<td>St. Louis, MO 63166-6564</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Fax (New prescriptions) For physicians and physician’s office use only</th>
<th>1-800-837-0959</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some prescriptions cannot be accepted by fax (Class II controlled substances)</td>
<td>Available 24 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Call-in (New prescriptions)</th>
<th>1-866-544-7950</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some prescriptions cannot be accepted by phone (Class II controlled substances)</td>
<td>Available 24 hours</td>
</tr>
</tbody>
</table>
Formulary Information, Prior Authorization and Formulary Exceptions

Formularies outlining the covered drugs and the associated limitations such as Prior Authorization (PA), STEP therapy or Quantity Limits are updated monthly and posted on the UCare.org site (choose “Health Plans”) and the Provider site at UCare.org/providers (choose “Pharmacy” under Eligibility & Authorization column). Please refer to the website monthly for any changes or updates. Pharmacy and Therapeutics decisions are also posted on the Provider site following meetings.

ePA is the preferred method to submit Prior Authorization requests to Express Scripts. Providers may access ePA through Express Path, Surescripts, CoverMyMeds, or through the Electronic Health Record.

Prior authorization and formulary exception request forms are found on UCare’s Provider site under Pharmacy Information. These forms can be faxed to ESI at the number on the form or called into ESI directly by the physician’s office. If you wish to prescribe a medication that requires prior authorization or is a formulary exception request, you may reach out to ESI at the following numbers:

<table>
<thead>
<tr>
<th>Medicare Phone line for Prior Authorization</th>
<th>Medicare FAX for Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-877-558-7521</td>
<td>1-877-251-5896</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Phone line for Prior Authorization</th>
<th>Medicaid FAX for Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-877-558-7523</td>
<td>1-877-251-5896</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Exchange Phone line for Prior Authorization</th>
<th>HealthCare Exchange FAX for Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-877-558-7523</td>
<td>1-877-251-5896</td>
</tr>
</tbody>
</table>

Physician Administered Drugs

Some medical injection drugs given in the doctor’s office may require authorization. A pre-service determination can be requested from UCare by completing the Injectable Drug Prior Authorization Request Form found on UCare’s Eligibility and Authorizations web pages for Injectable Drug Authorizations (under Authorization Requirements, select the product and click submit, then select the Injectable Drug tab at the top of the next page).

Medicare FAX for UCare Injectable Drug Prior Authorization
612-884-2094 or 1-866-610-7215

Medicaid FAX for UCare Injectable Drug Prior Authorization
612-884-2300

Health Care Exchange FAX for UCare Injectable Drug Prior Authorization
612-884-2094 or 1-866-610-7215
**Specialty Medications**

UCare works exclusively with Fairview Specialty Pharmacy for our Medicaid, UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview members.

Medicare members can fill specialty medications using Fairview Specialty Pharmacy or any of our network Specialty Pharmacies.

**Fairview Pharmacy Contact Information:**
Provider Phone Line: 612-672-5260 OR 1-800-595-7140 toll free
Provider Fax Line: 1-866-347-4939
www.FairviewSpecialtyRx.org

**Dental Services**

**DELTA DENTAL OF MINNESOTA**

UCare is proud to partner with Delta Dental of Minnesota to serve the dental needs of UCare members throughout Minnesota. For credentialing information and more, please visit www.deltadentalmn.org.

Providers may call Delta Dental of Minnesota at the following numbers, depending on the member’s product:

- UCare State Public Programs: 1-855-648-1415 toll free or 651-768-1415
  - Members in UCare’s State Public Programs are considered in-network with Delta Dental of Minnesota Select Dental Providers.
- UCare Medicare Plans and EssentiaCare (Medicare Advantage): 1-855-648-1416 toll free or 651-768-1416
  - Members in Medicare Advantage Plans are considered in-network with Delta Dental of Minnesota, Delta Dental Medicare Advantage Providers.
- UCare Individual & Family Plans/UCare Individual & Family Plans with Fairview: 1-855-648-1417 toll free or 651-768-1417
  - Members in UCare Individual & Family Plans/UCare Individual & Family Plans with Fairview are considered in-network with Delta Dental of Minnesota, Minnesota Select Dental Providers.

**UCare Dental Connection**

Members of Prepaid Medical Assistance (PMAP), MinnesotaCare, UCare Connect, UCare Connect + Medicare, Minnesota Senior Care Plus and Minnesota Senior Health Options (MSHO) are able to take advantage of UCare’s new program called UCare Dental Connection. The goal of UCare Dental Connection is to help our members manage their dental care with one simple phone call. UCare Dental Connection helps members: Find a dental home, schedule dental appointments, coordinate transportation and interpreter services for dental appointments and find answers to claim questions.
UCare encourages members to call UCare Dental Connection at 1-855-648-1415 toll free, 651-768-1415 or TTY/hearing impaired: 711 toll free.

Dental providers should submit claims electronically through a clearinghouse to Delta Dental of Minnesota.

**Chiropractic Services**

**FULCRUM HEALTH**

UCare contracts with Fulcrum Health, Inc. (Fulcrum), an administrator of UCare’s chiropractic benefits and manager of the chiropractic network, ChiroCare, utilized by UCare members. ChiroCare was founded in 1984 as the nation’s first chiropractic network and has continued to be a leader in physical medicine management.

Fulcrum Health maintains contractual relationships with chiropractic providers.

Fulcrum Health offers an online ChiroCare provider directory at www.chirocare.com. This online provider directory is also available through UCare’s website.

You can contact Fulcrum Health’s ChiroCare Service Department through www.chirocare.com or by calling 1-877-886-4941.
UCare Nondiscrimination Policy

UCare complies with applicable Federal civil rights laws and does not discriminate against, exclude or treat differently beneficiaries, applicants, enrollees or the public-at-large on the basis of race, color, national origin, age, disability or sex. Additionally, for members in State Public Programs and Special Needs Plans for Dual Eligibles, UCare accepts all eligible beneficiaries who select or are assigned to UCare without regard to medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance status or political beliefs.
Provider Responsibilities

**Appointment Availability Standards:** To ensure members receive care in a timely manner, UCare has established appointment availability standards for Primary Care, Behavioral Health and High Impact/High Volume Specialty providers. UCare monitors providers to ensure adherence to these standards. If providers are identified as being outside of the guidelines, we will follow up to understand and address any systemic issues.

**Primary Care**
- Emergency: Immediately or call 911
- Urgent Care: Within 24 hours
- Routine/Follow Up Care: Within 2 weeks
- Preventive: Within 60 days

**Behavioral Health**
- Emergency: Immediately or call 911
- Non-life Threatening Emergency: Within 6 hours
- Urgent Care: Within 48 hours
- Initial Visit for Routine Care: Within 10 days
- Follow Up Care: Within 20 days

**High Impact/High Volume Specialty Care**
(Cardiovascular, General Surgery, OB/GYN, Ophthalmology, Oncology, Orthopedic Surgery, Neurology)
- Established Patients Follow Up Care: Within 60 days
- New Patient: Within 60 days

**Change of Ownership:** Provider agrees to notify UCare within three months prior to the effective date of a change in its ownership status due to: (a) the removal, addition or substitution of a partner; (b) the transfer of title to property to another party in the case of a sole proprietorship; (c) the merger of the corporation into another corporation, or (d) the consolidation of two or more corporations into a new corporation. Provider notification should be in the form of a letter or email communication and should be sent to UCare’s provider data validation mailbox at: Providerdatavalidation@UCare.org

**Communication with Enrollees:** Provider shall have the right and is encouraged to discuss with each Enrollee pertinent details regarding the diagnosis of such Enrollee’s condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment, regardless of benefit coverage limitations.

Provider may discuss UCare’s provider reimbursement method with an Enrollee, subject to Provider’s general contractual and ethical obligations not to make false or misleading statements, to Provider’s obligation under this Agreement to maintain the confidentiality of specific reimbursement rates paid by UCare to Provider, and to Provider’s agreement as a participating provider not to disparage UCare or to encourage Enrollees to disenroll in UCare.
Confidentiality: UCare and Provider shall safeguard an Enrollee’s privacy and confidentiality of all information regarding Enrollees in accordance with all applicable Federal and State statutes and regulations, including the requirements established by UCare and each applicable product.

Demographic Data Updates: Provider agrees to notify UCare within 10 business days of any changes to demographic information and further agrees to review and confirm demographic information on file with UCare at least quarterly. Provider shall submit updates to demographic information via UCare’s Provider Profile web page.

Ineligible Providers: Contracted UCare providers shall make sure that they, their company, owners, managers, practitioners, employees and contractors are not on the UCare Ineligible Providers List. Providers should search the list of UCare Ineligible Providers on a regular basis and before hiring or entering into contracts with individuals to provide services or items to UCare members. This list contains:

- Provider type description
- Last name, first name, middle name
- Effective date of ineligibility

*Please note: This list is not inclusive of every provider type. In addition, this list is not a substitute for any ineligible provider lists maintained by CMS, DHS or other regulatory entities.*

Questions regarding the UCare Ineligible Providers List should be directed to compliance@UCare.org.

Medical Review and Evaluation: Provider agrees to cooperate fully with, participate in and abide by UCare’s decisions concerning any reasonable programs, such as quality assurance review, utilization management and peer review, that may be established from time to time by, at the direction of, or in cooperation with UCare to promote the provision of high quality Covered Services to Enrollees and to monitor and control the utilization and cost of Covered Services rendered to Enrollees by Provider. Provider further agrees to cooperate, as may be reasonably requested by UCare, with any independent organization or entity contracted by UCare to provide quality review, utilization review and quality improvement activities related to Covered Services provided under this Agreement. Provider shall make available to UCare all information pertaining to Enrollees reasonably requested by UCare connection with each such review or program.

Performance Data: Provider agrees to allow UCare to use data regarding performance by Provider, including its practitioners, for purposes as permitted by law, including but not limited to quality improvement activities, public reporting to consumers, and designation as a preferred or tiered network.
Sales & Marketing by Providers

This chapter provides an overview of Medicare regulations related to marketing activities that are both allowed and not allowed by health care providers. These regulations apply to the marketing of the following plans offered by UCare:

- Our Medicare Advantage plans called UCare Medicare Plans, UCare Medicare with Fairview & North Memorial Health and EssentiaCare.
- Our Medicare Advantage Special Needs Plans called UCare’s Minnesota Senior Health Options and UCare Connect + Medicare.

Medicare is concerned about provider marketing activities for the following reasons:

- You may not be fully aware of all plan benefits and costs, which could result in Medicare beneficiaries not receiving information needed to make informed decisions about their health care options.
- You may confuse Medicare beneficiaries if you are perceived as acting as an agent of the plan.
- You may have conflicting incentives when acting as a plan representative.

Permitted Marketing Activities

Medicare understands that patients may seek your advice and does allow you to assist patients in objectively assessing their needs and discussing potential options to meet those needs. However, you need to remain neutral when assisting with enrollment decisions. You should assist a beneficiary with an objective assessment of his/her needs and potential options to meet those needs.

In addition, as a contracted provider, you are permitted to do the following:

- Tell your patients you contract with UCare.
- Allow UCare to conduct sales meetings in common areas such as common entryways, cafeterias and community/conference rooms.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (including in areas where care is delivered).
- Provide information and assistance to patients in applying for Extra Help for Medicare Part D, also known as the low-income subsidy.
- Provide objective information on UCare’s formulary (list of covered drugs), based on a particular patient’s medications and health care needs.
- Make available and/or distribute plan marketing materials in common areas such as waiting rooms.
- Refer your patients to other sources of information, such as the State Health Insurance Program (SHIP), plan marketing representatives, the State Medicaid office, the local Social Security office, the Medicare website at [www.medicare.gov](http://www.medicare.gov) or **1-800-MEDICARE** (1-800-633-4227).
- Print out and share information from Medicare’s website, such as the “Medicare and You” Handbook or “Medicare Options Compare” ([www.medicare.gov](http://www.medicare.gov)).
Provide links from your website to UCare plan enrollment information, including applications.

Specific to long-term care facilities:
  - Upon request by a resident, UCare is permitted to schedule appointments with people residing in long-term care facilities.
  - Long-term care facilities are permitted to provide materials in admission packets announcing all contractual relationships with health plans.

Prohibited Marketing Activities

You **may not** conduct the following activities:

- Offer scope of appointment forms.
- Accept UCare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade patients to enroll in UCare based on financial or any other interests.
- Mail marketing materials on behalf of UCare.
- Offer anything of value to induce UCare members to select you as their provider.
- Offer inducements to either persuade patients to enroll in UCare or to enrollees to select you as their provider.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from UCare for patient enrollment activities.
- Allow sales activities near the pharmacy counter area located within a retail store.
- Allow sales activities in areas where patients receive health care services (such as exam rooms, hospital patient rooms, waiting rooms).
- Distribute materials/applications within an exam room.
- When advertising non-health-related items or services, do not suggest or imply a relationship with or coverage by UCare.

If you have any questions about these guidelines, or if you are concerned you may have witnessed abuse of these policies, please contact UCare’s investigation team.
Member Enrollment and Eligibility

UCare’s provider website gives an overview of eligibility, key benefits and provider resources. Often you can save a phone call by checking online for coverage levels, co-payments, co-insurance and other common provider questions.

View Member Benefits and Provider Resources for each UCare Plan

Minnesota Health Care Programs (MHCP)

<table>
<thead>
<tr>
<th>Product</th>
<th>Application Submission</th>
<th>Eligibility Determination / Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepaid Medical Assistance Program (PMAP)</td>
<td>MNsure*</td>
<td>Counties via MNsure</td>
</tr>
<tr>
<td>MinnesotaCare</td>
<td>MNsure*</td>
<td>DHS via MNsure</td>
</tr>
<tr>
<td>Minnesota Senior Care Plus (MSC Plus)</td>
<td>MNsure*</td>
<td>DHS via MNsure</td>
</tr>
<tr>
<td>UCare’s Minnesota Senior Health Options (UCare’s MSHO)</td>
<td>Counties, UCare</td>
<td>DHS, CMS</td>
</tr>
<tr>
<td>UCare Connect</td>
<td>Counties, UCare</td>
<td>DHS (some renew via MNsure)</td>
</tr>
<tr>
<td>UCare Connect + Medicare</td>
<td>UCare</td>
<td>DHS, CMS, some renew via MNsure</td>
</tr>
</tbody>
</table>

*Paper applications are to be sent to the applicant’s county of residence. The county then enters it in the MNsure eligibility system.

The local county human services agency educates MHCP enrollees either in person or by mail about the MHCP health plans available in the county. If the recipient does not select a plan, DHS will assign recipients to an available health plan.

Prepaid Medical Assistance (PMAP – now called Families & Children) and MinnesotaCare members enroll through MNsure, either directly or with the assistance of their county of residence. (Only select counties process MinnesotaCare enrollment, but enrollees can also work with MinnesotaCare support staff at DHS.)

MSHO applicants may enroll either directly through UCare or through their county. UCare Connect members enroll passively through DHS or actively through UCare. UCare Connect + Medicare applicants enroll directly through UCare. An applicant interested in enrolling in MSHO, UCare Connect or UCare Connect + Medicare can find details on the UCare website. Interested applicants may order an information kit online to initiate the enrollment process or call UCare’s Sales Department at 612-676-3554 or 1-800-707-1711 toll free. A licensed UCare representative will speak with the applicant.

Everyone who enrolls with UCare should choose a primary care clinic. If the person does not choose a clinic, UCare will assign one based on proximity to the member’s home ZIP code. Members do not need referrals to see other network providers.
UCare sends information to pregnant members reminding them to contact their financial worker at the county to ensure that the baby is enrolled on the mother’s health plan once the baby is born. The newborn will be assigned to the primary care clinic chosen by the mother for her child. If no clinic is indicated, UCare will assign the newborn to the mother’s clinic, if appropriate. Minnesota DHS will notify UCare if the baby has been enrolled.

**Medicare Programs**

**UCARE MEDICARE PLANS, ESSENTIACARE AND UCARE MEDICARE WITH FAIRVIEW & NORTH MEMORIAL**

Individuals who are eligible and wish to join UCare Medicare Plans, EssentiaCare and UCare Medicare with Fairview & North Memorial must submit a completed enrollment application form to UCare. Applications are available on the UCare website. Prospective members can also call the UCare Sales Department to enroll:

- UCare Medicare Plans: 612-676-3500 or 1-877-523-1518 toll free.
- EssentiaCare: 218-722-4783 or 1-855-432-7027 toll free.

In addition, there are online enrollment options through the Centers for Medicare & Medicaid Services (CMS). An application must be complete (including signature) in order to be processed. Applications are processed in the date order received.

There are some limits to when and how often a Medicare beneficiary can change health plans. These timeframes are called Election Periods.

**Note:** If an individual is already a member of another health plan with a Medicare contract, membership in that health plan will automatically end on the effective date of enrollment in UCare Medicare Plans, EssentiaCare or UCare Medicare with Fairview & North Memorial.

**Individual & Family Plans**

**UCARE INDIVIDUAL & FAMILY PLANS AND UCARE INDIVIDUAL & FAMILY PLANS WITH FAIRVIEW**

Individuals and/or their dependents who wish to purchase UCare Individual & Family Plans or UCare Individual & Family Plans with Fairview must enroll for coverage through MNsure. Consumers can access MNsure through the link on the UCare website, directly via Mnsure.org or by calling the UCare Sales Department at 612-676-6606 or 1-855-307-6975 toll free.

For most people, the annual Open Enrollment Period is the only time to obtain new coverage or change plans. However, those experiencing certain life events (e.g., losing other coverage due to job loss, getting married, or having a baby) can enroll or change plans through a Special Enrollment Period within 60 days of their event.
Changing a Member’s Primary Care Clinic (PCC)

UCare supports and values primary care and encourages all of our members to establish a partnership with a doctor or clinic. Some UCare products require members to be assigned to a PCC. Members in these products can choose a PCC upon enrollment with UCare. If a PCC is not selected, UCare will auto-assign members to a PCC within the same ZIP code as their home address.

To determine which clinic a patient is assigned to at UCare, visit the Provider Portal and look up a patient’s information under the “Member Information” option.

PCC assignment changes can be made by the member, the member’s authorized representative, power of attorney, care coordinator or responsible party through spoken or written communication with UCare. In addition, nursing home staff can request primary care clinic changes for Minnesota Health Care Program members only. Primary care clinic changes are effective the first day of the following month.

Note: UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview do not require a PCC selection.

Terminating Member Care (Dealing with Unacceptable Member Behavior)

When a UCare contracted provider experiences unacceptable member behavior, the provider can contact the UCare Provider Assistance Center (PAC) team in Customer Services to obtain support and guidance on dealing with the situation. If a provider determines they can no longer deal with a member and they wish to end the relationship with the member, the provider must:

1. Send a certified letter to the member advising the member of the decision to terminate the relationship. The certified letter from the provider must include:
   - The reason(s) for discharge.
   - The last day the member can be seen at the clinic, which will be the last day of the month following the minimum 30-day notice.
   - A statement directing the member to contact UCare’s Customer Services Department for assistance in choosing a new clinic.
   - A release form for the member to sign and return authorizing the release of medical records to their new provider.
   - Instructions for the member to access care in the event of emergency or urgent situations.

2. Send a copy of the certified letter to:
   UCare
   Attention: Provider Assistance Center
   P.O. Box 52
   Minneapolis, MN  55440
Verification of Eligibility

To verify that an individual is an active UCare member, providers have three options available 24 hours a day, seven days a week:

- Use the Member Lookup page on the UCare Provider Portal.
- Use the Interactive Voice Response (IVR) system by calling the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.
  - Have the individual’s UCare member ID number and date of birth ready.
  - For claim status inquiries, have your NPI number, UCare member ID, member’s date of birth and the claim date of service ready.
- Access the 270/271 transaction via McKesson PCS Support. If your clearinghouse has not already done so, they can enroll with PCS to begin transmitting these transactions to your organization. Have your clearinghouse contact PCSSupport@Mckesson.com or call 1-877-411-7271 to begin the enrollment and provisioning process.

For Minnesota Health Care Program members, you can also use MN-ITS, the Minnesota DHS system for MHCP claims and other transactions. You must be MHCP-enrolled and registered with MN-ITS to use the system. If you have questions or need access to MN-ITS, contact the MHCP Provider Call Center at 651-431-2700 or 1-800-366-5411.

MN-ITS has the most current eligibility information and reflects changes in a member’s eligibility before the health plan is notified. You should use MN-ITS to verify a patient’s eligibility on the working day before or the day services are provided. MN-ITS indicates which health plan a patient is assigned to, but does not include specific information such as primary clinic or member ID number. If UCare is the patient’s health plan, you can use the UCare Provider Portal to obtain primary care clinic information and the member’s UCare ID number.

UCare encourages all providers to verify patient eligibility and coverage prior to rendering services to avoid claim denials/rejections. The Minnesota Administrative Uniformity Committee (AUC) provides a Best Practice for verifying eligibility under the Standard Companion Guide for Eligibility Inquiry and Response (270/271). Visit the Resources for Electronic Transactions web page for UCare’s Eligibility Benefit Inquiry and Response 270/271 Companion Guide and additional information.
Restricted Recipient / Restricted Member Program

For Minnesota Health Care Programs products (PMAP, MnCare, SNBC)

The Minnesota Restricted Recipient Program (MRRP) is a program for Minnesota Health Care Program (MHCP) members, developed and operated under the direction of the Minnesota Department of Human Services (DHS) for recipients who have used services at a frequency or amount that is not medically necessary and/or who have used health services resulting in unnecessary costs to MHCP. The program follows the standards set in Minnesota Rules.

Upon identification, recipients are reviewed to determine if criteria for program enrollment is met as defined by MN State Statute, administrative rule 9505.2165 subpart 2 part B.

After review, restrictions may be imposed. Restricted Recipient Coordinators (RRC) work with recipients throughout the restriction period to coordinate care and services and assist members in meeting their individual health care needs in a cost-effective manner.

- All restricted recipients have designated providers that must provide all services, including a primary care provider, clinic, hospital (including emergency room) and pharmacy. The designated primary care provider manages referrals to non-designated providers.
- Initial placement in the restricted recipient program lasts for a period of 24 months.
- An additional 36-month restriction may be imposed following the initial restriction period if the recipient has not maintained compliance with program rules, based on a review of medical and pharmacy claims.

Reasons for restriction include, but are not limited to:

- Obtaining equipment, supplies, drugs or health services in excess of MHCP program limitations or that are not medically necessary and paid for through a MHCP program.
- Obtaining duplicate or comparable services for the same health condition from multiple vendors, such as going to multiple pharmacies or physicians.
- Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services or drugs.
- Continuing to engage in practices that are abusive of the program after receiving UCare’s written warning that the conduct must cease.
- Duplicating or altering prescriptions.

In addition, MHCP members can be restricted by DHS or another health plan. MHCP members under restriction who change plans remain under restriction with the new MHCP plan until they have satisfied the time period of the restriction and meet criteria for discharge.

**Prescription monitoring**: All prescriptions for restricted recipient members must be written or approved by their designated primary care physician and filled at the member’s designated participating pharmacy.
Program Management

- The RRC obtains available medical and pharmacy claims data to identify potential members for the program. The data is reviewed to determine if the member meets criteria for program enrollment.
- Once the member has met criteria for program enrollment, the member is contacted by the RRC to assist in provider selection, coordination of care and services.

Provider Involvement

- The designated primary care provider authorizes all prescriptions for the member.
- The designated primary care provider authorizes referrals to other providers, as medically necessary.
- The designated primary care provider may authorize some or all of the other providers in the primary care clinic to see and prescribe for the member if the primary care provider is not available.

Providers should check MN-ITS, the Minnesota Department of Human Services billing and eligibility system, at https://mn-its.dhs.state.mn.us/ before providing care to a patient. If care is provided to a restricted recipient by someone other than the designated providers, or a provider referred by the designated primary care provider, the claim may not be paid.

The forms below may be used when referring members to the UCare Restricted Recipient Program. They are located on the Eligibility & Authorization web page, under Restricted Recipient Program:

- Restricted Recipient Program Intake Form | This referral form is used when referring UCare members to the Restricted Recipient program.
- Medical Referral Form | This referral form is used when referring an already restricted member to a specialist.
- Prescribing Privileges for PCP Partners | This referral form is used when allowing an already restricted member to see and receive medications from other providers in the primary care clinic.

For more information about the UCare Restricted Recipient Program, call Behavioral Health Services at 612-676-3397 or 1-888-447-4384 toll free.

For additional information on the Minnesota Restricted Recipient Program, providers may refer to the DHS website at the following link: https://edocs.dhs.state.mn.us/Ifserver/Public/DHS-6752-ENG
For Exchange Products (UCare Individual & Family Plans, UCare Individual & Family Plans with Fairview)

Members may be required to select a single in-network physician, hospital and pharmacy for coordination of services if UCare determines a member has been receiving health care services or prescription drugs in a manner that may be harmful to his or her health.

There is no restriction for emergency care.

The forms below may be used when referring members to the UCare Individual & Family Plans/UCare Individual & Family Plans with Fairview Restricted Member Program. They are located on the Eligibility & Authorization web page, under Restricted Recipient Program:

UCare Individual & Family Plans Restricted Member Program Intake Form
UCare Individual & Family Plans Medical Referral for UCare Restricted Member Enrollee
UCare Individual & Family Plans Prescribing Privileges for PCP Partners

For more information about the UCare Individual & Family Plans/UCare Individual & Family Plans with Fairview Restricted Member Program, call Behavioral Health Services at 612-676-3397 or 1-877-447-4384 toll free.
Provider Credentialing

Practitioners that Require Credentialing

- LAc  Acupuncturist
- BDS  Bachelor of Dental Surgery
- MBBCH  Bachelor of Medicine and Bachelor of Surgery
- MBBS  Bachelor of Medicine and Bachelor of Surgery
- CICSW  Certified Independent Clinical Social Worker (WI only)
- CNM  Certified Nurse Midwife
- CNP  Certified Nurse Practitioner
- CNS  Clinical Nurse Specialist
- CSW-PIP  Certified Social Worker – Private Independent Practice (SD only)
- DDS-Dental  Dentist (Delegated to Delta Dental)
- DDS-Medical  Dentist
- DC  Doctor of Chiropractic (Delegated to Fulcrum Health, Inc.)
- DMD  Doctor of Medicine in Dentistry or Doctor of Dental Medicine
- DO  Doctor of Osteopathy
- DPM  Doctor of Podiatric Medicine
- LADC  Licensed Alcohol and Drug Counselor (MN Only)
- LPC  Licensed Clinical Counselor (MN only and able to practice without supervision)
- LCSW  Licensed Clinical Social Worker (WI only)
- LICSW  Licensed Independent Clinical Social Worker (MN and ND only)
- LISW  Licensed Independent Social Worker (IA only)
- LMFT  Licensed Marriage and Family Therapist
- LPCC  Licensed Professional Clinical Counselor
- LPC-MH  Licensed Professional Counselor-Mental Health (SD only)
- LP  Licensed Psychologist
- LTM  Licensed Traditional Nurse Midwife (only providing services at birthing centers)
- MDS  Masters of Dental Surgery
- OD  Optometrist
- MD  Physician
- PA  Physician Assistant

Note: Residents: Moonlighting Only require credentialing.

Practitioners that Do Not Require Credentialing

- AuD  Audiologist
- AAAE  Association for Anesthesiologist Assistant Education
- CMHRP  Certified Mental Health Rehabilitation Professional
• CRNA  Certified Registered Nurse Anesthetist
• MD    Doctor of Anesthesiology (pain management practicing in a clinic setting require credentialing)
• HB    Hospital-based practitioners
• HP    Hospitalist
• OT    Occupational Therapist
• Path  Pathologists
• PCA   Personal Care Assistant
• PharmD Pharmacist (Licensed for medication therapy management services only)
• PT    Physical Therapist
• Rad   Radiologists (radiation oncology practicing in a clinic setting require credentialing)
• RD    Registered Dietician
• SLP   Speech Language Pathologists

Non-billable Practitioners

• CADC Certified Alcohol and Drug Counselor
• CGC   Certified Genetic Counselor
• COTA  Certified Occupational Therapy Assistant
• CDP   Chemical Dependency Professional
• OPA-C Orthopedic Physician Assistants
• PTA   Physical Therapy Assistant
• RN    Registered Nurse
• SA/SAC Surgical Assistant

Facilities that Require Credentialing

MEDICAL

• Ambulatory Surgery Center – Free standing only
• Birth Center – Free standing only
• Home Health Care Agency that provides skilled nursing services (not a PCA-only agency)
• Hospital – All types including Psychiatric
• Skilled Nursing Facility/Nursing Home

BEHAVIORAL HEALTH

• Ambulatory setting
• Inpatient
• Outpatient
Provider Credentialing | Purpose & Standards

Credentialing is the process used to determine if a practitioner or organizational provider is qualified and competent to render acceptable medical care to UCare members. All actions related to acceptance, denial, discipline and termination of participation status for a practitioner or organizational provider are governed by UCare’s Credentialing Plan. This Provider Manual section is not intended to supersede the Credentialing Plan.

Providers should not provide service to UCare members until their credentialing process has been completed. UCare has no obligation to reimburse claims submitted for a practitioner’s services until the practitioner has successfully completed the credentialing process. UCare will collect and verify all credentialing criteria in accordance with the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) and Minnesota Department of Health (MDH) standards. Applicants need to cooperate fully in providing all documents requested by UCare.

Credentialing and Recredentialing Application Submission Process

PRACTITIONERS

For credentialed type practitioners, the Minnesota Uniform Credentialing and Recredentialing Application can be submitted at www.mncred.org.

Initial

Applications should be submitted at least three months prior to an individual practitioner’s start date at a clinic. UCare uses a standard 90-day turnaround time and does not retrospectively apply effective dates. Therefore, the sooner completed applications are received, the sooner UCare members can be seen. If an application is incomplete, it will be returned to the submitter unprocessed. The application will need to be resubmitted along with all missing information. The 90-day turnaround will not start until the completed application is received.

Recredentialing

1. When recredentialing is requested from UCare, applications should be submitted through the link above.
2. If an individual practitioner’s recredentialing application is not submitted in the time allowed, the practitioner’s UCare participating network status will be administratively terminated. Once terminated, no claims will pay, and the practitioner will need to complete the initial credentialing process.

ORGANIZATIONS

Organizations that require credentialing are required to complete the MN Uniform Facility Credentialing Application located on UCare’s Provider Website. The application and supporting documents can be submitted to credentialinginfo@UCare.org.
Credentialing and Recredentialing Process

1. Completed applications are evaluated by UCare’s Credentialing staff to determine eligibility. If it is determined that the provider is eligible to participate or continue participating as a UCare provider, the primary source verification process is completed by the Credentialing Staff.
2. Applications that are determined “clean” credentialing/recredentialing files are approved by UCare’s Medical Director on a weekly basis.
3. If a practitioner has variations from established credentialing criteria, a review and decision making for network or continued network participation is completed by UCare’s Credentialing Committee. The Credentialing Committee meets on a monthly basis to consider these items.
4. Recredentialing is performed every three years, or earlier for any recredentialing files with variations from credentialing.
5. Recredentialing is conditional upon the practitioner continuing to meet UCare’s credentialing standards and quality performance standards, including but not limited to:
   - Member complaints
   - Results of quality reviews
   - Utilization management information
   - Member satisfaction surveys, where applicable
   - Medical record reviews, when available

Credentialing Decisions

The Credentialing Committee has been delegated the authority by the UCare Quality Improvement Council (QIC) to make decisions on the provider files that may have variation to criteria for acceptance. The Credentialing Committee may accept, accept with restriction(s) or deny an applicant’s request for participation or continued participation within the UCare provider network. The Credentialing Committee may request further information from applicants; table an application pending the outcome of an investigation; or take any other action it deems appropriate. The QIC has the responsibility and authority for the acceptance, discipline and the activities that may lead to final termination of providers. The Credentialing Committee provides a monthly summary report to the QIC.

Notification of Credentialing Decisions

A practitioner shall be notified within 60 calendar days from final decision of initial credentialing approvals and 20 calendar days for any adverse recredentialing decisions. In the event of an adverse credentialing or recredentialing decision that is subject to appeal, notice given to the practitioner shall meet the requirements in the Credentialing Plan per Section XVII Credentialing Appeal Process.

In addition, the practitioner will receive a billing notification from UCare’s Provider Enrollment Department within 30 business days of the initial credentialing approval. Please do not begin submitting claims prior to receiving the billing notification from the Provider Enrollment Department as this will result in denied/rejected claims.
Appeals

A practitioner may appeal the Credentialing Committee’s decision to accept an application with restrictions or to deny an application due to concerns related to professional competency. This notification reports any restrictions that may have been placed on an individual practitioner’s participation status. If the Credentialing Committee determines restriction(s) or termination, the practitioner is given the facts upon which the Credentialing Committee has based its decision. If the Credentialing Committee makes a determination to deny participation, the applicant is advised and notified of the right to review the information upon which the determination was made and to submit corrections.

The practitioner must request a hearing, in writing, within 30 days of notification. The Appeals Committee conducts a hearing for individual practitioners. The Appeals Committee has the authority to uphold, reject or modify the decisions of the Credentialing Committee. The Appeals Committee recommendation is presented to the Quality Improvement Advisory and Credentialing Committee (QIACC). The QIACC may approve, overturn or modify the Appeals Committee’s recommendation.

Other Reviews

From time to time, UCare may obtain information about licensure, State or Federal Office of Inspector General (OIG), Preclusion List and Medicare Opt Out actions taken with respect to its individual participating providers. If such licensure actions indicate a disciplinary action or OIG/Preclusion List exclusion, UCare will take whatever disciplinary or termination actions are appropriate in view of the information obtained.

Practitioner’s Rights

Per section IX of UCare’s Credentialing Plan, practitioners applying for network participation or continued participation have the following rights:

1. The right to review the information submitted in support of their credentialing application. The credentialing record contains documents obtained for the review of the credentialing application. The practitioner does not have the rights to review peer review protected information, references, recommendations and/or information obtained from the National Practitioner Data Bank (NPDB). Practitioners may contact UCare’s Credentialing Department at credentialinginfo@UCare.org with questions.

2. The right to correct erroneous and/or discrepancy information that was submitted by the practitioner that varies substantially from the information that UCare primary sourced verified during the credentialing process. UCare’s Credentialing Staff will notify the credentialing contact and/or practitioner that there is a discrepancy and provide the opportunity to correct any erroneous information, which must be submitted within 14 days from the receipt of the notification.
3. The right to be informed, upon request, of the status of the practitioner’s (re)credentialing application. Practitioners may contact UCare’s Credentialing Department via email at credentialinginfo@UCare.org and ask for the status of their (re)credentialing application.

More Information

**PROVIDER CREDENTIALING FORMS**

Credentialing questions: Contact UCare’s Credentialing Department via email at credentialinginfo@UCare.org

Claims questions: Contact UCare’s Provider Assistance Center at pac@UCare.org or 612-676-3300 or 1-888-531-1493 toll free

**CHIROPRACTIC**

Fulcrum Health, Inc.
www.chirocare.com
1-877-886-4941 toll free

**DENTAL**

Delta Dental of Minnesota
www.deltadentalmn.org
Claims & Payment

Claim Payment

Below are the addresses and fax numbers for submitting claims for UCare members.

**UCARE MEDICAL CLAIMS**

Mail paper claims to:
UCare
Attention: Claims
P.O. Box 70
Minneapolis, MN 55440-0070

Claim attachments:
Fax: 612-884-2261

**CLAIM RECONSIDERATION REQUESTS (ADJUSTMENTS, RECOUPMENTS, APPEALS)**

Provider Claim Reconsideration Request Form, located on the Claims and Billing web page, under Forms & Links.

Mail:
UCare
Attention: Claims
P.O. Box 405
Minneapolis, MN 55440-0070
Fax: 612-884-2186

**Chiropractic Claims**

If you have questions about Chiropractic claims submissions, please call Fulcrum Health, Inc.’s ChiroCare Provider Services Department at 1-877-886-4941 toll free or visit https://www.chirocare.com/chiropractic-practice-management/chiropractic-tools-forms/administrative-resources/chiropractic-claims-insurance-billing/

**Dental Claims**

If you have questions about Dental claims submissions, please call Delta Dental of Minnesota (Delta Dental) at the numbers listed below or visit www.deltadentalmn.org/providers.

**State Public Programs**: 651-768-1415 or 1-855-648-1415 toll free

**Medicare**: 651-768-1416 or 1-855-648-1416 toll free

**Commercial**: 651-768-1417 or 1-855-648-1417 toll free
Pharmacy Claims

If you require assistance processing Pharmacy claims, please call the Express Scripts Pharmacy Help Desk at 1-800-922-1557 toll free.

VACCINES COVERED BY MEDICARE PART D

UCare members receiving Medicare Part D-eligible vaccinations must have both the vaccine and its administration billed through the member’s Part D benefit. UCare offers an electronic claims adjudication portal called TransactRx that allows providers to electronically submit vaccine claims for UCare members. By submitting the claims electronically, the patient is charged the same copay that they would receive at a retail pharmacy at the time of service, and the provider is reimbursed for their cost in a timely manner. There is no need to submit a claim form to UCare.

Using TransactRx is a voluntary process for providers administering Part D vaccines to UCare members. If the provider’s office or clinic prefers, it may bill UCare directly for this service instead.

To use the TransactRx claims submission portal, providers need to enroll with POC Technologies at: http://www.transactrx.com/physician-vaccine-billing. Enrollment information and instructions are available online.

Providers who need to track vaccine claims trends and reimbursement for claims will be able to do so with TransactRx, as POC Technologies saves past data.

Providers filing a Medicare Part D vaccine and administration claim must accept UCare’s reimbursement amount (including member’s copay) as payment in full for the vaccine.

Notifying UCare of Contracts with Third-Party Billers

Providers that contract with a third-party biller must have a signed acknowledgement form on file giving UCare permission to release information to the biller when they call UCare on behalf of the provider.

The form requires the third-party biller’s name, contact information and the effective date of the provider’s relationship with them. In addition, the provider’s name and title and other location information are also required on the acknowledgement form.

The Provider Notification/Change/Update/Termination Third Party Agreement form is found on the Provider Center page, select Update Your Information, then open “Notify UCare of a Contract or Contract Changes with Third-Party Billers.”

Additional instructions for third-party billers calling UCare:

- When third-party billers call UCare’s Provider Assistance Center (PAC), they should tell the PAC representative what company they are calling from (e.g., ABC billing, etc.). In doing so, the PAC representative can verify that UCare has a signed acknowledgement on file to release information to them.
• To safeguard members’ protected health information (PHI) according to HIPAA, UCare will not release information to any third-party biller if we do not have the acknowledgement form on file.
• If the third-party biller does not reveal that they are a third-party, UCare may call the phone number displayed on caller ID to verify who is calling. We do not want to share PHI with anyone who should not have access.

Timely Filing

Initial claims must be received no later than 12 months after the date of covered services in a format approved by UCare and in compliance with state and federal law.

Provider Exclusion

UCare will not reimburse a provider excluded from participation in public health care programs under 42 CFR 1001.1901 for services rendered before or after the exclusion date. Providers must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs or terminated for cause from Medicare or any state’s Medicaid or other government health care program. UCare will deny payment for a health care item or service furnished or prescribed by an individual or entity on the CMS Preclusion List.

If a non-contracted provider (with respect to any line of business) is on the CMS Preclusion List:

• UCare has the right to deny claims (including retroactively).
• Claims may be denied at any time from the date of service for the claim through the date the provider receives payment for the claim (if at all).

Clean Claims

A clean claim is defined as a claim that is submitted without defect or impropriety, includes any required substantiating documentation and has no particular circumstance requiring special treatment that prevents timely payment from being made on the claim (42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75).

EOP

UCare accompanies all payments with an Explanation of Payment (EOP) that outlines billing information and UCare claim processing information. We list payment/non-payment code explanations at the bottom of each EOP.

Review EOPs as you receive them. If you have questions regarding the status of submitted claims, first check the Provider Portal, then call the Provider Assistance Center at 612-676-3300 or 1-888-531-1493.
UCare recommends that you retain EOPs according to your business record retention policies.

## Claims Forms

### CMS 1450/UB-04

The CMS 1450, or UB-04, form is for the submission of facility claims. The National Uniform Billing Committee (NUBC) publishes an instruction manual that explains how to complete the CMS 1450/UB-04 form. A copy of the instruction manual is available on the NUBC website at [www.nubc.org](http://www.nubc.org).

### CMS 1500

The CMS 1500 form is for the submission of professional claims. The National Uniform Claim Committee (NUCC) has an instruction manual that explains how to complete the CMS 1500 form. A copy of the instruction manual is available on the NUCC website at [www.nucc.org](http://www.nucc.org).

## Claim Submission Tips

Maintaining current insurance information for members helps to ensure successful and timely claims processing. Wrong member information can cause suspected fraudulent claims investigations and HIPAA violations. Providers should ask for a current member insurance card each time a member presents for services and update their electronic records with any changes.

When submitting a claim, providers should verify that the information on the claim submission matches the information of the member receiving the service. Avoid commonly missed or incorrectly completed claim forms by double-checking the items listed below:

- Member ID or group number – include all numeric and alpha characters exactly as they appear on the member ID card with no spaces. All UCare members have unique member ID numbers. Do not submit claims using the subscriber ID number with a dependent code.
- Patient name – submit exactly the way it appears on the UCare ID card.
- Date of birth – double-check for accuracy.
- Individual provider NPI number – ensure this is in field 24J.
- Procedure codes – ensure they are billed with the correct units of service.
- Diagnosis fields on CMS 1500 – correct combinations of field 24E and field 21.
- Ensure all surgical procedures for the same date of service are combined on a single claim.
- Bill type – use the correct bill type; see Claim Adjustments section of this chapter.

## Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

UCare offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Provider should visit the Claims and Billing section of the UCare website to complete the UCare Electronic Funds Transfer and Electronic Remittance Advice Authorization Agreement. This agreement, which is available as an online form or as a PDF to be completed and mailed in, is used for new enrollments, to change...
enrollments or to end enrollments for EFTs or ERAs.

**Paper Claims**

Beginning March 1, 2019, UCare will require all Minnesota providers to submit claims electronically. **Mailed paper claims received from Minnesota providers will be rejected for all products** including: Medicare, Individual & Family Plans, and Minnesota Health Care Programs. UCare will continue to accept paper claims from providers outside Minnesota. For these claims, we use an optical character reader (OCR) for the entry of claim information into UCare’s claim payment system. Faxed copies of claims may not be accepted due to poor image quality.

Mail paper claims to:
UCare
Attention: Claims
P.O. Box 70
Minneapolis, MN 55440-0070

The following instructions for completing the CMS-1500 and UB-04 forms are recommended. Failure to follow these guidelines could delay the processing of the claim. If necessary, UCare will return the claim to the provider with a letter indicating what corrections are needed. Use only the official Drop-Red-Ink forms. We cannot accept black and white or photocopied claim forms.

Providers who make changes to the form should consider the following:

- Ink should be dark and dense (Red ink is not acceptable).
- Use UPPERCASE characters only.
- Use 10 or 12 font size.
- Use a standard font such as Arial.
- Do not hand-write on the claim form.
- Do not use slashes, dashes, decimal points, dollar signs or parentheses.
- Enter all information on the same horizontal line.
- Left align all fields.
- A maximum of 6 line items are allowed in field 24A.
- Line items must be double-spaced.
- Do not use staples.
- Do not fold claims.

**BASIC SUBMISSION GUIDELINES**

- Taxonomy Code Requirements: Professional and facility claims received by UCare on or after March 1, 2017, are required to submit taxonomy codes for billing and rendering or attending provider. When providers submit NPI(s) anywhere on a claim, the corresponding taxonomy must also be submitted. Provider types that are not required to submit NPI are not required to submit taxonomy on claims to UCare.
- If an unlisted procedure code is used, a narrative description is required on both the CMS 1500 and UB-04.
- All services should be billed line by line and identified by Revenue, CPT or HCPCS codes, ICD-10-CM codes, modifiers (when appropriate), location codes and units.
• Do not stamp over billing data—claims must be legible and all data must be readable.
• If the member has other insurance, submit a remittance advice from the primary insurance carrier with the claim.
• Only one member or provider per claim.

Duplicate Claim Submission

Prior to resubmitting a claim, please verify that UCare received the initial claim. You can verify this the following ways:

• Consult 277CA response reports from your clearinghouse.
• Check claim status on the Provider Portal.
• Call the Provider Assistance Center at 612-676-3300 or 1-888-531-1493.

Verifying the receipt of your claim may eliminate the need to resubmit.

It is UCare’s standard practice to process clean claims within 30 days of receipt. Re-submission of duplicate claims prior to 30 days is unnecessary, inefficient and costly for providers and UCare.

For replacement, voided claim submission or payment appeals, see the Claim Adjustments section.

To avoid the most common causes of duplicate claims:

• Eliminate “automatic” re-billing from your claims system.
• Allow 30 calendar days for UCare to process original claims.
• Do not combine previously submitted claims with new claims, as this practice will delay payment of new claims. Notify the UCare member that you will bill their insurance so the member does not submit a duplicate claim.

COORDINATION OF BENEFITS (COB)

When a member has other insurance primary to UCare, it is the provider’s responsibility to bill all third-party liability payers (including Veterans Benefits, private accident insurance, HMO coverage and other health care coverage) and receive payment to the fullest extent possible before billing UCare.

UCare follows CMS and MHCP eligibility and billing guidelines respectively to determine service coverage. Providers eligible for Medicare coverage may choose to opt-out or not enroll in Medicare. However, for dually eligible members, UCare will not reimburse services covered by, but not billed to, Medicare because the provider has chosen not to enroll in Medicare.

For additional information on Opt-out Providers, please visit the MN Department of Human Services Provider Manual.

A remittance advice from the primary payer(s) must be submitted and received by UCare within six (6) months of the remittance date or within 12 months from the date of service, whichever is greater. When Medicare is primary, the remittance advice must be received within 12 months of the remittance date.
For specific loop and segment submission guidelines, please refer to the Minnesota Uniform Companion Guides for claim submission.

**OTHER INSURANCE INFORMATION CHANGES**

If other insurance information changes for one of our members and UCare is determined the primary insurer, UCare will update its systems and reprocess claims denied for needing the primary payer EOP. There is no need for the provider to submit a reconsideration form.

**UNSUCCESSFUL THIRD-PARTY LIABILITY (TPL) BILLING**

Providers may bill UCare in cases when three (3) unsuccessful attempts have been made to collect from a third-party payer within 90 days, except where the third-party payer has already made payment to the recipient.

The following documentation is required for payment to be considered:

- A copy of the first claim sent to the third-party payer.
- Documentation of two further billing attempts to the third-party payer, each up to 30 days after the previous attempt.
- Written communication received from the third-party payer.

Claims must be submitted to UCare within 12 months of the date of service to qualify for payment determination.

Submit claims and supporting documentation to:

Mail:
UCare
Attn: Claim Adjustments
P.O. Box 52
Minneapolis, MN  55440

Fax:
Subject: Unsuccessful TPL Billing
612-884-2261

If payment is received from the third-party payer following UCare’s payment, a replacement claim is required with the remittance advice from the primary payer(s).

**Member Liability**

“Balance billing” occurs when a provider requests that a patient pay the difference between the amount the provider billed and the amount paid by UCare. This includes covered and non-covered services. This does not include cost-sharing that may be paid by enrollees in accordance with their benefit package.

Providers may collect applicable co-payments from the member at the time of service.

**MINNESOTA HEALTH CARE PROGRAMS (MHCP)**
Balance billing of UCare enrollees is prohibited under Minnesota Administrative Rules, part 9505.0225 when remittance advice is received. The provider must accept the health plan reimbursement as payment in full for covered services. This notification appears on the UCare remittance advice that accompanies your payment.

MHCP members may be billed for a service only when the following conditions apply:

- UCare never covers the service or the member does not meet UCare coverage criteria for the service, and the provider reviewed with the member:
  - Service limits
  - Reason(s) the service, item or prescription is not covered
  - Available covered alternatives
- The provider informs the member in writing before services are delivered that the member is responsible for payment.
- The provider obtains a member signature on the [Advance Recipient Notice of Non-covered Service/Item (DHS-3640) Form](https://www.dhs.state.mn.us/dhspub/mhcp/וצג/3640.html).

**Copayments and Cost Sharing Reminders for Minnesota Health Care Program Members**

UCare members who qualify for MHCP may have special circumstances related to their copays and cost sharing. There are exceptions to how copays and cost sharing apply. Providers cannot deny services to enrollees who are unable to pay cost sharing.

The following reminders will help you to provide services to these members:

- MinnesotaCare and Prepaid Medical Assistance Plan (PMAP): Children younger than age 21 and pregnant women enrolled in PMAP and MinnesotaCare through UCare do not have copays.
- Minnesota Senior Care Plus (MSC+) and PMAP: Non-pregnant adults on PMAP and MSC+ have monthly cost sharing limited to 5% of household income.
  - This means that some non-pregnant adults on PMAP and MSC+ with very low incomes may have no copay or copays lower than the base amounts printed on UCare Member ID cards.
  - Copay responsibility for these members changes monthly, and a member’s progress towards the limit is calculated across the month, so it is not possible to put the exact cost sharing on the Member ID card.
  - If a PMAP or MSC+ member insists that they do not have cost sharing, contact the Provider Assistance Center at 612-676-3300 or 1-888-531-1493, and a representative can verify the cost sharing level for the member.
- Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare: Enrollees in UCare Connect + Medicare and UCare MSHO are only responsible for Part D prescription drug copays, but only if they reside in the community and are not receiving Home and Community Based Services (waiver services).
- UCare Connect members do not have any cost sharing responsibility for UCare-covered services.
- MSC+, MSHO, PMAP and Special Needs Basic Care (SNBC) plans (UCare Connect and UCare Connect + Medicare): UCare waives the family deductible for PMAP, MSC+, SNBC and MSHO members subject to cost sharing. See the [DHS policy](https://www.dhs.state.mn.us/dhspub/mhcp/がら/3640.html) on billing Minnesota Health Care Programs enrollees for services.
MEDICARE ADVANTAGE PLANS

UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare members’ financial liability, including cost-share amounts, is determined by the CMS-approved benefit packages for these plans.

In order for a provider to hold a member financially responsible for services that are not clearly excluded in the member’s Evidence of Coverage (EOC), a pre-service determination must be obtained from UCare prior to rendering. A pre-service determination can be requested from UCare by completing the Clinical Service Authorization Form on UCare’s Eligibility and Authorizations web page. UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare providers should not use the Advanced Beneficiary Notice (ABN).

When the member’s EOC clearly indicates a service is never covered, a pre-service determination is not needed to bill the member for the services.

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Federal law bars Medicare providers from charging Medicare eligible individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program for Medicare Part A and B deductibles, coinsurances or copays.

For people enrolled in the QMB Program, Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the Medicaid State plan for these charges, QMBs are not liable for them).

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. Sections 1902(n)(3); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.

Note: Copayments still apply for Medicare Part D benefits. For those eligible for QMB, this will be copayments at the Low Income Subsidy level.

The QMB program applies to all Medicare providers, both participating and non-participating. Further, providers are obliged to accept assignment on all services to these beneficiaries, even if they would not do so otherwise. Accepting assignment means the provider agrees to accept the Medicare and Medicaid payment as payment in full, regardless of whether Medicaid pays or not.

Providers who are not enrolled as a Medicaid provider are still subject to the QMB program limitations. Because Medicaid won’t pay providers who aren’t enrolled with Medicaid, Medicare cost-sharing balances must be written off and may not be billed to QMB program enrollees.

There are a number of potential ways to identify QMB individuals:

- If you are a Minnesota Health Care Programs (MHCP) provider, you can directly query the Minnesota Department of Human Services (DHS) MN-ITS system to verify QMB eligibility.
- You can ask the beneficiary if they are enrolled in the Qualified Medicare Beneficiary (QMB) program through MHCP. Medicare beneficiaries eligible for Medicaid QMB programs may have documentation, e.g., QMB eligibility verification letters they can show providers.
For Original Medicare (Medicare fee-for-service), see CMS MLN Matters “Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System” (Transmittal R3764CP, MM Article # MM9911). This notes providers are able to identify the QMB status of patients in CMS’ HIPAA Eligibility Transaction System (HETS).

Find more information on CMS’ QMB plans.

**COMMERCIAL PLANS (UCARE INDIVIDUAL & FAMILY PLANS AND UCARE INDIVIDUAL & FAMILY PLANS WITH FAIRVIEW)**

Providers without Qualified Health Plan products (UCare Individual & Family Plans or UCare Individual & Family Plans with Fairview) contained in their agreement are considered non-participating for these products. Claims will be processed with out-of-network member benefits and non-participating provider reimbursement rates.

Qualified Health Plan providers contracted for UCare Individual & Family Plans, but not UCare Individual & Family Plans with Fairview, are considered participating with both plans for contractual reimbursement purposes. However, out-of-network benefits will be applied for care rendered to UCare Individual & Family Plans with Fairview members. Members enrolled in either product may not be balance billed for amounts over the UCare allowed amount.

Although no specific form is required, providers should obtain a waiver from the member prior to rendering and billing the member for non-covered services.

**Claim Adjustments**

UCare shall have the right to make, and participant shall have the right to request, adjustments to any previous payment for, or denial of, a claim for covered services.

**ADJUSTMENT TIME LIMITS**

Adjustment requests submitted by the provider must be received within 12 months from the initial claim’s payment or denial date. Requests received outside of this established timeline will result in a timely filing denial.

**PROVIDER ADJUSTMENT REQUESTS**

Providers should use the Provider Claim Reconsideration Request Form, under Forms & Links on the Claims & Billing web page when requesting an adjustment in situations where the original claim processed incorrectly even though correct information was provided.

**PROVIDER APPEALS**

Providers can submit to UCare a request for an appeal to resolve issues relating to administrative and contractual determinations. If a provider disagrees with the processing of a claim, an appeal request must be submitted to UCare. Providers must submit a completed Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing web page with supporting documentation. UCare will review and, if appropriate, the claims will be reprocessed. If no change is made in the
processing of the claim, a written response will be sent to the provider within 60 days of receipt. In the event a UCare member may have a grievance, the appeal should follow the member appeal process outlined in the Member Appeals & Grievances section of this manual.

Providers have the option to request a voluntary second level review. Second level appeals must be submitted with additional information over and above what was submitted with the initial appeal. These requests must also be submitted on the UCare Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing web page and check “Second Request” on the form. UCare will review if the claim’s adjudication is upheld, a written response will be sent to the provider within 60 days of receipt.

Post Service-authorization Appeals

A provider may appeal a denied authorization request within 30 days from the date of the original remittance advice notification. UCare’s review is based on medical necessity. Payment for these services is subject to benefits outlined in the member’s Explanation of Coverage. Services may be denied because of exclusions, limitations on pre-existing conditions and/or medical necessity requirements. During the appeal process, all available information is provided to a physician reviewer who is board certified and was not involved in the original determination.

Coding Appeals

UCare utilizes claims editing software that aligns with the Centers for Medicare and Medicaid’s (CMS) National Correct Coding Initiative (NCCI) and other regulatory guidance such as Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). The software is updated on a regular basis to incorporate changes (additions, deletions or text revisions) to CPT and HCPCS codes as well as changes made to other regulatory guidance (NCDs and LCDs). Claims will be adjudicated against any rules or regulatory guidance in place on the date of service. When appealing a denial, providers should be sure to use the regulatory guidance or references that were in place on the date of service and are from the Medicare Administrative Contractor (MAC) or state agency that has jurisdiction for Minnesota.

We will consider the appeal with additional documentation; however, the denial may still be upheld. Appeals submitted without additional information will not be reviewed.

Non-Contracted Provider Appeal Process

If you disagree with a denial of payment (zero payment), you may request an appeal. You must make your request within 60 calendar days of the remittance advice notice to have second level appeal rights.

Fax or mail your request to:

UCare - Attn: CLAIMS
P.O. Box 405
Minneapolis, MN 55440-0405

Fax: 612-884-2186

Include the following: UCare Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing web page and documentation that supports your request for reimbursement (e.g., the
original claim, remittance notification showing the denial and any clinical records). Also include the following program specific documents:

- UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare: Waiver of Liability
- MSHO and UCare Connect + Medicare: Waiver of Liability and signed written consent from the enrollee.
- Medical Assistance and MinnesotaCare: signed written consent from the enrollee.

Your paper claim along with the Provider Claim Reconsideration Request Form can be faxed to 612-884-2186. A Claims Attachment Cover Sheet should not be sent. See the Electronic Attachments section for more info on attachments.

**VOID AND REPLACEMENT CLAIMS**

Minnesota Statutes, section 62J.536 requires providers to submit all claims electronically, including void and replacement claims. Effective March 1, 2019, UCare will only accept paper void/replacement claims from providers outside of Minnesota.

Void claims are claims that should not have been billed or where key claim information such as the billing provider or patient name was submitted incorrectly. Examples include, but are not limited to:

- Claims billed in error
- Changes or updates to:
  - Billing provider information
  - Bill type/submission code
  - Patient information
  - Payer information
  - Service dates
  - Subscriber information

Replacement claims are sent when data elements submitted on the original claim were incorrect or incomplete. Examples include, but are not limited to:

- Procedure code missing
- Line being added
- Changes or updates to:
  - Diagnosis code
  - Procedure code
  - Revenue code
  - Place of service
  - Injury date

Please refer to the State of Minnesota Uniform Companion Guide requirements and the AUC Best Practices for replacement claims at [http://www.health.state.mn.us/facilities/auc](http://www.health.state.mn.us/facilities/auc).
REFUNDS

When an overpayment is identified within 12 months of the claim’s initial payment date, a replacement or void claim is the accepted method for returning these funds. See Void and Replacement Claim section above.

UCare expects refund checks within 12 months of the claim’s initial payment date only when claims were subject to coordination of benefits or third-party liability rules. Mail refund checks to UCare Accounting (see below).

If a refund needs to be applied to a claim that was initially paid over 12 months ago, providers may do the following:

- Select “Refund” on and submit the Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing web page; note the overpaid claim or service(s), including the amount of over payment by line. Claim adjustments will be made per the information submitted on the form.
- Mail refund check with a copy of the remittance advice indicating the overpaid claim or service(s), the amount to be refunded per line of the claim, the member ID, dates of service and reason for refund request.

Note: Refund checks will be returned when a replacement/void claim is more appropriate to correct payment.

Mail refund checks to:
UCare
ATTN: Accounting
P.O. Box 52
Minneapolis, MN  55440

CLAIMS AUDITING AND RECOVERY

As required by law, and consistent with sound business practice, UCare has a procedure to ensure that we pay only for eligible services that have been provided and appropriately billed. We expect that any overpayment received by a contracted network service provider is refunded to UCare within sixty (60) calendar days after the date on which the overpayment was identified, and to notify UCare of the reason for the overpayment, pursuant to section 1128J(d) of the Social Security Act. See the Refunds section for returning overpayments to UCare.

Overpayments are UCare payments a provider or beneficiary has received in excess of amounts due and payable under relevant statutes and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the provider to UCare.

In addition to standard claims processing practices and system edits, UCare conducts regular post-payment claim audits to identify overpayments. These efforts, in addition to any fraud, waste and abuse investigations, may result in recovery of payments.

When UCare identifies an overpayment, a recovery letter is sent to the servicing provider requesting return of the overpaid amount. The provider has 30 days to return the amount owed. If no response is received within 30 days, UCare will recoup the amount due.
If you have questions regarding a claim overpayment letter you receive, please call the Claims Recovery line at 612-676-6511.

**Coding Resources**

Providers should use available references and resources to determine which ones best suit the claim they are submitting.

Resources include the following (external links):

- [DHS Provider Manual](#)
- MN AUC Companion Guides and Coding Practice Recommendation Table
  - [MN AUC Companion Guides](#)
  - [MN AUC Coding Practice Recommendation Table](#)
- [CMS Internet Only Manuals (IOMs)](#)
- [CMS Lab NCDs Index](#)
- [CMS ICD-10](#)
- [CMS National Correct Coding Initiative Edits (NCCI)](#)
- [Medicaid (DHS) National Correct Coding Initiative Edits (NCCI)](#)
- National Government Services (NGS) - Medicare Administrative Contractor (MAC)
  - [National Government Services NGS](#)
- [CGS Administrators, LLC (DME MAC)](#)
- [Medicare Physician Fee Schedule](#)
- [Minnesota DHS Fee Schedule](#)
- [DHS Medical Supply Guide](#)

**OVERVIEW**

All professional and institutional claims for medical procedures, services and supplies must be submitted with valid codes. UCare requires providers to use Healthcare Common Procedural Coding System (HCPCS) codes, International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM), Procedure Coding System (ICD-10-PCS) and Current Procedural Terminology (CPT) codes as well as Revenue codes. Code sets must be reported in accordance with the type of claim submitted.

**The Health Insurance Portability and Accountability Act (HIPAA)**

Transaction and Code Set regulation stipulates submission and acceptance of approved medical code sets. All codes must be valid for the date of service on which the service or supply was rendered.

Providers are expected to submit ICD-10-CM codes to the highest level of specificity. It may be reasonable to submit unspecified diagnosis codes during the initial evaluation of a sign, symptom or complaint; however, once diagnostic testing and/or physical assessment has been performed and a definitive diagnosis has been determined, providers should submit the diagnosis code(s) that provides the greatest detail and specificity.

Any claim submitted with an ICD-10-CM or ICD-10-PCS code, CPT, HCPCS or Revenue code that is not valid for the date of service will be denied.
MODIFIERS

A modifier is a two-digit numeric, alpha-numeric or alpha code that is used to indicate that the service or procedure that has been performed has been altered by some specific circumstance but has not changed the definition or code.

Modifiers are categorized into two principal classifications. Informational modifiers can represent specific anatomical locations, identify various circumstances under which services are provided, indicate separately identifiable services or reflect provider type involved in a service. Payment modifiers identify circumstances that alter the payment for the service provided in some manner.

When submitting a claim with multiple modifiers, payment modifiers should be listed in the first modifier position and informational modifiers should be listed in subsequent modifier positions.

A complete listing of modifiers can be found in Appendix A of the CPT Manual and in the HCPCS Manual. Additional modifier information can be located on the National Government Services website (Medicare Administrative Contractor for Minnesota). Level I CPT codes are not restricted to use with CPT modifiers. HCPCS Level II modifiers may also be used with Level I codes and/or in combination with CPT modifiers.

NGS Medicare
To reference UCare’s complete Professional Modifier Grid, visit UCare’s Payment Policy.

FEATURED MODIFIERS

Modifier 22 – Increased Procedural Services

Any claim submitted with a modifier 22 appended to a procedure code must be accompanied by documentation. Operative reports, procedural narratives and/or other relevant documentation must accompany the claim.

Documentation must clearly detail the following:

- Additional time spent above and beyond the typical time for the procedure. Include total additional time and indicate what circumstances required the additional time and/or clinical effort.
- Anatomical challenges (i.e., body habitus, atypical anatomy) that impacted the procedure or service.
- Complexity of procedure and what circumstances made it complex.

Modifier 22 should not be used when there is an existing code to describe the procedure or service. Modifier 22 should be appended only to those procedure codes with a 0.10 or 90-day global indicator. The availability of additional payment will be determined based on review of the supporting documentation submitted.

Claims without supporting documentation will be denied. Claims with documentation that fails to clearly indicate the rationale for use of the modifier 22 will be paid at the standard rate.
**Modifier 62 – Two Surgeons**

Modifier 62 is used when two surgeons work together at the same operative session as primary surgeons. Each surgeon must perform a distinct part(s) of a procedure.

The work performed by each surgeon must be documented in the operative record. Each surgeon should document the specific components of the procedure that they performed.

Modifier 62 should be appended to the CPT code(s) representing the surgical procedure(s) performed as co-surgeons. Each surgeon should submit a claim for these services.

Modifier 62 should not be used when one surgeon acts as an assistant.

UCare will use the Medicare Physician Fee Schedule (MPFS) Relative Value File (RVF) (also known as the data base) in determining whether procedures reported with modifier 62 are eligible for co-surgeons.

- 0 = Co-surgeons not permitted for this procedure.
- 1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity.
- 2 = Co-surgeons permitted. No documentation is required when the two specialty rule is met.

If modifier 62 is appended to a procedure code with a status of “0,” the procedure will be denied.

Documentation is required to be submitted if modifier 62 is appended to a procedure code with a status of “1.”

Claims for co-surgeons that do not list at least one common procedure code will be denied.

For additional information see [CMS Internet-Only Manuals (IOM) Publication 100-04, Chapter 12, section 40.8 on co-surgeons](https://www.cms.gov/Medicare/Coding/Code-Edits-Manuals).  

**Modifier 59 – Distinct Procedural Service**

Modifier 59 should be used to identify procedures or services (non-evaluation and management codes) that are not typically reported together but may be appropriate under certain circumstances.

*The use of modifier 59 should be limited.* If another established modifier is appropriate, that modifier should be used rather than modifier 59.

Circumstances in which it may be appropriate to report modifier 59 include:

- A different session of care
- A different anatomical site or organ system
- Separate and distinct lesions
- A different procedure
- A separate injury
- A separate incision or excision

Modifier 59 must always be appended to the component or lesser procedure code (i.e., NCCI Column II code). Claim lines with modifier 59 appended to every procedure will be denied for inappropriate use of modifier.
Documentation supporting the separate and distinct status represented by modifier 59 must be present in the patient’s medical record and available upon request.

Situational modifiers (XE, XS, XP and XU) may be used in place of modifier 59. These modifiers may not be reported with modifier 59. One or the other must be used. Claims received with both modifier 59 and one of the situational modifiers appended to the same procedure or service will be denied.

The situational modifiers are described below:

**XE – Separate Encounter**, a service that is distinct because it occurred during a separate encounter.

**XS – Separate Structure**, a service that is distinct because it was performed on a separate organ/structure.

**XP – Separate Practitioner**, a service that is distinct because it was performed by a different practitioner.

**XU – Unusual, Non-Overlapping Service**, the use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 59 is applicable only to the code combinations in the CMS National Correct Coding Initiative (NCCI) with an indicator of “1” in the modifier column. This indicator specifies that services are distinct and separate and, therefore, would be appropriate to report together with modifier 59 or the appropriate situational modifier appended to the correct code(s).

**UNLISTED CODEs**

UCare providers should submit documentation with any claim that contains an unlisted CPT or HCPCS code.

An unlisted code can represent a wide variety of services. During the adjudication of a claim with an unlisted code, it should be clear what the unlisted code applies to in the documentation. Documentation should:

- Indicate which procedure, service or supply is being reported under the unlisted code.
- Include a detailed description of the service.
- Indicate why the procedure, service or supply was necessary.
- Include the name of the drug and the dosage given (in box 19 of CMS 1500 claim form) when using an unlisted code for a drug (J series of HCPCS).

Each section of the CPT book contains at least one unlisted code that represents a procedure or service for which a more specific CPT code, Category III code or HCPCS code does not exist. Many unlisted CPT codes end with “99” and are typically found at the end of each specific section of the manual; although there are numerous exceptions throughout the manual.

Claims reporting an unlisted code that are submitted without appropriate accompanying documentation will initially be denied. Providers will receive a Claims Adjustment Reason Code (CARC) of 16 (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and a Remittance Advice Remark Code (RARC) of M127 (Missing patient medical record for this service) indicating that documentation is required before the claim can be processed.
UCare Claims Edits

**INDIVIDUAL & FAMILY PLANS SERVICES EDITS**

Effective Jan. 1, 2019, UCare applied the following changes to edits for UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview:

**Expanded SNIP Edits**

UCare Minnesota added a higher SNIP level to inbound claim submission in 2019 to all Individual & Family Plans. UCare uses the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Validation. Any 837 submissions that do not pass WEDI SNIP Validations will be rejected. Below are a few examples of the health plans’ SNIP level requirements:

<table>
<thead>
<tr>
<th>2018 Edits</th>
<th>Additional 2019 Edits (including 2018 edits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNIP 1-2</td>
<td>SNIP 1-5</td>
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<td>Invalid Character or data element</td>
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<td>Date of service expected to be in numeric format CCYYMMDD</td>
<td>Diagnosis code has been already used</td>
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<td></td>
<td>Admission dates are required on inpatient claims</td>
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<td></td>
<td>The taxonomy code is not valid or inactive on transaction date</td>
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<tr>
<td>Custom Edits - Taxonomy Requirements and APRDRG Birth Weight is required</td>
<td>Custom Edits - 2018 CE plus Zero Units/Minutes will not be accepted</td>
</tr>
</tbody>
</table>

**Optum Claims Editing System™ (CES)**

UCare implemented version 5.4 of the Claims Edit System (CES) in the new claims adjudication system for Individual & Family Plans. During implementation, UCare reviewed all of the existing edits for the UCare Individual & Family Plans for appropriateness within a commercial population. As a result, providers may experience a different editing pattern (e.g., some new edits, elimination of edits more appropriate for Medicare or Medicaid populations, etc.).

**LCD/NCD UPDATES**

UCare uses an automated claims editing software to ensure consistent and accurate processing of Local Coverage Determinations (LCD) and National Coverage Determinations (NCD). A third-party vendor delivers published LCD/NCD updates to UCare bi-weekly. Once UCare receives the updates, we implement them within 15 business days.

The published LCD/NCD updates are retroactive to the latest CMS published effective date. UCare will not retroactively adjust the claims impacted by the updates related to the LCD/NCD but will reprocess claims per provider request. Providers wishing to reprocess claims will need to complete and submit a Provider Claim Reconsideration Request Form, under Forms & Links on the Claims & Billing web page.
UCare Pricing Edits

UCare uses automated claims pricing and editing software. These tools provide consistent and objective claims review to align claims adjudication and payment with expected regulatory and industry requirements.

Claims edits apply across all UCare products and apply criteria as outlined in various industry and regulatory manuals such as:

- Centers for Medicare & Medicaid Services (CMS) guide
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 10th Edition (ICD-10)

Pricing-related edits are applied to only the following Medicare services for UCare’s Medicare Advantage products (UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare) and dual-products (MSHO and UCare Connect + Medicare):

- Skilled nursing facilities (SNF)
- Inpatient rehabilitation facilities (IRF)
- Inpatient psychiatric facilities (IPF)
- Federally qualified health clinics (FQHC)
- Professional claims

Pricing software is also used to apply the following methodologies, when appropriate:

- Ambulatory Payment Classifications (APC)
- Ambulatory Surgical Center (ASC)
- Diagnostic Related Groups (DRGs)

These edits align with CMS guidelines and UCare’s published payment policies (see Payment Policy on the UCare provider website).

Optum Prospective Payment System™ (PPS)

For claims with dates of service on or after Jan. 1, 2019, UCare will use an automated pricing tool for claims for Skilled Nursing Facilities (SNF), Inpatient Psychiatric Facilities (IPF) and Inpatient Rehabilitation Facilities (IRF) for Individual & Family Plans. This change brings greater efficiency to the claims payment process and consistency to provider payments.

UCare’s Payment Policies

The information outlined in UCare’s payment policy is intended to provide general information regarding the payment methodologies used by UCare, and is not intended to be a guarantee of payment or address all of the details associated with a particular service. Additional factors may affect reimbursement including, but not limited to, legislative mandates, medical policies, coverage documents, and the physician or other provider contracts. Payment policies may be modified by UCare at any time by publishing a new version of the policy on the UCare website.
UCare Payment Policies

FEE SCHEDULE UPDATES

- The rules for the guidelines include events where the Centers for Medicare and Medicaid Services (CMS) and/or where the Minnesota State Department of Human Services (DHS) publishes rate or methodology changes.

- UCare implements such changes within 40 business days of the date that such changes are finalized and published, unless specified by the appropriate regulatory agency, in accordance with the scheduled frequency below. Rate updates due to CMS and DHS coding and billing changes impacting the allowable units of service may occur outside of the frequency listed.

- If implementation takes more than 40 business days after the date of the final rate change notice, upon request, UCare will retroactively adjust claims processed from the 41st business day until the date rates are updated. If updates are implemented within 40 business days, UCare will not retroactively adjust claims.

- Government-based adjustments as they apply to Managed Care may be reflected in final payment.

- Rate Letters - Critical Access Hospitals (CAHs) and organizations designated as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs) are responsible for notifying UCare of future updates to federal rates and/or state cost-based per diem rates. Federal rate update letters and/or state cost-based per diem rate letters should be sent to UCare at: RateLetters@UCare.org or 612-884-2382 (dedicated fax line for rate letters). UCare will apply the new rates within 30 calendar days of receiving rate updates. That day becomes the new effective date.

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<thead>
<tr>
<th>Product</th>
<th>Physicians/Ancillary/ASC</th>
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<th>SNF</th>
<th>Specialized Providers or Services Paid Outside Published MHCP and CMS Fee Schedules</th>
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<td>Per Provider Contract</td>
<td>Annual – January (from July of previous year)</td>
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<td>Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: As Notified EIDBI and CCDTF Services: As Notified Other Services: SA Jan &amp; July MHCP file</td>
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<td>State Only Services: Annual Other Services: Quarterly</td>
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<td>Quarterly</td>
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</tbody>
</table>

*Includes, but not limited to Hospice, Elderly Waiver, HealthCare Home, Enteral Nutrition subject to product specific pricing per DHS, Mental Health and Chemical Dependency Facilities

SA = Semi-Annual

All updates are subject to a 40 business day implementation delay

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**Unauthorized Provider Services**

Effective for dates of service on or after January 1, 2018, UCare will comply with [Minnesota Statute §62Q.556](https://www.researchgate.net/publication/227880556) legislation regarding the use of unauthorized provider services for UCare Individual & Family Plans products. Emergency services are exempt from the definition of unauthorized provider services.

Specifically, UCare will seek to process member claims for covered medical services at in-network benefit levels when:
• Care is delivered by a non-participating provider while the member is at a participating hospital or ambulatory surgical center (e.g., when a participating provider sub-contracts with non-participating providers for covered services within their facilities).
• A participating clinic sends a lab specimen to a non-participating lab, pathologist or other testing facility for processing.
• Services received are part of a member’s covered benefit set.
• Proper authorizations have been received (if required; see Eligibility & Authorizations page on UCare’s provider website for related authorization grids).

IDENTIFICATION OF NON-PARTICIPATING PROVIDER SERVICES ELIGIBLE FOR IN-NETWORK BENEFITS

Because participating providers are currently not required to inform UCare of sub-contracted services, and because the non-participating claim may be received by UCare prior to the claim from the participating provider, proper identification is challenging. UCare will review the Service Facility submitted in Loop2310C - NM109 in the electronic claim submission for all non-participating claims to determine if the NPI submitted is at an in-network provider location.

Failure to properly identify the Service Facility on submitted claims could lead to initial processing with inappropriate member benefit levels, member dissatisfaction and additional administrative steps to rectify. Members who appeal a claim processed against out-of-network benefits from a non-participating provider who failed to properly identify the Service Facility in their initial claim will have the claim re-processed.

PAYMENT TO NON-PARTICIPATING PROVIDERS

In accordance with the statute, UCare will pend identified claims and send a letter to the non-participating provider requesting to negotiate the final payment rate. The letter will:

• Identify the action steps needed to bring the claim to resolution as a “clean claim” so that payment can be issued. See Minnesota Statute §62Q.75 for additional information.
• Describe actions UCare will take if there is no responses (i.e., adjudicate at the standard non-par rate) or if parties cannot reach agreement.

If a non-participating provider fails to respond within thirty (30) calendar days, providers without existing QHP agreements will be reimbursed at UCare’s standard non-participating rates.

Should a non-participating provider and UCare engage in negotiation and are unable to reach agreement, UCare will obtain the requisite Non-Disclosure Agreements and work with the non-participating provider to secure Mediation Services according to the statute.

UCare will regularly review non-participating provider claims for potential contracting opportunities to provide more seamless care for members and minimize the administrative burden associated with properly processing these non-participating provider claims associated with UCare’s contracted provider’s subcontractors.

Non-participating providers can also complete a Provider Claim Reconsideration Request Form under Forms & Links on the Claims & Billing web page to appeal the initial non-participating provider rate.
payment and negotiate a new payment in accordance with Section 13 of the statute. To ensure proper handling of these appeals, non-participating providers must do the following:

- Indicate the request as an **Appeal Request** (top of form).
- Complete all required fields.
- Indicate **Payment Dispute** as the Reason for Request and in the **Detailed Description for Request** section, indicate: **Unauthorized Provider Service payment negotiation requested**.

Please note, UCare will be unable to process this request if the Service Facility information is missing on the original claim, or if the place of services information is not a participating provider in the member’s network.

Should a non-participating provider appeal for a negotiated payment rate and UCare and the non-participating provider are unable to reach agreement, the legislation allows for arbitration. Costs for these services are shared equally between the non-participating provider and UCare.

**Telemedicine**

Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site.

To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the UCare telemedicine policy. This can occur by sending UCare a copy of the **Provider Assurance Statement for Telemedicine** form that was submitted to DHS.

By submitting the form to UCare (Fax: 612-676-6501--ATTN: CLAIMS SUPPORT), the provider will satisfy the assurance form requirements for both Minnesota Health Care Program (MHCP) and Commercial products (only one form is needed).

**More Information**

See the following sections of the provider manual for additional information on Claims and Payments.

- Working with UCare’s Delegated Business Services
- Electronic Data Interchange
- Behavioral Health
- UCare’s Federally Qualified Health Center – Rural Health Clinic Carve-Out Process
- Home & Community Based Services – Waiver Services
- Interpreter Services
- Obstetrics & Gynecology
- Transportation Services
Electronic Data Interchange (EDI)

Utilizing electronic transactions for core health care business processes reduces the administrative burden for both UCare and health care providers.

Minnesota Law Requires Electronic Claim Submission

Minnesota State Statute, section 62J.536, requires all health care providers to submit all health care claims electronically, including institutional (837I), professional (837P), dental (837D) and pharmacy (NCPDP 5.1) and secondary claims, using a standard format. This statute applies to all UCare members enrolled in Minnesota Health Care Programs (Prepaid Medical Assistance Program, MinnesotaCare, Minnesota Senior Care Plus, UCare’s Minnesota Senior Health Options, UCare Connect, UCare Connect + Medicare and Individual and Family products including UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview).

UCare can only accept paper claims for members of our Medicare programs (UCare Medicare Plans, UCare Medicare Group Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare) and from providers outside of Minnesota.

You can find details on this requirement online at:
- Minnesota Department of Health
- Minnesota Office of the Revisor of Statutes

Electronic Claims Submission (837) Payor ID List

- Effective Jan. 1, 2019, UCare Individual & Family Plans (IFP) will have changes that will affect claims submission. These changes will assist in streamlining claims processing and improve efficiencies of claims routing to our primary claims adjudicator. The changes include the following:
  - New Payer ID: 55413
  - The Payer ID for UCare Individual & Family Plans (formerly UCare Choices products) will change to (55413) for claims submitted with dates of service (DOS) on and after Jan. 1, 2019. Providers should contact their clearinghouse to confirm the new Payer ID for this plan — as other clearinghouses may assign their own unique number.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Product</th>
<th>Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mc</td>
<td>UCare Medicare Plans (formerly UCare for Seniors), UCare Medicare Group Plans (formerly UCare for Seniors Group), EssentiaCare, UCare Medicare with Fairview &amp; North Memorial Health</td>
<td>52629</td>
</tr>
<tr>
<td>Ma</td>
<td>UCare Minnesota Health Care Programs (UCare Prepaid Medical Assistance Program, UCare MinnesotaCare, UCare Minnesota Senior Care Plus, UCare Minnesota Senior Health Options, UCare Special Needs BasicCare, UCare SNBC + Medicare, UCare Connect, UCare Connect + Medicare</td>
<td>52629</td>
</tr>
<tr>
<td>IFp</td>
<td>UCare Choices, Fairview UCare Choices for all DOS prior to 1/1/2019</td>
<td>52629</td>
</tr>
<tr>
<td>IFp</td>
<td>UCare Individual &amp; Family Plans, UCare Individual &amp; Family Plans with Fairview for DOS on and after 1/1/2019</td>
<td>55413</td>
</tr>
</tbody>
</table>

The new payer ID **55413** should be used for IFP claim submission of electronic claims that are for dates of service on or after Jan. 1, 2019. All claims for dates of service prior to Jan. 1, 2019, should be sent to payer ID 52629.

**Electronic Claims Submission (837)**

UCare’s electronic claims transactions are accessible through two different trading partners. Providers must contact a trading partner directly to enroll in available electronic transactions. Contact information for UCare’s trading partners is listed below:

**Change Healthcare (formerly RelayHealth)**
- Registration: 1-800-527-8133, Option 1
- Registration Email: DBQTSHEnrollments@RelayHealth.com
- Claims & Remits: 1-800-527-8133, Option 1
- Claims & Remits: Email: DBQTSInsuranceSupport@RelayHealth.com
  [https://www.changehealthcare.com/](https://www.changehealthcare.com/)

**MN E-Connect/Health EC**
- (free, AUC-compliant web-based claims data entry tool)
  - support@healthec.com
  - Phone: 1-877-444-7194
  - [https://www.healthec.com/](https://www.healthec.com/)
Taxonomy Code Requirements

As of March 1, 2017, UCare requires the corresponding taxonomy to be submitted whenever a National Provider Identification (NPI) is reported on a claim submitted directly to UCare or on claims that will crossover and be coordinated with UCare coverage. When taxonomy is not reported on a claim that includes a NPI number(s), the claim will be rejected.

The following categories of taxonomy are required when the corresponding NPI is submitted on claims to UCare:

- For professional claims (submitted via 837P or CMS 1500) – billing and rendering taxonomy.
- For institutional/facility claims – billing (submitted via 837I or UB04) and attending taxonomy (submitted via 837I).

Remember, when NPI(s) are submitted on any claim, the corresponding taxonomy is required.

- Does taxonomy need to be included on claims that need to be coordinated with other insurance (e.g., Medicare crossover claims)?
  Yes. When billing and rendering/attending NPI is included on a claim that may be coordinated with UCare coverage, the corresponding taxonomy must be included in order for UCare to process the claim. Claims that are coordinated with UCare coverage and do not have taxonomy reported, when applicable, will be rejected.

Provider types that are not required to submit claims with NPI are not required to submit taxonomy on claims to UCare.

The rendering provider NPI and taxonomy should be reported when it is different than the billing provider NPI/taxonomy information. Providers may submit multiple rendering provider NPI and taxonomy at the line level on the CMS paper 1500 form, but rendering provider NPI and taxonomy can only be submitted at the claim level on the 837. NPI is always required when submitting taxonomy. For more information, see the 1500 Claims Instruction Manual at www.nucc.org.

WHAT IS TAXONOMY?

The Healthcare Provider Taxonomy Code Set (HPTC) available here is maintained by the National Uniform Claim Committee (NUCC). It is a hierarchical code set consisting of codes, code descriptions and definitions. This code set is designed to categorize the type, classification and specialization of health care providers. The HPTC includes two sections:

1. Individuals and Groups of Individuals (e.g., provider groups, physicians defined by specialty, Behavioral Health and Social Service Providers, Pharmacy Providers, Physician Assistant and Advance Practice Providers)
2. Non-Individuals (e.g., Agencies, Ambulatory Health Care Facilities, Hospitals, Nursing and Custodial Care Facilities)

NUCC makes regular updates to the taxonomy code set. CMS published a MLN Matters (MM9659) in October 2016 regarding updates to HPTC.
REPORTING TAXONOMY ON CLAIMS

Please refer to the NUCC for guidance on where taxonomy should be reported on paper and electronic claims. Below is more detail on where taxonomy should be reported on paper and EDI claims.

<table>
<thead>
<tr>
<th>Taxonomy Type</th>
<th>Paper Claim Box</th>
<th>837P Loop Professional</th>
<th>837I Loop Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UB04 Box: 81CC, box a First box - Qualifier B3</td>
<td>PRV01 – BI for billing provider</td>
<td>PRV01 – BI for billing provider</td>
</tr>
<tr>
<td></td>
<td>Second box over – taxonomy number</td>
<td>PRV02 – PXC (Health Care Provider Taxonomy)</td>
<td>PRV02 – PXC (Health Care Provider Taxonomy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRV03 – Taxonomy number</td>
<td>PRV03 – Taxonomy number</td>
</tr>
<tr>
<td>Rendering Provider</td>
<td>*CMS-1500 Box: 24J with ZZ indicator</td>
<td>2310B – Rendering Provider Specialty Information</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRV01 – PE for performing provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRV02 – PXC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRV03 – Taxonomy number</td>
<td></td>
</tr>
<tr>
<td>Attending Provider</td>
<td>N/A – Taxonomy not required on paper claims</td>
<td>N/A</td>
<td>2310A – Attending Provider Specialty Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PRV01 – AT for attending provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PRV02 – PXC (Health Care Provider Taxonomy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PRV03 – Taxonomy number</td>
</tr>
</tbody>
</table>

REJECTION REPORTS

When claims reject for missing taxonomy, the rejected claims will be reported to providers by their clearinghouses on acknowledgement or 277CA reports. These reports indicate if a claim was accepted into or rejected from UCare’s claim payment system. The report also indicates why a claim was rejected.

When a claim is rejected due to taxonomy not being properly reported, a provider may see the rejection or error category of A6 (The claim/encounter is missing the information specified in the status details and has been rejected) and error code 145 (Entity’s specialty/taxonomy code). To avoid payment delays on these claims, add taxonomy to the claim and resubmit it to UCare.
**NPPES NUMERATION**

The taxonomy code(s) submitted to UCare must be registered with the corresponding NPI in the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES), and must closely align with the services being provided. It is important that providers regularly verify and update their enumeration with CMS and NPPES. Please confirm the taxonomies linked to your NPPES and CMS enumeration are up to date and accurately reflect the provider specialties billed under each NPI.

At this time, UCare is not currently requiring taxonomy information on provider enrollment forms. The taxonomy will only be required at the claim level when professional and facility claims are submitted to UCare. The taxonomy codes must match with the ones that are registered for their NPI(s) on the CMS NPPES website.

Additional information is available in the Taxonomy FAQ, found in the Taxonomy Code Requirements drawer on the Resources for Electronic Transactions web page.

**Electronic Claim Attachments**

A claim attachment may be required to be submitted when either an 837I or an 837P is sent to UCare for adjudication. When an attachment to a claim is necessary, providers will need to populate the paperwork (PWK) segment in Loop 2300 of the electronic claim. The Administrative Uniformity Committee (AUC) Claim Attachment Cover Sheet must accompany each attachment to ensure a proper match to the electronically submitted claim. To submit a claim attachment after completing the AUC Claim Attachment Cover Sheet, fax the documents to UCare at 612-884-2261. UCare follows the submission guidelines as outlined in the AUC best practice for claims attachments.

**Eligibility and Benefits (270/271)**

Providers can access UCare’s eligibility and benefit information through Change Healthcare (formerly RelayHealth) PCS Support. If your clearinghouse has not already done so, it can enroll with PCS to begin transmitting these transactions to your organization. Clearinghouses working directly with the provider can contact CHC_pcssupport@changehealthcare.com or call 1-877-411-7271 to begin the enrollment and provisioning process.

UCare’s Health Care Eligibility Benefit Inquiry and Response 270/271 Companion Guide will give providers and their clearinghouses the necessary information to fully utilize this information. It can be found in the 270/271 Eligibility and Benefits drawer on the Resources for Electronic Transactions web page.

**Health Care Claim Status (276/277)**

Providers can access UCare’s claims status information through Change Healthcare (formerly RelayHealth) PCS Support. If your clearinghouse has not already done so, it can enroll with PCS to begin
transmitting these transactions to your organization. Clearinghouses working directly with the provider can contact CHC_pcssupport@changehealthcare.com or call 1-877-411-7271 to begin the enrollment and provisioning process.

UCare’s Health Care Claim Status Inquiry and Response 276/277 Companion Guide will give providers and their clearinghouses the necessary information to fully utilize this information. It can be found in the 276/277 Health Care Status Inquiry and Response drawer on the Resources for Electronic Transactions web page.

## Important EDI Reports

When electronic claims are submitted to UCare, there are three reports that a clearinghouse will receive as claims move through UCare’s claim processing system. The following table lists these reports in the order that they are sent by UCare to our clearinghouse. Please note that a claim can be accepted into the UCare claims processing system but then deny for various reasons as it processes.

<table>
<thead>
<tr>
<th>Step</th>
<th>Report</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 1    | 999 ACKNOWLEDGMENT | A 999 acknowledges that the EDI batch submitted to UCare is “packaged” appropriately.  
1. Batch is readable and will move on, or  
2. Batch is unreadable and is being returned. |
| 2    | 277CA ACKNOWLEDGMENT | A 277CA report validates the claims at the pre-processing stage.  
Report will show the following for each claim line:  
1. Claim is accepted, will receive a claim number & be processed, or  
2. Claim was rejected along with the reason why. |
| 3    | 835/REMITTANCE ADVICE* (RA)/REMIT | An 835 Remittance Advice assigns a UCare claim number and provides itemized reasons for payments, adjustments and denials.  
Remittance Advice will show the following for each claim line:  
1. Denied, or  
2. Paid (payment information will be listed). |

*Additional information about 835 Remittance Advice, including a companion guide, is available on the Resources for Electronic Transactions web page in the 835 Electronic Remittance Advice drawer.
Other Resources

Minnesota Uniform Companion Guide
Entities subject to Minnesota Statutes, section 62J.536 and related rules must follow the data content and other transaction-specific information of the Minnesota Uniform Companion Guide. A copy of the Minnesota Uniform Companion Guide is available at no charge from the Minnesota Department of Health at the above link.

EDI definitions and acronyms
There are many terms used to support electronic transactions. This document defines the most commonly used terms. It is found in Other Resources on the EDI webpage.

Washington Publishing Company
Washington Publishing Company (WPC) is the exclusive publisher for ASC X12’s Insurance subcommittee, X12N. WPC provides documentation adopted under the Health Insurance Portability and Accountability Act (HIPAA) and other related, value-added documents, such as the Health Care Code lists (ANSI X12 CARC & RARC).

Electronic Attachments

UCare accepts electronic attachments for initial claims submitted electronically. All attachments must be faxed to UCare at 612-884-2261.

All attachments must include an AUC attachment cover sheet. UCare follows best practice guidelines set forth by the AUC: http://www.health.state.mn.us/facilities/auc

See the Claim Adjustments section for specifics on adjustment attachments.
Authorization & Notification Standards

This chapter provides information regarding authorization and notification requirements for UCare. It also provides information on what is needed when a service is denied.

All services must be medically necessary, and coverage criteria may differ between UCare plans.

Definitions

Approval Authority is UCare or an organization delegated by UCare to approve or deny prior authorization requests.

Notification is the process of informing UCare or delegates of UCare of a specific medical treatment or service prior to, or within a specified time period after, the start of the treatment or service.

Pre-Service Determination (PSD) An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service determination if there is a question as to whether an item or service will be covered by the plan.

Prior Authorization is an approval by an Approval Authority prior to the delivery of a specific service or treatment. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service or treatment is medically necessary, an eligible expense and appropriate and that other alternatives have been considered.

General Guidelines

Some services require an authorization or notification, and these services are listed on the Eligibility & Authorizations page of the UCare provider website (https://UCare.org/providers).

If a member needs a service or procedure listed in the Authorization and Notification Requirement Grids, the provider must obtain an authorization prior to providing the service. For services indicated as notifications, the provider must notify UCare within the timeframe stated. Failure to obtain authorization in advance or follow notification requirements will result in claim payment delays and potential provider liability denials.

UCare does not require a referral for members to see specialists within their plan network, and members may directly access medically necessary care within their plan benefits.

Services That Require Authorization or Notification

UCare strives to minimize the administrative requirements placed on providers. General authorization and notification oversight is used for:

- Services for which lower-cost tests or treatments with comparable safety and effectiveness exist
- Services or procedures that have accepted indications for limited usage
Services that are often overused or inappropriately used

UCare uses requirement documents to detail which services require authorizations or notification. The authorization and notification requirement document lists the approving authority that makes determinations for each type of service. If a medically necessary service or procedure is not listed in the Authorization and Notifications Requirements, and it is a covered benefit, then, in most cases, an authorization or notification is not required.

Authorization and Notification Requirements documents are available on the Eligibility & Authorizations page of the UCare provider website (www.UCare.org/providers).

**How To Submit Authorization or Notification Documentation**

Authorization requests should be submitted via fax to the appropriate approval authority. UCare’s authorization request forms are available on the Eligibility & Authorization page of the UCare provider website (www.UCare.org/providers). The forms will assist you with determining the information needed for an authorization to be considered for a specific service or procedure. UCare’s medical necessity criteria and resources are available in the Medical Necessity Criteria section of this manual. Additional information regarding documentation required for authorization and notification review is outlined there.

At a minimum, the following information must be included in authorization requests:

- Member name and UCare ID number
- Rendering and billing provider information, including name, address, NPI numbers for both rendering and billing provider, if they differ
- Detail and rationale for requested services
- Past medical history and treatment pertinent to the request
- Photographs/X-rays where appropriate
- Pertinent primary care and/or specialist notes
- Proposed date of service, provider and location
- Requestor name, title and contact information
- Procedure code (CPT or HCPCS) and description of service
- ICD-10 diagnosis code and description

**REMINDERS WHEN SUBMITTING AUTHORIZATION REQUESTS**

All fields on the Behavioral Health and Medical authorization request should be filled out completely. Completing these forms correctly will reduce the need for additional information and prevent delays in UCare’s response. The authorization forms for behavioral health and medical services can be found on the Eligibility & Authorization page of UCare’s provider website (www.UCare.org/providers). Under Authorizations, select a UCare product, then on the results page choose the Medical, Behavioral Health or Injectable Drugs tab at the top, and scroll down to find the forms section.

*To comply with HIPAA and internal compliance requirements, providers should fax one prior authorization form at a time. When authorization requests are faxed in bulk, it increases the risk of information being lost or inappropriately filed.*
Services That Require Pre-Service Determination (PSD)

A pre-service determination (PSD) is needed in order to hold a UCare Medicare Plans, UCare Medicare Plans with Fairview & North Memorial, or EssentiaCare member financially liable for non-covered services that are not clearly excluded in the member’s Evidence of Coverage (EOC). Providers must obtain a PSD BEFORE rendering a service, item or procedure that may not be covered. The non-covered service should not be rendered until UCare issues a determination. UCare Medicare Plans, UCare Medicare Plans with Fairview & North Memorial and EssentiaCare providers should not use the Advanced Beneficiary Notice (ABN).

Advanced Notices of Non-Coverage FAQs

Timelines for Decision and Notification for Authorization Requests

Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received.

Notification to requesting provider/attending or ordering provider is made via fax, telephone or secure email, followed by a written decision when applicable within one business day of the decision, but not to exceed a total of 14 calendar days or 10 business days from the date the request was received.

Written notification of the decision is sent to the member via U.S. mail or a confirmed secure email within one business day of the decision, but not to exceed a total of 14 calendar days or 10 business days from the date the request was received.

Expedited review timeframe for urgent/emergent requests is 72 hours. Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member’s health, life or ability to regain function.

Notification to requesting provider/attending or ordering provider is made via fax, telephone or secure email, followed by a written decision when applicable within one business day of the decision, but not to exceed a total of 72 hours from the date/time the request was received.

Verbal notification attempts are made and written notification of the decision is sent to the member via U.S. mail, FedEx, courier or a confirmed secure email within one business day of the decision.

Do not submit expedited requests for authorization for post-service or retrospective authorizations.

Fax medical requests to:

UCare
Attn: Clinical Services
612-884-2499 or 1-866-610-7215
Mail medical requests to:
UCare
Attn: Clinical Services
P.O. Box 52
Minneapolis, MN 55440-0052

Hospital Notifications: See the Hospital Services section

Nursing Home Admissions: See the Nursing Facility section

Transplant Notification: Call UCare upon inpatient admission at 612-676-6705 or 1-877-447-4384 toll free

Fax Behavioral Health requests to:
Attn: UCare Behavioral Health
Fax: 1-855-260-9710

Behavioral health forms are located online by health plan. On the Eligibility & Authorization page, under Authorization Requirements, select a UCare Product. On the results page, click the Behavioral Health section. Questions may be directed to 612-676-3300 or 1-888-531-1493 toll free.

Fax Therapy - PT, OT, ST requests to:
Magellan Healthcare, Inc.
Fax: 1-888-656-1952
Direct questions to 1-888-660-4705 toll free

FAQ - UCare Authorizing Entities

More Information:

- FAQs Regarding Advanced Notices of Non-Coverage (Dec. 28, 2015)
- Discontinue Use of Advance Beneficiary Notice of Non-Coverage (ABN) or an ABN-Like Form (Jan. 2015)

**Decision-Making on Authorization Requests**

UCare or delegated approval authorities use written medical necessity review criteria based on clinical evidence to make authorization decisions. The criteria used to evaluate an individual case are available upon request, are referenced in the Medical Necessity Criteria section of this manual, or in our Medical Policy documents. Additionally, you may speak to a Medical Director at UCare or at the delegated approval authority who considered your request.

Authorization decisions are based on appropriate level of care and the member’s coverage. Authorization decisions do not constitute the practice of medicine, and UCare does not reward providers or other individuals for issuing denials of coverage or services. Additionally, UCare does not encourage decisions through financial or other means that results in underutilization of services.

Approval of an authorization request does not guarantee payment. Reimbursement is subject to the member’s eligibility status and benefits at the time of service.
Member Appeals & Grievances

Member Rights and Responsibilities

UCare takes member rights and responsibilities seriously. Members can access these rights and responsibilities in their Evidence of Coverage or Member Contract. UCare expects that providers be familiar with the Member Rights and Responsibilities and has included them here for your reference.

MEMBER RIGHTS AND RESPONSIBILITIES

As a UCare member of this plan, you have the right to:

- Available and accessible services including emergency services, as defined in your Contract, 24 hours a day and seven days a week;
- Be informed of health problems, and to receive information regarding medically necessary treatment options and risks that is sufficient to assure informed choice, regardless of cost or benefit coverage;
- Refuse treatment, and the right to privacy of medical and financial records maintained by UCare and its health care providers, in accordance with existing law;
- Make a grievance or appeal a coverage decision, and the right to initiate a legal proceeding when experiencing a problem with UCare or its health care providers. (See the Appeals and Grievances section for more information on your rights);
- Receive information about UCare, its services, its practitioners and providers, and your rights and responsibilities;
- Be treated with respect and recognition of your dignity and your right to privacy;
- Participate with your providers in making health care decisions; and
- Make recommendations regarding the organization’s member rights and responsibilities policy.

As a UCare member of this plan, you have the responsibility to:

- Supply information (to the extent possible) that the organization and its providers need in order to provide care;
- Follow plans and instructions for care that you have agreed to with your providers to sustain and manage your health;
- Understand your health needs and problems, and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Pay copayments at the time of service and to promptly pay deductibles, coinsurance and, if applicable, additional charges for non-covered services.

Member Appeal and Grievance Process | UCare Medicare Plans

See also: Evidence of Coverage and Medicare Managed Care Manual, Chapter 13: Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals.
DEFINITIONS & OVERVIEW

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which UCare provides health care services, regardless of whether any remedial action can be taken.

Grievances do not involve problems related to coverage or payment for medical care, problems about being discharged from the hospital too soon, and problems about coverage for skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation services ending too soon.

Examples of grievances:

- Problems with the quality of the medical care, including quality of care during a hospital stay.
- Problems with Customer Services.
- Problems with wait time on the phone, in the waiting room, in a clinic/hospital or in the exam room.
- Problems with getting appointments, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists or other staff.
- Cleanliness or condition of doctor’s offices, clinics, nursing facilities or hospitals.
- Difficult-to-understand notices and other written materials.
- Failure to provide required notices.
- Discrimination.

Who can file:
A member or their representative.

Timeline for filing:
Within 60 days of the date of the incident that precipitated the grievance. The filing timeline may be extended if there is good cause for the delay.

How to file:
By calling UCare Customer Services or submitting a written grievance to Member Appeals and Grievances.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Oral Grievances
- Oral grievances are investigated and the findings or outcome are verbally communicated to the member within 30 calendar days from receipt of the grievance. A member can request a written response.
- The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.
- If the member does not agree or is dissatisfied with the response, the member can file a written grievance.
**Written Grievances**

- Written grievances are investigated and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within ten (10) calendar days after receipt of the written grievance.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

An expedited grievance is a member’s complaint that UCare or one of its delegated entities refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. UCare must resolve these grievances within 24 hours of receipt.

**Quality of Care Grievances**

A quality of care complaint may be filed through UCare’s grievance process (See Quality of Care Review Process section in this chapter) and/or a Quality Improvement Organization (QIO).

If UCare receives a grievance about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process. The letter also includes information on how to file a quality of care grievance with the QIO.

**Quality Improvement Organization (QIO):** An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans and ambulatory surgical centers. A QIO determines whether the quality of services meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The member or their representative has the right to file a quality of care grievance with the QIO in the state where they reside.

Quality of care grievances filed with the QIO must be made in writing.

A member who files a quality of care grievance with the QIO is not required to file the grievance within a specific time period.

Below is the QIO where a UCare Medicare Plans or EssentiaCare member can file a quality of care grievance or seek additional information about the QIO’s review process:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 888-524-9900 | Fax: 833-868-4059
MEMBER APPEALS | DEFINITIONS & OVERVIEW

Plans: UCare Medicare Plans (Total, Classic, Complete, Essentials Rx, Standard, Prime, Value, Group), EssentiaCare (Grand, Secure), UCare Medicare with Fairview & North Memorial (Care Core, Care Advantage)

Organization determination: Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care or urgently needed services.
- Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Medicare health plan.
- The Medicare health plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the Medicare health plan.
- Discontinuation of a service if the member believes that continuation of the services is medically necessary.
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by UCare and if necessary, an independent review entity – MAXIMUS Federal Services, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC) and judicial review.

Reconsideration: This is a member’s first step in the appeal process after an adverse organization determination. UCare re-evaluates an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Standard Reconsideration: A written request asking UCare to reconsider the denial, reduction or termination of coverage for a service or the denial of payment for services already received.

Expedited Reconsideration: A verbal or written request asking UCare to reconsider the denial, reduction or termination of coverage for a service. This does not include requests for payment of services already furnished. An expedited request is granted to the member if applying the standard 30 calendar day timeframe could seriously jeopardize the member’s life, health or ability to regain maximum function.

Who can file an appeal?

- A member or their authorized representative. A valid appointment of representative form must be received before a request for reconsideration is accepted and the review process timeline begins. This could include, Power of Attorney document, Health Care Proxy document, or a
signed CMS Appointment of Representative form (CMS 1696), or a UCare Statement of Representation form.

- The legal representative of a deceased member’s estate.
- An assignee of the member: A non-contracted physician or other non-contracted provider who has furnished a service to the member and signs a Waiver of Liability form agreeing to waive any right to payment from the member for that service.
- For appeal of a pre-service determination, a physician may request reconsideration on behalf of the member.
- For post-service (claims) a physician may request a reconsideration but must be an authorized representative for the member. See Claim Appeals section of this Provider Manual.

**Expedited Reconsideration:** A physician can request an expedited reconsideration. A physician may also provide oral or written support for a member’s request for an expedited reconsideration.

**Timeline for Filing:** Members or their representative(s) must file an appeal request within 60 days of the date of the notice of denial. The filing timeline can be extended if the party shows good cause for the delay in filing a request.

**How to file:**

- Standard reconsideration must be filed in writing.
- Expedited reconsideration may be filed verbally or in writing.

**Decision:**

- UCare Appeals and Grievances staff reviews all information and facts related to the case before making the reconsideration decision. A Provider Relations and Contracting Coordinator may also contact the provider involved in the case to obtain information, provide guidance on contract or CMS requirements, etc.
- Requests for reconsideration involving a decision based on medical necessity will be reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue and who was not the individual who made the initial determination.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

UCare notifies the member in writing of the decision.

Timelines for resolution include:

- **Standard reconsiderations:** For service requests, as expeditiously as the member’s health requires but within 30 calendar days from receipt of the request. The timeframe for resolving a service reconsideration can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member and/or the appealing party is immediately notified in writing of the reason(s) for the delay.
  - For payment requests, within 60 calendar days from receipt of the request.
- **Expedited reconsiderations:** As expeditiously as the member’s health requires but within 72 hours of receipt of the request. The timeframe for resolving an expedited reconsideration can be extended by up to an additional 14 calendar days if the member requests the extension or if
UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member and/or appealing party is immediately notified verbally and in writing of the reason(s) for the delay.

**Automatic 2nd Level Appeals**

If UCare does not make a fully favorable decision, that is, does not agree to fully cover or pay for a service, the reconsideration request is automatically forwarded to an independent review entity under contract with CMS, MAXIMUS Federal Services for an external review.

**Appeal Levels 3-5**

If the decision by the independent review entity is fully or partially adverse to the member, the member may, based on certain requirements, request an Administrative Law Judge hearing (ALJ), review by the Medicare Appeals Council (MAC), and judicial review. See Evidence of Coverage or Member Handbook for further information on these appeal levels.

**Note: “Fast Track” Appeals with the QIO**

- Members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with UCare’s decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end.
- When UCare has approved coverage of a member’s admission to a SNF, or coverage of HHA or CORF services, the member must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 days in advance of the termination of coverage for these services (See the Skilled Nursing Facility, Home Care Services or Rehabilitation Services sections).
- A timely request for an expedited review by the QIO is one in which a member requests an appeal from the QIO either by noon of the day following receipt of the NOMNC; or, where a member receives the NOMNC more than two days prior to the date coverage is expected to end, a member requests an appeal with the QIO no later than noon of the day before coverage ends (that is, the “effective date” of the notice).
- A member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with UCare under the provisions explained above for an expedited reconsideration.
- A member who disagreed with the decision to be discharged from the hospital can appeal the discharge decision that inpatient care is no longer necessary and must request an immediate QIO review. (See Hospital Services section). A member who fails to request an immediate QIO review of the discharge decision in accordance with the filing timeline requirements may request an expedited reconsideration with UCare.

**Medicare Part D Prescription Drug Program | Member Appeal and Grievance Process**

Plans: UCare Medicare Plans (Total, Classic, Complete, Essentials Rx, Standard, Prime, Value, Group), EssentiaCare (Grand, Secure), UCare Medicare with Fairview & North Memorial (Care Core, Care Advantage), UCare’s Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare.
See also: Evidence of Coverage or Member Handbook and Prescription Drug Benefit Manual, Chapter 18: Part D Enrollee Grievances, Coverage Determinations, and Appeals.

**GRIEVANCE | DEFINITIONS AND OVERVIEW**

**Grievance:** Any complaint or dispute, other than one involving a coverage determination or a Low Income Subsidy (LIS) or Late Enrollment Penalty (LEP) determination, expressing dissatisfaction with any aspect of UCare’s operations, activities or network pharmacies, regardless of whether remedial action is requested.

Examples include:

- Problems with wait times at the pharmacy when filling a prescription.
- Delays in reaching someone by phone or getting information you need when filling a prescription or requesting prescription drug benefit information.
- Problems with the quality of the prescription dispensing (e.g., errors in drug or dose).
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of network pharmacy.
- Notices and other written materials are difficult to understand.
- Failure to provide required notices.
- Discrimination.

**Who Can File?**

A member or their representative.

**Timeline for Filing:**

Within 60 days of the date of the incident that precipitated the grievance for UCare Medicare Plans Minnesota. The filing timeline may be extended if there is good cause for the delay.

**How to File:**

By calling UCare Customer Services or submitting a written grievance to Member Appeals and Grievances.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

**Oral Grievances**

- Oral grievances are investigated and the findings or outcome are verbally communicated to the member within 30 calendar days from receipt of the grievance for UCare Medicare Plans Minnesota and 10 calendar days from receipt of the grievance for MSHO and UCare Connect + Medicare. A member can request a written response.
- The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.
- If the member does not agree or is dissatisfied with the response, the member can file a written grievance.
Written Grievances

- Written grievances are investigated and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within ten (10) calendar days after receipt of the written grievance.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

An expedited grievance is a member’s complaint that UCare or its Pharmacy Benefits Manager (PBM) refused to expedite a coverage determination or redetermination request. UCare must resolve these grievances within 24 hours of receipt.

Quality of Care Grievances

- A quality of care complaint may be filed through UCare’s grievance process (See Quality of Care Review Process section in this chapter) and/or a Quality Improvement Organization (QIO).
- If UCare receives a grievance about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process. The letter also includes information on how to file a quality of care grievance with the QIO.

Quality Improvement Organization (QIO): Comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, Medicare Part D prescription drug plans and ambulatory surgical centers. A QIO must determine whether the quality of services provided by a Medicare Part D prescription drug plans providers meets professionally recognized standards of health care.

The member or their representative has the right to file a quality of care grievance with the QIO in the state where they reside.

Quality of care grievances filed with the QIO must be made in writing.

A member who files a quality of care grievance with the QIO is not required to file the grievance within a specific time period.

Below is the QIO where a UCare Medicare Plans or EssentiaCare member can file a quality of care grievance or seek additional information about the QIO’s review process:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 888-524-9900 | Fax: 833-868-4059
**APPEAL | DEFINITIONS & OVERVIEW**

**Coverage determination:** Any determination (i.e., an approval or denial) made by UCare or its Pharmacy Benefits Manager (PBM) with respect to the following:

- A decision about whether to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the plan’s formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the Part D plan sponsor determines that the drug is otherwise excluded under section 1862(a) of the Act if applied to Medicare Part D) that the member believes may be covered by the plan.
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the member.
- A decision concerning a tiering exceptions request under 42 CFR 423.578(a).
- A decision concerning a formulary exceptions request under 42 CFR 423.578(b).
- A decision on the amount of cost sharing for a drug.
- A decision whether a member has, or has not, satisfied a prior authorization or other utilization management requirement.

**Appeal:** Any of the procedures that deal with the review of adverse coverage determinations made by UCare or its PBM on the benefits under a Part D plan the member believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amounts the member must pay for the drug coverage, as defined in §423.566(b). These procedures include redeterminations by UCare, reconsiderations by the independent review entity (IRE) MAXIMUS Federal Services, Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC) and judicial reviews.

**Redetermination:** The first level of the appeal process, which involves UCare re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Standard Redetermination:** A verbal or written request asking UCare to reconsider the denial of coverage for a medication (prior authorization, non-formulary exception, tier exception, quantity limit exception). (1/1/2008 UCare will accept oral requests from members for a redetermination.)

**Expedited Redetermination:** A verbal or written request asking UCare to reconsider the denial of coverage for a medication (prior authorization, non-formulary exception, tier exception, quantity limit exception). This does not include requests for payment of medication already furnished. An expedited request is granted to the member if applying the standard 7 calendar day timeframe could seriously jeopardized the member’s life, health or ability to regain maximum function.

**Who Can File?**

- A member or the member’s authorized representative. A valid appointment of representative form must be received before a request for reconsideration is accepted. This could include, Power of Attorney document, Health Care Proxy document, or a signed CMS Appointment of Representative form (CMS 1696), or a UCare Statement of Representative form.
- The legal representative of a deceased member’s estate.
• A physician may also request a redetermination.
  Standard Redetermination: A physician may request a redetermination.
  Expedited Redetermination: A physician can request an expedited redetermination.
• A physician may also provide oral or written support for a member’s request for an expedited reconsideration.

**Timeline for Filing:**
Within 60 days of the date of the notice of denial. The filing timeline can be extended if the party shows good cause for the delay in filing a request.

**How to File:**
• Standard redetermination may be filed orally or in writing. (1/1/2008 UCare will accept oral requests from members for a redetermination.)
• Expedited redetermination may be filed orally or in writing.

**Decision:**
• UCare Appeals and Grievances staff obtain all information used to make the initial coverage determination, contact the prescribing provider for any new or additional information, and gather the coverage criteria for the prescription medication in question. For payment requests, review of coverage requirements and current status of TrOOP etc. are reviewed. All information and facts related to the case are gathered before making the redetermination decision.
• Requests for redetermination involving a decision based on medical necessity will be reviewed by a pharmacist and/or physician with expertise in the field of medicine that is appropriate for the services at issue and who is not the individual who made the initial determination.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**
• The member is notified in writing of UCare’s decision.
• Timelines for resolution include:
  o Standard redeterminations: As expeditiously as the member’s health requires but within 7 calendar days from receipt of the request.
  o Expedited redeterminations: As expeditiously as the member’s health requires but within 72 hours of receipt of the request.

**2nd Level Appeals**
If UCare does not make a fully favorable decision, that is, does not agree to fully cover or pay for a prescription medication, the member is informed of the reconsideration process. The member must request a 2nd level appeal by the independent review entity under contract with CMS, MAXIMUS Federal Services.

**Appeal Levels 3-5**
If the decision by the independent review entity is fully or partially adverse to the member, the member may, based on certain requirements, request an Administrative Law Judge hearing (ALJ), review by the
Medicare Appeals Council (MAC) and judicial review. See Evidence of Coverage or Member Handbook for further information on these appeal levels.

**Integrated Appeal Process | UCare's Minnesota Senior Health Options (MSHO), UCare Connect + Medicare**

**GRIEVANCE | DEFINITIONS & OVERVIEW**

**Grievance:** Any complaint, other than one that involves a request for an initial determination, or an appeal. Grievances do not involve problems related to approving or paying for medical care, services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility services ending too soon.

Examples:

- Problems with the quality of the medical care, including quality of care during a hospital stay.
- Problems withMember Services.
- Problems with wait time on the phone, in the waiting room, in a clinic/hospital or in the exam room.
- Problems with getting appointments, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists or other staff. Cleanliness or condition of doctor’s offices, clinics, nursing facilities or hospitals.
- Notices and other written materials are difficult to understand.
- Failure to provide required notices.
- Discrimination.

**Who Can File?**

A member or their appointed representative.

**Timeline for Filing:**

A member or authorized representative that files a grievance with UCare is not required to file the grievance within a specific time period.

**How to file:**

Call UCare Customer Services or submit a written grievance to Member Appeals and Grievances.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

**Oral Grievances**

- Oral grievances are investigated and the findings or outcome are verbally communicated to the member within 10 calendar days from receipt of the grievance. A member can request a written response.
• The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

• If the member does not agree or is dissatisfied with the response, the member can file a written grievance with UCare, or contact the Ombudsman Office or the Minnesota Department of Health.

**Written Grievances**

• Written grievances are investigated and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.

• An acknowledgement letter is sent to the member within 10 calendar days after receipt of the written grievance.

• The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

An expedited grievance is a member’s complaint that UCare or one of its delegated entities refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. UCare must resolve these grievances within 24 hours of receipt.

### Quality of Care Grievances

A quality of care grievance may be filed through UCare’s grievance process (See Quality of Care Review Process section in this chapter) and/or through a Quality Improvement Organization (QIO).

If UCare receives a grievance about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process. The letter also includes information on how to file a quality of care grievance with the QIO.

**Quality Improvement Organization (QIO)**: Comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans and ambulatory surgical centers. A QIO determines whether the quality for services meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The member or member’s representative has the right to file a quality of care grievance with the QIO in the state where they reside.

Quality of care grievances filed with the QIO must be made in writing.

A member who files a quality of care grievance with the QIO is not required to file the grievance within a specific time period.
Below is the QIO where a UCare MSHO or UCare Connect + Medicare member can file a quality of care grievance or seek additional information about the QIO’s review process:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Phone: 888-524-9900 | Fax: 833-868-4059

**APPEAL | DEFINITIONS & OVERVIEW**

**Organization determination:** Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care or urgently needed services.
- Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan.
- The Medicare health plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the Medicare health plan.
- Discontinuation of a service if the member believes that continuation of the services is medically necessary.
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

**Appeal:** Any of the procedures that deal with the review of adverse organization determinations or the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined 42 CFR422.566(b). These procedures include reconsideration by UCare and if necessary, an independent review entity – MAXIMUS Federal Services, hearings before Administrative Law Judges (ALJ’s), review by the Medicare Appeals Council (MAC) and judicial review.

**Reconsideration:** This is a member’s first step in the appeal process after an adverse organization determination. UCare re-evaluates an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

- Standard Reconsideration: A verbal or written request asking UCare to reconsider the denial, reduction or termination of coverage for a service or the denial of payment for services already received.
- Expedited Reconsideration: A verbal or written request asking UCare to reconsider the denial, reduction or termination of coverage for a service. This does not include requests for payment of services already furnished. An expedited request is granted to the member if applying the standard 30 calendar day timeframe could seriously jeopardized the member’s life, health or ability to regain maximum function.

**Who Can File?**

- A member or their authorized representative. A valid appointment of representative form must be received before a request for reconsideration is accepted and the review process timeline
begins. This could include Power of Attorney document, Health Care Proxy document, a signed CMS Appointment of Representative form (CMS 1696) or a UCare Statement of Representative form.

- The legal representative of a deceased member’s estate.
- An assignee of the member: A non-contracted physician or other non-contracted provider who has furnished a service to the member and signs a Waiver of Liability form agreeing to waive any right to payment from the member for that service.
- For pre-service, a physician may also request a reconsideration on behalf of the member.
- For post-service (claims) a physician must be an authorized representative to file on behalf of the member.

**Expedited Reconsideration:**

A physician can request an expedited reconsideration. A physician may also provide oral or written support for a member’s request for an expedited reconsideration.

**Timeline for Filing:**

Within 60 days of the date of the notice of denial. The filing time line can be extended if the party shows good cause for the delay in filing a request.

**How to File:**

- Standard reconsideration may be filed verbally or in writing.
- Expedited reconsideration may be filed verbally or in writing.

**Decision:**

- UCare Appeals and Grievances staff reviews all information and facts related to the case before making the reconsideration decision. A Provider Relations and Contracting team member may also contact the provider involved in the case to obtain information, provide guidance on contract or CMS requirements, etc.
- Requests for reconsideration involving a decision based on medical necessity will be reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue and who was not the individual who made the initial determination.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

UCare notifies the member in writing of the decision. Timelines for resolution include:

- Standard reconsiderations: For service requests, as expeditiously as the member’s health requires but within 30 calendar days from receipt of the request. The timeframe for resolving a service reconsideration can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member and/or appealing party is immediately notified verbally and in writing of the reasons(s) for the delay. For payment requests, within 30 calendar days from receipt of the request.
- Expedited reconsiderations: As expeditiously as the member’s health requires but within 72 hours of receipt of the request. The timeframe for resolving an expedited reconsideration can
be extended by up to an additional 14 calendar days if the member requests the extension or if
UCare justifies a need for additional information and the delay is in the member’s best interest.
If UCare extends the deadline, the member and/or appealing party is immediately notified
verbally and in writing of the reason(s) for the delay.

**Automatic 2nd Level Appeals**

If UCare does not make a fully favorable decision, that is, does not agree to fully cover or pay for a
service, the reconsideration request is automatically forwarded to an independent review entity under
contract with CMS, MAXIMUS Federal Services for an external review.

**Appeal Levels 3-5**

If the decision by the independent review entity is fully or partially adverse to the member, the member
may, based on certain requirements, request an Administrative Law Judge hearing (ALJ), review by the
Medicare Appeals Council (MAC) and judicial review. See Evidence of Coverage or Member Handbook
for further information on these appeal levels.

Note: “Fast Track” Appeals with the QIO

If the appeal decision is adverse to the member, the member is informed of their right to request a State
Appeal (State Fair Hearing).

A copy of the Member Rights is attached to the appeal resolution letter.

**STATE APPEAL (STATE FAIR HEARING) | DEFINITION &
OVERVIEW**

**State Appeal:** A hearing filed according to a member’s written request with the State pursuance to
Minnesota Statute, related to the delivery of health services or participation in UCare, denial (full or
partial) of a claim or service, failure to make an initial determination in 30 days, or any other Action or
Grievance.

**Note: “Fast Track” Appeals with the QIO**

Members have the right to an expedited review by a Quality Improvement Organization (QIO) when
they disagree with UCare’s decision that Medicare coverage of their services from a skilled nursing
facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF)
should end.

When UCare has approved coverage of a member’s admission to a SNF, or coverage of HHA or CORF
services, the member must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 days in
advance of the termination of coverage for these services (See the Skilled Nursing Facility, Home Care
Services or Rehabilitation Services sections).

A timely request for an expedited review by the QIO is one in which a member requests an appeal from
the QIO either by noon of the day following receipt of the NOMNC; or, where a member receives the
NOMNC more than two days prior to the date coverage is expected to end, a member requests an
appeal with the QIO no later than noon of the day before coverage ends (that is, the “effective date” of
the notice).
A member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with UCare under the provisions explained above for an expedited reconsideration.

A member who disagreed with the decision to be discharged from the hospital can appeal the discharge decision that inpatient care is no longer necessary and must request an immediate QIO review. (See the Hospital Services section).

A member who fails to request an immediate QIO review of the discharge decision in accordance with the filing timeline requirements may request an expedited reconsideration with UCare.

**Appeal and Grievance Process | UCare Minnesota Health Care Programs (PMAP, MinnesotaCare, Minnesota Senior Care Plus, UCare Connect)**

See also: Member’s Evidence of Coverage.

**GRIEVANCE | DEFINITIONS & OVERVIEW**

**Grievance:** An expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. A grievance may also involve a privacy concern.

**Who Can File?**

A member or their representative.

**Timeline for Filing:**

A member or authorized representative that files a grievance with UCare is not required to file the grievance within a specific time period.

**How to File:**

Orally by calling UCare Customer Services or can submit a written grievance to Member Appeals and Grievances.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

**Oral Grievances**

- Oral grievances are investigated and the findings or outcome are verbally communicated to the member within 10 calendar days from receipt of the grievance. A member can request a written response.
The timeframe for resolving an oral grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.

Urgent Resolution: If the grievance is about urgent health care issues or UCare’s decision not to grant a member’s request for an Expedited Appeal, the determination and verbal notification must be done within 72 hours.

If the member does not agree or is dissatisfied with the response, the member can file a written grievance, or can contact the Minnesota Department of Health or the Ombudsman.

If the grievance is about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process.

**Written Grievances**

- Written grievances are investigated and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within ten (10) calendar days after receipt of the written grievance.
- Urgent Resolution: If the grievance is about urgent health care issues or UCare’s decision not to grant a member’s request for an Expedited Appeal, the determination and notification must be done within 72 hours.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.
- If the grievance is about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process.

**Adverse Decisions**

If the member does not agree or is dissatisfied with the response, the member can contact the Minnesota Department of Health or Minnesota Department of Human Services.

Minnesota Department of Health (MDH)
Health Policy and Systems Compliance Division
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882
Phone: 651-201-5100 or 1-800-657-3916

Minnesota Department of Human Services
Ombudsman Office for State Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249
Phone: 651-431-2660 or 1-800-657-3729
**APPEAL | DEFINITIONS & OVERVIEW**

**Appeal:** A request to UCare for review of an Action. An oral or written request from the member, or the provider acting on behalf of the member with the member’s written consent, to UCare for review of an Action or a member’s written request for review of a Grievance.

** Expedited Appeal:** A request from an attending health care professional, a member or their representative that UCare reconsider its decision to fully or partially deny authorization for services as soon as possible but no later than 72 hours after receiving the request because the member’s life, health, or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a decision. The request is made prior to or during an ongoing service.

**Action:**
- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by the State.
- Failure of a Managed Care Organization (MCO) to act within the timeframes for resolution of Appeals and Grievances.
- For a resident of a rural area with only one MCO, the denial of a Medicaid member’s request to exercise his or her right to obtain services outside the network.

**Who Can File?**
- A member or their authorized representative
- The legal representative of a deceased member’s estate
- A physician may also request an appeal

**Standard Appeals:**
For utilization management decision the attending health care professional can request an appeal. For all other standard appeals, the physician must be an authorized representative.

**Expedited Appeals:**
A physician can request an expedited appeal. A physician may also provide oral or written support for a member’s request for an expedited appeal.

**Timeline for Filing:**
Within 60 days of the date of the notice of denial. The filing time line can be extended if the party shows good cause for the delay in filing a request.

**How to File:**
Appeals may be filed orally or in writing.

**Continuation of Benefits During an Appeal**
- If the member or their representative requests an appeal before the effective date of action, and requests continuation of benefits within the time allowed, UCare may not reduce or
terminate a member’s ongoing medical services that have been ordered by a participating or treating provider until 10 days after a written decision is issued in response to the appeal.

- For members in which the decision was made to impose sanctions (restricted members), if the member requests an appeal prior to the date of the proposed sanction, UCare may not impose the sanction until the appeal process is completed.
- UCare Appeals and Grievances staff obtains or reviews all information used to make the initial decision, contact the provider for any new or additional information, reviews the benefit and coverage rules. All information and facts related to the case are gathered before making the appeal decision.
- Requests for appeals that involve a decision based on medical necessity will be reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue and who is not the individual who made the initial determination.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

Timelines for resolution include:

- Standard appeals: For service appeals, as expeditiously as the member’s health requires but within 30 calendar days from receipt of the request. For payment appeals, within 30 calendar days from receipt of the request. The timeframe for resolving an appeal can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member and/or the appealing party is immediately notified verbally and in writing of the reason(s) for the delay.
- Expedited appeals: As expeditiously as the member’s health requires but within 72 hours of receipt of the request. The member is notified in writing of UCare’s decision.

**Adverse Decisions**

If the appeal decision is adverse to the member, the member is informed of their right to request a State Appeal.

A copy of the Member Rights is attached to the appeal resolution letter.

**STATE APPEAL (STATE FAIR HEARING) | DEFINITION & OVERVIEW**

**State Appeal:** A hearing filed according to a member’s written request with the State pursuant to Minnesota Statute, related to the delivery of health services or participation in UCare, denial (full or partial) of a claim or service, failure to make an initial determination in 30 days, or any other Action or Grievance.

**Who Can File?**

- A member or their authorized representative
- The legal representative of a deceased member’s estate
Timeline for Filing

- Within 120 days of the health plan appeal. The filing time line can be extended up to 90 days if the party shows good cause for the delay in filing a request.
- The member or their representative can appeal at any time to DHS about an Action taken by UCare. A member is required to exhaust UCare’s appeal process before requesting a State Appeal.

How to File

- Appeals must be filed with the Department of Human Services Appeals Unit in writing.
- UCare will provide reimbursement to the member for transportation, child care, photocopying, medical assessment outside the MCO network, witness fee, and other necessary and reasonable costs incurred by the member or former member in connection with a request for State Appeal. Necessary and reasonable costs shall not include the member’s legal fees and costs, or other consulting fees and costs incurred by or on behalf of the member.

Continuation of Benefits During an Appeal

- If the member or their representative requests an appeal before the effective date of Action and requests continuation of benefits within time allowed, UCare may not reduce or terminate a member’s ongoing medical services that have been ordered by a participating or treating provider until the State issues a written decision issued on the Appeal.
- For members in which the decision was made to impose sanctions (restricted members), if the member requests a State Appeal (State Fair Hearing) prior to the date of the proposed sanction, MCO may not impose the sanction until the State Appeal process is completed.

Decision

- Prior to the hearing, UCare reviews the action, information used to make the decision and any new information.
- If the initial action or grievance decision/issue is changed prior to the hearing, UCare will attempt to verbally notify the member or representative. A letter explaining the issue and the resolution is sent to the member or representative, Human Services Judge and the Ombudsman. The member is informed that if he or she feels the appeal or grievance issue is resolved to their satisfaction, he or she may to call the Human Services Judge to withdraw the request for a State Appeal (State Fair Hearing).
- If there is no change to the initial decision, UCare must submit to the Human Services Judge and the member or representative a State Agency Appeal Summary form and any exhibits at least 3 days prior to the State Appeal (State Fair Hearing) date.
- At the hearing (usually telephone unless the member requests an in-person hearing), UCare representatives present the action taken and the basis or reason for the action (denial, reduction or termination). The member or their representative then responds to why they feel the decision was not correct and why they need the type or level of service in dispute or why UCare should pay for a service already received.
- For expedited State Appeal (State Fair Hearing), UCare must send the file to the Human Services Judge as expeditiously as the member’s health requires, and no later than one working day from notification of the expedited State Appeal.
- The Human Services Judge reviews testimony and any written exhibits and makes the decision. A written order is sent to UCare and the member or representative.
- Decision in favor of the member: If the initial decision is overturned, MCO must comply with the hearing decision as expeditiously as the member’s health requires. MCO must pay for any services the member received that are subject to the hearing.

**Required Resolution Timeframe and How the Resolution is Communicated to the Member:**

The State must make a final decision on the Action within 90 days of the following, whichever is earlier:

- The date the member filed an Appeal of the same issue with UCare, excluding the days it subsequently took for the member to file a request for a State Appeal (State Fair Hearing), or
- The date the request for a State Appeal (State Fair Hearing) was filed with DHS.
- Expedited State Appeal (State Fair Hearing) decisions: State must make a final Action within 3 working days of receipt of the file from MCO or a request from the member which meets the criteria of 42 CFR 438.410(a).

**Adverse Decisions**

If the appeal decision is adverse to the member, the member is informed of their right to request a reconsideration of the Judge’s decision or to request a District Court Hearing.

**Appeal and Grievance Process | UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview**

**GRIEVANCE | DEFINITIONS & OVERVIEW**

**Grievance:** An expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights. A grievance may also involve a privacy concern.

**Who Can File?**

A member or their representative.

**Timeline for Filing:**

Within 180 days of the date of the incident that precipitated the grievance. The filing timeline may be extended if there is good cause for the delay.

**How to File:**

Orally by calling UCare Customer Services or can submit a written grievance to Member Appeals and Grievances.
Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Oral Grievances

- Oral grievances are investigated and the findings or outcome are verbally communicated to the member within 10 calendar days from receipt of the grievance. A member can request a written response.
- Urgent Resolution: If the grievance is about urgent health care issues or UCare’s decision not to grant a member’s request for an Expedited Appeal, the determination and verbal notification must be done within 72 hours.
- If the member does not agree or is dissatisfied with the response, the member can file a written grievance, or can contact the Minnesota Department of Health or the Minnesota Department of Commerce.
- If the grievance is about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process.

Written Grievances

- Written grievances are investigated and the findings or decision are communicated to the member in a letter within 30 calendar days from receipt of the grievance.
- An acknowledgment letter is sent to the member within ten (10) calendar days after receipt of the written grievance.
- Urgent Resolution: If the grievance is about urgent health care issues or UCare’s decision not to grant a member’s request for an Expedited Appeal, the determination and notification must be done within 72 hours.
- The timeframe for resolving a written grievance can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member is immediately notified verbally and in writing of the reason(s) for the delay.
- If the grievance is about potential quality of care issues, a letter is sent to the member or representative with a summary of the issues and an explanation of the confidential peer review process.

Adverse Decisions

If the member does not agree or is dissatisfied with the response, the member can contact the Minnesota Department of Health or Minnesota Department of Commerce at any time.

In-Network Services:
Minnesota Department of Health (MDH)
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882
Phone: 651-201-5100 or 1-800-657-3916

Non-Network Services:
Minnesota Department of Commerce
Attn: External Review Process
85 7th Place East
St. Paul, MN 55101
Phone: 651-539-1500
APPEAL | DEFINITIONS & OVERVIEW

Appeal: A request to UCare for review of an Action. An oral or written request from the member or the provider acting on behalf of the member with the member’s written consent, to UCare for review of an Action or a member’s written request for review of a Grievance.

Expedited Appeal: A request from an attending health care professional, a member, or their representative that UCare reconsider its decision to fully or partially deny authorization for services as soon as possible but no later than 72 hours after receiving the request because the member’s life, health or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a decision. The request is made prior to or during an ongoing service.

Action:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by the State.
- Failure of a Managed Care Organization (MCO) to act within the timeframes for resolution of Appeals and Grievances.

Who Can File?

- A member or their authorized representative
- A physician may also request an appeal.

Standard Appeals:
For utilization management decision the attending health care professional can request an appeal. For all other standard appeals, the physician must be an authorized representative.

Expedited Appeals:
A physician can request an expedited appeal. A physician may also provide oral or written support for a member’s request for an expedited appeal.

Timeline for Filing:
Within 180 days of the date of the notice of denial. The filing timeline can be extended if the party shows good cause for the delay in filing a request.

How to File:
Appeals may be filed orally or in writing.

Continuation of Benefits During an Appeal

- If the member or their representative requests an appeal before the effective date of action, and requests continuation of benefits within the time allowed, UCare may not reduce or terminate a member’s ongoing medical services that have been ordered by a participating or treating provider until 10 days after a written decision is issued in response to the appeal.
- For members in which the decision was made to impose sanctions (restricted members), if the member requests an appeal prior to the date of the proposed sanction, UCare may not impose the sanction until the appeal process is completed.
Decision:

- UCare Appeals and Grievances staff obtains or reviews all information used to make the initial decision, contact the provider for any new or additional information, reviews the benefit and coverage rules. All information and facts related to the case are gathered before making the appeal decision.
- Requests for appeals that involve a decision based on medical necessity will be reviewed by a physician with expertise in the field of medicine that is appropriate for the services at issue and who is not the individual who made the initial determination.

Required Resolution Timeframe and How the Resolution is Communicated to the Member:

Timelines for resolution include:

- Standard appeals: For service appeals, as expeditiously as the member’s health requires but within 30 calendar days from receipt of the request. The timeframe for resolving a service appeal can be extended by up to an additional 14 calendar days if the member requests the extension or if UCare justifies a need for additional information and the delay is in the member’s best interest. If UCare extends the deadline, the member and/or the appealing party is immediately notified verbally and in writing of the reason(s) for the delay.
- For payment appeals, within 30 calendar days from receipt of the request.
- Expedited appeals: As expeditiously as the member’s health requires but within 72 hours of receipt of the request.

The member is notified in writing of UCare’s decision.

Adverse Decisions

If the appeal decision is adverse to the member, the member is informed of their right to request an external review through the State of Minnesota.

A copy of the Member Rights is attached to the appeal resolution letter.

UCare Quality of Care Review Process

- Quality of Care (QOC) grievances/concerns involve situations where the reporter indicates that the quality of clinical care or quality of service did, or potentially could have, adversely affected a member’s health or well-being.
- Potential clinical QOC situations may be identified and reported internally by any UCare staff person, including Customer Service, Quality Management, Clinical Services, or externally by members or their representatives, delegated entities, regulatory agencies, or providers.
- The QOC grievance/concern is reviewed to ensure that it is appropriate for a QOC review and to determine if the case warrants priority evaluation.
- All cases are reviewed using a confidential Peer Review process.
• A nurse reviewer is responsible for coordinating the QOC review process. The nurse reviewer collaborates with the Chief Medical Officer (CMO) or Medical Director to discuss the approach and information needed for the review.

• CMO or Medical Director reviews the QOC referral to decide whether or not it is appropriate for a QOC review.

• When a QOC review is opened, the CMO or Medical Director decides to request medical records or send a letter to the facility’s leadership regarding the issues.
  o Medical Records
    ▪ The nurse reviewer will review Medical Records and report the findings to CMO or Medical Director. CMO or Medical Director may request additional information from the facility’s leadership if needed.
  o Letter to the facility’s leadership
    ▪ The facility may be asked to conduct the investigation and report the findings to UCare.

• If the facility’s response is not satisfactory, UCare may perform an independent review to ensure that appropriate investigation and action is taken.

• If the QOC review indicates a potential serious outcome for other UCare members, it may include temporary suspension of member access to the service(s) provided by the provider and transition of current members to the care of another provider, pending the completion of the QOC review.

• The CMO or Medical Director makes the final determination if a QOC issue exists, its severity level and the action to be taken regarding the case.

• If the QOC issue is substantiated, the CMO or Medical Director decides if notification to the facility is appropriate. If it is, UCare notifies the appropriate person responsible for supervising the involved provider or staff (e.g., clinic or hospital Medical Director, nursing facility Director of Nursing, etc.) regarding the QOC review outcome.

• If a QOC issue is substantiated and notification is appropriate, the Chief Medical Officer or Medical Director makes recommendations in the letter about areas of potential process or service improvement. The provider is responsible for ensuring that appropriate measures are implemented to prevent recurrent issues. The provider is then monitored through the threshold monitoring process.

Clinic Responsibilities: Appeals and Grievances

REPORTING REQUIREMENT

Primary care clinics or care systems are required to send a quarterly report to UCare listing all written and oral grievances that the clinic received from UCare members. Minnesota Rule requires that UCare conduct ongoing evaluation of all member grievances, including those from participating providers (Minnesota Rule 4685.1110 Subpart 9).

Quality Complaint Reporting Form
Grievances from the member or their representative about the provider group should be investigated and resolved by the provider group, whenever possible.

**RESPONSIBILITIES**

The primary care clinic or care system will:

- Designate the responsibility of handling and resolving grievances to a person(s) with appropriate skills and authority.
- Have internal grievance policies and procedures that outline the clinic’s process for receipt, documentation, investigation and resolution of grievances. In addition the clinic will have systems to review trends in grievances for possible quality improvement endeavors.
- Determine if the member’s concern is an appeal (disagreement with decision to pay or authorize coverage of a service). See preceding sections for definitions.
- Log all grievances from UCare members on the Quality Complaint Reporting form. If the clinic uses another form or a computerized tracking system, the report must include all of the information contained on the Quality Complaint Reporting Form.
- Submit the online Quality Complaint Reporting Form to UCare within 30 days after the end of the quarter.

You must complete this form even if there were no complaints/grievances for the quarter that you are reporting for. If you have any questions, please call UCare’s Provider Assistance Center at 612-676-3300 or 1-888-531-1493. Failure to comply with this procedure is considered a breach in contractual responsibilities.
- UCare will monitor receipt of the report and trends in complaint issues.

If the member’s concern is an appeal, direct the member to do one of these:

- Call UCare Customer Services: Phone numbers and hours of operation are on the member ID card.
- Call UCare Appeals and Grievances: 612-676-6841 or 1-877-523-1517.
- Fax the request for an appeal to UCare Appeals and Grievances at 612-884-2021 or 866-283-8045.

UCare is responsible for the receipt and resolution of all member appeals.

- If the grievance issue is about a UCare process, department, etc., the member should be directed to UCare Customer Services.
- Document oral and written grievances expressing dissatisfaction about the clinic’s practitioners, facility, services, process, etc. Grievance issues may include:
  - Access Issues: Grievances about referral process, service timeliness, appointment scheduling, wait times, access to medical information, availability of handicap services, geographic options, access to culturally diverse members, etc.
  - Communication or Behavior Issues: Grievances that the provider or clinic’s communication or behavior was rude, unprofessional, inappropriate, uncooperative, rushed, unresponsive, uncaring, culturally insensitive, etc.
  - Coordination of Care Issues: Grievances about failure to follow up with the member on a health concern, information not provided or available at time of care, lack or delay of
provider communication with each other, lack of coordination of care, delay in referrals to other care, etc.

- Technical Competence or Appropriateness of Care Issues: Grievances about failure or delay in diagnosis, inappropriate or incomplete treatment, incorrect diagnosis, ordering of wrong test, incomplete examination or assessment, procedural errors, performing procedure/service outside scope of practice or expertise, failure to refer to specialist, etc.

- Facilities or Environment Issues: Grievances about physical accommodation of patient needs, temperature of room, uneven sidewalks, uncomfortable environment, equipment malfunctions, infection control, cleanliness, etc.

  - Investigate, resolve and communicate the outcome or resolution for the grievance to the member or their representative.

Timelines for resolution, as defined by state and federal regulations, are: 10 calendar days for oral grievance and 30 calendar days for written grievance.

If it is in the member’s best interest to seek more information an extension of 14 additional calendar days can be done.

If the member is not satisfied with the outcome or resolution they should be given options for further consideration of their grievance. The member can be directed to:

- Call UCare Customer Services to file a grievance.
- For Minnesota Health Care Programs, members can contact the Minnesota Department of Health or the Department of Human Services (see preceding section for phone numbers).
Medical Necessity Criteria for Services Requiring Authorization

In order for services to be eligible for payment by UCare, the services must meet UCare’s standards for coverage, including medical necessity criteria. Coverage and benefits vary significantly among different UCare plans. Refer to the Evidence of Coverage, Member Handbook or Member Contracts specific to the member’s UCare plan.

See the following sections of the Provider Manual for additional details:

- Skilled Nursing Facility Services
- Home Care Services
- Request form for Medical Necessity Coverage Criteria

Minnesota Heath Care Program and Medicare Plans

Medical Necessity Criteria

Click on the above link to open a chart showing criteria and reference sources for the following procedures/services for State and Federal Programs:

- Acute inpatient rehabilitation
- Back (spine) surgery
- Bariatric surgery (gastric bypass)
- Bone growth stimulator
- Cosmetic or reconstructive procedures
- Durable medical equipment
- Genetic testing
- Home health care (SNV, HHA) (for UCare Connect and UCare Connect + Medicare products only)
- Long-term acute care (LTAC)
- Outpatient therapy
- Proton Beam therapy
- Skilled nursing facility (SNF) and swing bed admission
- Spinal cord stimulation
- Vagus Nerve Stimulator
- Vein procedures
- Wheelchairs and accessories

OVERVIEW OF MEDICAL NECESSITY

UCare uses a hierarchy of medical necessity clinical decision support tools and published criteria when evaluating medical necessity. This hierarchy is product specific. For Medicare products, UCare uses the following:
• McKesson InterQual nationally recognized evidence-based medical necessity criteria guidelines.
• Written criteria developed and published by Medicare.
• National coverage determinations (NCDs) and local coverage determinations (LCDs) may be used for medical necessity decisions for members with Medicare benefits for the following products:
  o UCare Medicare Plans
  o Minnesota Senior Health Options (MSHO)
  o EssentiaCare
  o UCare Medicare with Fairview & North Memorial
  o UCare Connect + Medicare
• Minnesota Medicaid medical necessity criteria are used for coverage determinations for the following products:
  o Prepaid Medical Assistance Program (PMAP)
  o MinnesotaCare (MnCare)
  o Specials Needs Basic Care (SNBC)
  o MSHO (when Medicare is not met)
  o UCare Connect + Medicare (when Medicare is not met)
  o Minnesota Senior Care Plus (MSC+)
• UCare’s Medical Policy may be used for decision-making for state and federal programs when InterQual and the regulatory criteria established by Medicare or Minnesota Medicaid are not met.

GENERAL REFERENCES

• Medicaid clinical criteria resource: Minnesota Health Care Programs (MHCP) Provider Manual
• Medicare clinic criteria resource: CMS Medicare Coverage Database at National Coverage Determinations (NCD), Local Coverage Determinations (LCD) CMS Gov Medicare-coverage-database
• National Government Services
• UCare Medical Policy

UCare Individual & Family Plans, UCare Individual & Family Plans with Fairview

During 2019, UCare will temporarily suspend the requirement for prior authorizations for services delivered to members with UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview (previously called UCare Choices and Fairview UCare Choices). This means providers will not need to submit prior authorization requests for medical services, behavioral health services and provider-administered drugs for these members from dates of service of Jan. 1, 2019, to Dec. 31, 2019.

Notification requirements will remain in effect for: inpatient services, skilled nursing facility admissions, nursing home facility admissions, and transplants.
For specific questions, contact the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.

**Behavioral Health Level of Care and Determination of Medical Necessity**

In order to determine if a level of care is medically necessary or meets the community standard of care, UCare adopted criteria created by: Medicare, the Minnesota Department of Human Services (DHS), Minnesota Administrative Rules, InterQual Behavioral Health Level of Care and UCare Medical Policies. Below you will find links to criteria that UCare has adopted and information on how to request a copy of the criteria utilized to make a decision. Also visit the [Behavioral Health](#) section for more information on services.

**GENERAL REFERENCES FOR BEHAVIORAL HEALTH SERVICES**

- State Public Programs ([Minnesota Health Care Programs (MHCP) Provider Manual](#))
- Medicare Products ([Medicare Coverage Database – Centers for Medicare & Medicaid Services](#))
- Medicare Products ([National Government Services](#))
- Medical Policies ([UCare Medical Policies](#))

InterQual Behavioral Health Level of Care – request a copy [UCare Medical Necessity Criteria Request form](#).
Clinical Practice Guidelines - Medical & Behavioral Health

UCare adopts and disseminates clinical practice guidelines to support good decision-making by patients and clinicians, improve health care outcomes, and meet state and federal regulatory requirements. Guidelines are designed to assist clinicians by providing a framework for the evaluation and treatment of members.

UCare adopts guidelines to assist health care professionals and providers in recommended courses of intervention but not as a substitute for the advice of a physician or other knowledgeable health care professional or provider. Guidelines can serve as a tool to identify areas of clinical improvement.

Medical

UCare, through the Quality Improvement Advisory and Credentialing Committee (QIACC), adopts medical clinical practice guidelines from nationally or locally recognized sources. Sources may include medical specialty societies and other professional organizations. The guidelines are based on reasonable medical evidence or a consensus on clinical treatment patterns by physicians in the selected field of practice.

The UCare QIACC reviews and approves the content of the medical guidelines at least every two years. To determine provider compliance with current guidelines, UCare annually audits clinic performance against established guidelines using a reasonable sample and appropriate data source. The results are included in the Annual Quality Program Evaluation.

The format of UCare’s clinical practice guidelines includes the primary source with a direct link to online content, modifications (if needed) for our unique populations, rationale for modifications and additional references if available.

Currently, UCare has seven medical clinical practice guidelines:

- **Asthma, Diagnosis and Management**
  Primary Source: Global Initiative for Asthma

- **Diabetes, Type 2; Diagnosis and Management**
  Primary Source: American Diabetes Association

- **Management of Heart Failure in Adults**
  Primary Source: Journal of the American College of Cardiology (JACC)

- **Obesity in Adults; Prevention and Management**
  Primary Source: American Academy of Family Physicians

- **Prenatal Care**
  Primary Source: American Academy of Family Physicians

- **Preventive Services for Adults**
  Primary Source: American Academy of Family Physicians
Preventive Services for Children and Adolescents  
Primary Source: American Academy of Pediatrics Bright Futures (AAP)

**Behavioral Health**

UCare adopted five behavioral health clinical practice guidelines to support good decision-making by patients and clinicians, improve member health outcomes and meet NCQA accreditation standards. Adult guidelines are adopted from American Psychiatric Association (APA). Child and adolescent guidelines are adopted from the Journal of the American Academy of Child Adolescent Psychiatry.

- **Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder**
  Primary Source: American Academy of Child and Adolescent Psychiatry
- **Assessment and Treatment of Children and Adolescents with Depressive Disorders**
  Primary Source: American Academy of Child and Adolescent Psychiatry
- **Treatment of Patients with Major Depressive Disorder**
  Primary Source: American Psychiatric Association
- **Treatment of Patients with Schizophrenia**
  Primary Source: American Psychiatric Association
- **Treatment of Patients with Substance Use Disorders (SUD)**
  Primary Source: American Psychiatric Association
Quality Program

UCare exists to improve the health care of our members through innovative services and partnerships across communities. UCare is committed to supporting the triple aim of improving health, delivering excellent patient experience of care, and reducing the cost of care for UCare members participating in all products.

UCare’s quality improvement program is designed to support our mission by accomplishing the following goals:

- Establish effective partnerships with providers, primary care clinics and provider networks committed to quality care.
- Establish and monitor performance in key aspects of care and service.
- Improve clinical and functional outcomes for our members.
- Address social determinants of health and health disparities for our members.
- Improve key business processes that result in better service and operational efficiencies.
- Meet or exceed quality standards set by government agencies.

We aim for continuous improvement in the quality of health care services and the health status of the populations we serve. A comprehensive quality improvement program directs our efforts.

UCare’s quality program is designed to meet or exceed the quality-related requirements of the Centers for Medicare & Medicaid Services (CMS), Minnesota Department of Health (MDH), the Minnesota Department of Human Services (DHS), Minnesota Department of Commerce (DOC) and the National Committee for Quality Assurance (NCQA).

The quality program’s scope encompasses all aspects of care delivered by participating and contracted providers. This includes medical, mental health, chemical dependency, dental, chiropractic and pharmacy services, which are provided in ambulatory, hospital, emergency department, skilled nursing facility and other settings.

UCare routinely elicits members’ perceptions of the health care services they receive and their interactions with the plan itself. UCare assesses service aspects of quality such as access, availability and other administrative issues that affect the delivery of care. UCare works with members and providers to ensure we are a responsive health plan that “does what we say we will do.” UCare also works with you, the provider, to share information, disseminate practice guidelines, and implement ways to improve care and service to our members.

Problems or concerns identified through monitoring activities and health care disparities may become performance improvement projects, focus studies or outcome studies. These activities may be related to referrals, case management, discharge planning, appointment scheduling, waiting periods to receive services, prior authorizations or other aspects of clinical care and service utilization. An action plan is developed and physician input is gained through our Quality Committee structure. After implementation of the action plan, data is collected to measure the effectiveness of our actions.
UCare identifies and implements a wide array of initiatives and projects that focus on improving the health of our members. In addition to working with our regulatory organizations, UCare collaborates with other health plans on performance improvement projects to improve the health of our members.

**Current UCare Quality Initiatives**

## Medical Record Documentation and Audits

UCare conducts an annual Medical Record Standards Audit. We review whether or not medical records are current, accurate, legible, detailed, accessible and permit effective and confidential member care and quality review of all patient interactions. We share results of these audits with providers.

At a minimum, providers should have policies and procedures in place to ensure medical record documentation meets the following criteria:

<table>
<thead>
<tr>
<th>No.</th>
<th>Medical Record Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Record is legible to someone other than the author.</td>
</tr>
<tr>
<td>2</td>
<td>For every entry, the visit note includes the practitioner's signature and credentials with the date and time documented.</td>
</tr>
<tr>
<td>3</td>
<td>Record contains a current problem list or problems are documented in the progress notes with dates.</td>
</tr>
<tr>
<td>4</td>
<td>The medication list, including OTC drugs, is updated at the last visit and is documented in the progress notes. Prescribed medications should include dosages and dates of initial and refill prescriptions.</td>
</tr>
<tr>
<td>5</td>
<td>The presence/absence of allergies/adverse reactions is documented in a consistent, prominent location. If the member has no known allergies or adverse reactions, this is noted in the record.</td>
</tr>
<tr>
<td>6</td>
<td>If the member has been referred to a specialist, the summary of care and/or operative treatment reports and other reports are present in the medical record.</td>
</tr>
<tr>
<td>7</td>
<td>If the member received care at a hospital or an outpatient care facility, the report for that care is in the medical record.</td>
</tr>
<tr>
<td>8</td>
<td>Immunizations are updated and documented on an immunization record.</td>
</tr>
<tr>
<td>9</td>
<td>Documentation exists related to the inquiry/counseling of smoking habits and/or exposure.</td>
</tr>
<tr>
<td>10</td>
<td>Documentation exists related to the inquiry/counseling of alcohol/other substances habits and/or exposure.</td>
</tr>
<tr>
<td>11</td>
<td>Abnormal lab/diagnostics are noted and there is documented follow-up*.</td>
</tr>
<tr>
<td>12</td>
<td>Documentation addresses the availability of preventive screening services.</td>
</tr>
</tbody>
</table>

*Follow-up: Forms or notes have notation of follow-up communication or visits to resolve or address any subsequent treatment or actions on the part of the patient or primary care provider. Consultation from a specialist (if needed) is formally requested and there is a plan for after the consultation with the primary care provider. Medical records should clearly document these steps and specialty consultation summaries should be included in the patient’s primary care record.
Continuity and Coordination of Medical Records

Maintaining a location for consulting or external facility patient medical records such as visit summaries, lab results and letters or progress notes is critical to ensure consistent care. Communications between providers should be in chronological order and accessible through the patient’s primary medical record. Pre- and Post-Hospitalization documentation should show the following coordination within the primary care record:

- Notification of inpatient admission on day of admission or day after; or evidence of a pre-admission exam completed in relation to a planned admission.
- Receipt of discharge information on day of discharge or day after. Discharging information must include:
  - The practitioner responsible for the member’s care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnoses at discharge.
  - Current medication list (including medication allergies).
  - Testing results or documentation of pending test results.
  - Instructions to the PCP or ongoing care provider for continued patient care.

Medication Reconciliation Post Discharge

A critical component of ensuring proper coordination of care post inpatient episode is to ensure members are having a complete medication reconciliation within 30 days of discharge. Medication reconciliations help reduce the likelihood of a readmission and can be part of a follow-up visit or can be prepared by a primary care provider without a patient encounter. Whenever possible, medication reconciliations post discharge should be billed by a provider’s office with the follow CPT codes:

- 99495: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision-making of at least moderate complexity during the service period and a face-to-face visit within 14 calendar days of discharge.
- 99496: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision-making of high complexity during the service period and a face-to-face visit within 7 calendar days of discharge.

Transitional Care Management (TCM) service codes may be used for new and established patients to the provider. For reimbursement, TCM codes require:

- Non-face-to-face communication within 2 business days of discharge;
- A face-to-face encounter within 7 to 14 days of discharge;
- Medication reconciliation and management no later than the face-to-face encounter.

Note: Inpatient status includes acute hospital, rehabilitation hospital and long-term acute care hospital.
Advanced Directives Audits and Resources

UCare conducts an annual audit of advanced directive documentation and evidence of advanced care planning found in UCare members’ medical records (for adults age 18 and older). We share results of these audits with providers. Resources for advanced care planning are made available to providers, members and care teams in the following ways:

- Honoring Choices Minnesota Resources. ([https://www.honoringchoices.org/tools-resources/informational-materials](https://www.honoringchoices.org/tools-resources/informational-materials))
- Minnesota Board on Aging’s Senior LinkAge Line: 1-800-333-2433

Questions and Answers About Health Care Directives

- Minnesota Health Care Program Members
- Medicare Members
Compliance and Fraud, Waste and Abuse

I. Preventing Health Care Fraud, Waste and Abuse

Health care fraud is a significant concern for UCare and the entire health insurance industry. According to National Health Care Anti-Fraud Association estimates, 3 to 10 percent of what Americans spend annually on health care is lost to fraud — that’s between $84 billion and $280 billion a year. Health care fraud can also put members’ safety at risk.

WHAT IS UCARE DOING ABOUT IT?

We take a proactive approach to detecting and investigating potential health care fraud, waste and abuse. UCare has a Special Investigations Unit (SIU) to detect and investigate allegations of fraud, waste and abuse. The SIU detects potential fraud, waste and abuse through ongoing audits and analysis of billing patterns. The SIU also receives reports or complaints of suspected fraud, waste and abuse. Regardless of how the issue is detected, the SIU investigates each instance of potential fraud, waste or abuse, including collection of necessary documents, data and information.

The mission of the UCare SIU is to prevent, detect, investigate, report and, when appropriate, recover money lost to health care fraud and abuse.

UCare strives to protect all health care dollars that otherwise might be lost or wasted. Our SIU works with members; providers; state, federal and other law enforcement agencies; and other health care providers to address fraud and abuse. The SIU is authorized to conduct pre-payment and post-payment reviews to ensure compliance with regulations and contract provisions.

WHAT IS FRAUD, WASTE AND ABUSE?

Federal and state laws have specific provisions describing fraud, waste and abuse, which providers must follow and UCare helps enforce. In addition, UCare’s provider contracts have important terms addressing fraud, waste and abuse.

One example of a federal anti-fraud law is the Anti-Kickback Statute (42 U.S.C. § 1320a-7b), which imposes criminal sanctions for the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of business paid by Medicaid or Medicare funds. Another example is the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), which imposes substantial financial penalties against a provider for certain activities including knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way, or offering or giving something of value to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services.

The following are more examples of fraud, waste and abuse.

**Fraud:** This occurs when someone makes a false statement, false claim or false representation to UCare where the person knows or should reasonably know the statement, claim or representation is false; and
where the false statement, claim or representation could result in an unauthorized benefit to the person or some other person.

Fraud includes, but is not limited to, intentionally committing the following acts:

- Billing for services or supplies that were not provided.
- Altering claims to receive a higher payment.
- Offering bribes or kickbacks in exchange for referrals.
- Allowing someone who is not eligible for UCare coverage to use a member’s ID card.
- Altering or creating documents to show delivery of items not received or services not rendered.

**Abuse:** This is any of the following:

1. A pattern of practice that is inconsistent with sound fiscal, business or medical practices and either directly or indirectly result in unnecessary costs to UCare, or that fail to meet professionally recognized standards for health care, including:
   - Practices that result in unnecessary costs to the federal and state program funds that UCare administers.
   - Practices that result in reimbursement for services that are not medically necessary.
   - Practices that fail to meet professionally recognized standards for health service.

   Abusive practices are not one-time errors. They include misusing codes on a claim, such as upcoding or unbundling codes as well as balance billing or imposing unauthorized charges on members.

2. Enrollee practices that result in unnecessary cost to UCare.

3. Substantial failure to provide medically necessary items and services that are required to be provided to an enrollee if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the enrollee.

**Waste:** This is any over-utilization of services and misuse of resources that is not caused by fraud or abuse.

Examples of waste include:

- Ordering excessive laboratory tests.
- Submitting excessive duplicate claims.

**DOCUMENTATION**

Providers must develop and maintain health service records in order to seek a claim for payment from UCare. Each occurrence of a health service must be documented and retained in the member’s health record in accordance with UCare, state and federal requirements. Claims paid for health care, services, supplies or equipment not documented in the health service record are subject to recovery by UCare, and may be considered fraud, waste or abuse.

The record must be legible at a minimum to the individual providing the care or service and contain the following elements, when applicable:
• The date on which the entry is made.
• The date or dates on which the health service is provided.
• The length of time spent with the member, if the amount paid for the service depends on time spent.
• The signature and title of the person from whom the member received the service.
• Report of the member’s progress or response to treatment, and changes in the treatment or diagnosis.
• The countersignature of the supervisor and documentation of supervision (if applicable).
• A copy of authorization for the service or item (if applicable).
• All other state and/or federal requirements.

In addition, the record must state, as applicable:

• The member's case history and health condition as determined by the provider’s examination or assessment.
• The results of all diagnostic tests and examinations.
• The diagnosis resulting from the examination.
• Reports of consultations that are ordered for the member.
• The member’s plan of care, individual treatment plan or individual program plan.
• The record of a laboratory or radiology service must document the provider's order for service.
• For other service-specific record requirements, refer to the appropriate chapter in this manual.

INVESTIGATIVE PROCESs

UCare, in conducting fraud, waste and abuse investigations, may:

• Interview providers, members or other witnesses.
• Visit a provider’s facility to collect records and/or inspect the equipment and premises.
• Request records via mail, fax or verbal request.
• Inspect business records, payroll, inventory or other items.

Providers are required to cooperate with UCare’s audit or investigation, consistent with your UCare contract provisions, UCare policy and applicable laws. Failure to cooperate may result in claim payments being denied or recovered by UCare.

If an investigation finds there is evidence of fraud, waste or abuse, UCare may recover identified overpayments, place the provider on a corrective action plan, bar the provider from billing certain codes, require pre-payment review of claims or submission of records, and if necessary, suspend or terminate the provider’s participation. If a credible allegation of fraud is uncovered, UCare must suspend payment to the provider in accordance with Minnesota Department of Human Services’ requirements and applicable law. As required by law, UCare makes referrals to appropriate law enforcement agencies.

HOW CAN YOU AVOID AND PREVENT HEALTH CARE FRAUD?

Avoid and prevent fraud by following applicable laws and regulations along with UCare’s contract requirements for claims submission and payment. Here are some other tips:

• Always remain current with billing and coding requirements for your area of service.
Monitor your patient base for potential card sharing and other acts of misrepresentation.
Only bill for service or equipment actually rendered, and only that which has been properly documented.
Implement internal audit or self-audit protocol to identify mistakes and errors in billing.
Proactively void, replace or request adjustment to any claims you identify as erroneous (see Claims section).
Most importantly, report any suspected fraud, waste or abuse to UCare (See “Contacting UCare” below).

II. OBLIGATIONS for Providers of Services to Medicare and/or Medicaid Enrollees

Providers of administrative or health care services to Medicare and/or Medicaid-eligible individuals, including UCare’s Medicare Advantage plans, are considered first-tier entities as defined by the Centers for Medicare and Medicaid Services (CMS). (See CMS Medicare Managed Care Manuals Chapters 9 and 21). To meet the CMS requirements related to UCare’s oversight of first-tier entities, we require providers to attest to the following:

1. Provider confirms that its owners, controlling interest parties, managing employees, employees and applicable downstream entities are not excluded from participation in state and/or federal health care programs prior to hire or contract, and annually thereafter.
2. Provider’s Code of Conduct is comparable to UCare’s Code of Conduct in that it meets the requirements of Medicare Managed Care Manuals Chapters 9 and 21.
3. Employees and applicable downstream entities have completed compliance and fraud, waste and abuse training that meets required standards. CMS requires completion of compliance and fraud, waste and abuse training by employees of organizations that provide health care or administrative services for Medicare and/or Medicaid–eligible individuals under the Medicaid, Medicare Advantage or Medicare Part D programs. This training must be completed within 90 days of hire and annually thereafter. The annual training must be completed no later than December 31 each year.
4. Provider will report suspected Medicare and/or Medicaid program violations and/or fraud, waste and abuse concerns to UCare and provider’s employees are trained on reporting processes including to the appropriate health plan. UCare has a strict no retaliation policy for good faith reporting.

Failure to report suspected Medicare and/or Medicaid program violations and/or fraud, waste and abuse concerns may result in disciplinary action up to and including termination of provider’s contract with UCare.

5. Monitoring your downstream entities. Providers, who are first-tier entities, as defined in the Medicare Managed Care Manuals Chapters 9 and 21, must ensure they have a system in place to monitor any of their downstream entities’ compliance with Medicare and/or Medicaid program requirements. Prohibited affiliations per 42 CFR 438.610 must be reported immediately in writing to UCare upon discovery.
6. To accomplish oversight of these Medicare and/or Medicaid requirements, UCare may:
   • Audit the provider;
   • Require self-monitoring reporting, such as training completion evidence, of the provider; and
   • Require the provider complete a survey or submit an attestation.

III. UCare’s Code of Conduct

As a provider serving UCare’s members, you are a critical component of UCare’s corporate culture of integrity and openness. UCare’s Code of Conduct reflects the ethical and legal expectations for our employees, volunteers, Board of Directors and business partners—such as you. UCare’s mission and values, and this Code of Conduct, express a consistent message of doing the right thing for UCare members, UCare’s employees and company, our business partners and government agencies. Please see Section D. Doing Right for Our Providers and Business Partners starting on Page 14 for provider-specific expectations related to UCare’s Code of Conduct.

UCare Code of Conduct

CONTACTING UCARE

If you suspect any of the above situations, or if you have any questions, please contact our toll free Compliance hotline at 1-877-826-6847. You may remain anonymous. If you are calling after hours, please leave a message with information about the situation you’ve observed, and the best way to contact you if applicable.

You may contact UCare regarding concerns the following ways:

   • Call the UCare Compliance hotline: 1-877-826-6847 toll free (anonymous and available 24/7)
   • Email your concern to: Compliance@UCare.org
   • Mail your concern to:

     UCare Special Investigations Unit
     P.O. Box 52
     Minneapolis, MN 55440-0052

IV. Risk Adjustment Data

Risk adjustment is a process that predicts the insurer’s enrollees health care expenditures based on their demographics (age/gender) and their health status (diagnostic data). Based on these predictions, a health plan receives capitated payments each month to cover the beneficiaries’ health care expenses. This differs from standard fee-for-service payments where payment is received for each service provided.

Risk scores are determined by reported diagnoses (ICD-10-CM codes) via encounter data. UCare must provide valid and accurate encounter data to government agencies for calculating risk adjustment payments. The primary source of encounter data submitted for this calculation is extracted from claims with additional health conditions being identified during chart review and health assessments. UCare
requires providers to submit complete, accurate and truthful encounter data. Risk adjusted payments occur in Medicare Advantage, Minnesota State health care programs and the MNsure exchange marketplace.

The provider’s role in risk adjustment includes:

- Code identified conditions in accordance to the current ICD-10-CM Official Guidelines for Coding and Reporting to the highest level of specificity.
- Documentation should be complete, clear, concise, consistent and legible.
- Reported diagnosis codes must be supported by the medical record documentation from a face-to-face encounter between the patient and the provider.
- Document all conditions being assessed during the encounter including those conditions that coexist and affect patient treatment or management.
- Document all active conditions including health status conditions at least annually to report the complete health profile.
- Document “history of” to indicate only those conditions that are no longer present. Do not use to report a condition that is present and actively being treated or monitored.
- Document an evaluation/assessment and plan for all active conditions. Diagnoses listed solely in a problem list are not acceptable for risk adjustment. Examples of assessment language: stable, improved, tolerating treatment, unstable, etc. Example of plans: monitor, d/c meds, continue current med, refer to, change med, etc.
- Records must be signed with credentials from the rendering provider.
- Use of standard abbreviations.
- Each progress note must “stand alone.” Do not refer to previous progress notes or problem lists.

The requirements for risk adjustment data imposed by CMS for Medicare Advantage plans are stated in 42 C.F.R. § 422.310 as well as other CMS guidance documents; and for MNsure exchange plans are stated in 45 C.F.R. § 153.610. UCare’s provider contracts require providers to follow CMS requirements in submitting accurate risk adjustment data and maintaining supporting medical documentation, and imposes financial penalties for a provider’s non-compliance.

Annually, CMS has stated it will audit a selection of Medicare Advantage plans to validate encounter data via a risk adjustment data validation (RADV). HHS requires all Affordable Care Act (ACA) exchange plans to participate in a data validation audit yearly. During an audit, it is imperative that providers cooperate with UCare in providing relevant medical records to support the sampled encounter data. CMS will intervene and take action against providers that do not cooperate with these audits.

It is expected that providers have quality assurance processes in place to validate the diagnosis codes submitted on claims (encounter data), and to report to UCare immediately any corrections or issues with respect to previously submitted codes. UCare’s expectation is that providers cooperate and support our internal chart review by providing access to specific member medical records to facilitate a risk adjustment chart and quality review in accordance with CMS guidelines.
Culturally Responsive Care

UCare actively supports and promotes behaviors, attitudes and policies that enable providers to deliver services in ways that meet the needs of consumers from diverse cultures.

What is Cultural Competence? Why is it Important?

Culturally responsive care, or cultural competence in health care, is defined as the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families and communities.

Cultural competence is important in every aspect of our public lives, but is critical for health care providers, who deal daily with diverse people in life-and-death situations. Find more resources on the Provider Manual web page, under Cultural Resources.

This definition is from the Minnesota Public Health Association’s Immigrant Health Task Force in the Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees report:

Culturally competent health care can contribute to better health outcomes, improve diagnostic accuracy, increases adherence to recommended treatment and is potentially cost efficient.

- It allows the provider to obtain complete information to make an appropriate diagnosis.
- It facilitates the development of treatment plans that are followed by the patient.
- It reduces delays in seeking care.
- It enhances overall communication between provider and patient.
- It enhances the compatibility between western health practices and traditional cultural health practices.

The culturally responsive provider:

- Has the knowledge to make an accurate health assessment, one which takes into consideration a patient’s background and culture.
- Has the ability to convey that assessment to the patient, to recognize culture-based beliefs about health and to devise treatment plans that respect those beliefs.
- Is willing to incorporate models of health and health care delivery from a variety of cultures into the biomedical framework.
- To be culturally competent, a provider should acknowledge culture’s profound effect on health outcomes and should be willing to learn more about this powerful interaction.
Diversity and Cultural Competence

UCare has a high concentration of members from non-white backgrounds across its MSHO, MSC+ and SNBC products. Out of its 294,667 State Public Program members, 110,932 identify as non-white and 85,815 register as unknown. Within PMAP and MinnesotaCare products, we have a large amount of members that register as language “unknown.” After that, Somali, followed by Hmong, are the two most highly represented non-English languages within UCare’s membership. UCare is a leader in serving members from many cultural backgrounds. We support members who speak more than 18 different languages, and serve more than 140,000 members from diverse cultural backgrounds.

The following chart illustrates the diverse membership enrolled in the Minnesota Health Care Programs UCare offers as of October 2018, as a percentage of enrollment:

<table>
<thead>
<tr>
<th>Self Identified Race</th>
<th>PMAP</th>
<th>MSC+</th>
<th>MnCare</th>
<th>MSHO</th>
<th>Connect+</th>
<th>Medicare</th>
<th>Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASIAN OR PACIFIC ISLANDER (ORIENTAL)</td>
<td>5.77%</td>
<td>20.03%</td>
<td>9.16%</td>
<td>18.43%</td>
<td>11.65%</td>
<td>7.75%</td>
<td></td>
</tr>
<tr>
<td>BLACK OR AFRICAN/AMERICAN</td>
<td>22.60%</td>
<td>32.40%</td>
<td>14.97%</td>
<td>18.36%</td>
<td>22.36%</td>
<td>22.40%</td>
<td></td>
</tr>
<tr>
<td>HISPANIC</td>
<td>7.26%</td>
<td>3.22%</td>
<td>5.25%</td>
<td>2.82%</td>
<td>3.25%</td>
<td>2.74%</td>
<td></td>
</tr>
<tr>
<td>NATIVE AMERICAN (AMERICAN INDIAN / ALASKAN NATIVE)</td>
<td>2.07%</td>
<td>1.23%</td>
<td>1.36%</td>
<td>0.84%</td>
<td>1.46%</td>
<td>3.57%</td>
<td></td>
</tr>
<tr>
<td>PACIFIC ISLANDER</td>
<td>0.22%</td>
<td>0.06%</td>
<td>0.42%</td>
<td>0.09%</td>
<td>0.13%</td>
<td>0.06%</td>
<td></td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>34.10%</td>
<td>3.24%</td>
<td>32.68%</td>
<td>2.06%</td>
<td>2.16%</td>
<td>3.93%</td>
<td></td>
</tr>
<tr>
<td>WHITE/CAUCASIAN (NOT OF HISPANIC ORIGIN)</td>
<td>27.88%</td>
<td>39.73%</td>
<td>36.53%</td>
<td>57.41%</td>
<td>59.06%</td>
<td>59.51%</td>
<td></td>
</tr>
</tbody>
</table>

UCare seeks to ensure members receive the care they need to maintain or improve their health. Several cross-departmental committees analyze a variety of data sources by race/ethnicity as well as other factors as a means to identify trends, barriers and root causes of utilization increase or decline that may indicate barriers to care. Data sources include the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Health Outcomes Survey (HOS) results, plus additional data such as claims, predictive modeling and population health analysis data. This analysis helps UCare better understand how to target interventions at improving members’ health.

**Culture Care Connection**

This online learning and resource center (developed by Stratis Health with UCare funding) supports health care providers, staff and administrators in their efforts to provide culturally competent care in Minnesota.

**Cultural Competence Self-Assessment Tool**

This questionnaire can help assess your strengths and training needs in addressing the cultural diversity of your patients and colleagues. Feel free to copy this survey to use with your staff members.
Culture & Health Resource List

National and local website and contacts.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

Issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

LEARN: Process for Improved Communication

UCARE INNOVATIONS IN CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

1. UCare’s Cultural Competence Plan addressed all 15 CLAS standards.
2. UCare involves its members to ensure that our health care services are patient focused. Examples include: Members comprise 40 percent of our Board of Directors; convene regular Member Advisory Committees; we conduct periodic focus groups to receive input from a diverse range of community representatives.
3. UCare is recognized nationally by health professionals for our work. An example is the America’s Health Insurance Plans awarding UCare with the Ellis J. Bonner Community Leadership Award for our Hmong Outreach Program, aimed at bridging the cultural gap separating the Hmong population and U.S. health care practitioners.
4. UCare developed a CMS-recognized cultural competence section for our Provider Manual.
5. UCare’s work force reflects the community we serve. Thirty percent of UCare employees are persons of color or American Indian. All new employees are required to attend “Valuing and Managing Diversity” training.
6. UCare integrates the cultural needs of our members into our daily activity. Examples include: an agreement with the Community Family Doula Program to provide prenatal and childbirth education to diverse pregnant members (Spanish-speaking, Native American, African born, teens, etc.); providing leadership for the Minnesota Community Health Worker (CHW) Alliance that supports the role of CHWs, which is a helpful approach in addressing health disparities.
7. UCare works with providers to improve cultural responsiveness, including using a clinic-specific cultural competency assessment tool and supporting activities that assist providers through the Culture Care Connection initiative led by Stratis Health throughout Minnesota (see www.culturecareconnection.org).
8. The UCare Foundation and community benefit program grants support community partner and county programs to reduce disparities in health care service and delivery across the state.
They also help fund research and provide infrastructure improvements to better service diverse and emerging populations at community clinics.

9. UCare addresses interpreter service needs, by actively participating in the Interpreting Stakeholder Group (ISG) to assure that improvement in interpreter services continues. We partner with TPT and community organizations to produce health-related videos and TV programs for Hmong, Latino, African American and American Indian populations. UCare also supports community education to help persons with limited English proficiency (LEP) understand their right to have an interpreter and what to expect from a trained interpreter (one tool for this is the video vignettes that the Multilingual Health Resource Exchange developed and are available on YouTube: https://www.youtube.com/channel/UCKPjzRExkJqYtnbTPomxqlw/videos.

10. UCare provides health information through innovating partnerships, and is a “funding partner” of the Multilingual Health Resource Exchange, a web-based clearinghouse of health materials in multiple languages (http://health-exchange.net/). To download multi-lingual health materials, use our Log-in: UCare and Password: UCare.

Interpreter Services

Find these guidelines in the Interpreter Services section:

- Access to interpreter services
- Arranging for interpreter services
- Contact information for UCare-contracted interpreter service agencies
- Interpreter requirements
- Service reimbursement and claims processing
- Professional standards for interpreters
- Guidelines for working with interpreters
- Interpreter services requirements and performance expectations

MINNESOTA INITIATIVES TO IMPROVE INTERPRETER TRAINING & SERVICES

Online resources from UMTIA
Interpreting Stakeholder Group
Disease Management Programs

UCare offers disease management programs to our members living with diabetes, heart failure and asthma. These programs reinforce and complement the provider-patient relationship, increase the patient’s level of self-care and improve health outcomes. The member’s primary care provider is notified of member enrollment into the disease management program. Please review our disease management programs and complete the referral form(s) for members that you feel would benefit from diabetes, heart failure or asthma disease management.

Candidates for our programs include those who:

- Are not checking their blood sugars as directed or weighing themselves daily.
- Are experiencing challenges with management of their chronic condition.
- Are not adhering to their chronic condition medication.
- Do not understand their diagnosis and could benefit from education/coaching on their condition.
- Are looking to improve their health through learning how to manage their chronic condition.

Asthma

Pediatric and adult members (under 65) in our asthma program receive a home asthma visit (if within 60 miles of the metro area) followed by regular asthma education and care management phone calls. This program helps members and families manage their asthma to lead a healthy lifestyle. Asthma management tools, such as pillowcase covers, medication chambers and other informative materials, are provided to participating members.

Diabetes

Adult members in our diabetes program receive regularly scheduled health coaching calls with a UCare health coach. Our team of coaches partners with members to discover their barriers and vision for the future, establishes short- and long-term behavior change goals, and empowers members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Diabetes management tools, such as our award-winning Health Journey education book, pedometer, diabetic bracelets/necklace, cookbooks and wrist blood pressure cuff, are provided to participating members.

Heart Failure

Healthy Hearts: Adult members in our Healthy Hearts heart failure program receive regularly scheduled health coaching calls with a UCare health coach. Our team of coaches partners with members to discover their barriers and vision for the future, establishes short- and long-term behavior change goals, and empowers members to achieve their goals. Health coaches use active listening, motivational
interviewing and behavior change techniques. Heart failure management tools, such as our award-winning Health Journey education book, bathroom scale, wrist blood pressure cuff and cookbooks, are provided to participating members.

**Telemonitoring program:** Adult members in our high-risk heart failure program receive a Medtronic telemonitoring scale to assess daily weight and heart failure symptoms. Member data is transmitted to a Medtronic RN for triage, assessment and follow up. If member data suggest a flare up of heart failure, the PCP is contacted. In addition, the member receives monthly RN phone calls with education on heart failure, co-morbid conditions and lifestyle management. Recent telemonitoring data is made available for member physician office visits. The telemonitoring scale is available in English, Hmong and Spanish.
Health Promotion Programs

UCare is committed to helping keep our members healthy and safe. The following Health Promotion programs and resources are available to eligible UCare members. Visit UCare’s Health and Wellness web page to learn more.

Fitness Programs | UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare

UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare members may choose one of two fitness benefit options.

OPTION 1: HEALTH CLUB SAVINGS

- A reimbursement of up to $20 maximum per month to participating health clubs. (SilverSneakers clubs are excluded from participating in the Health Club Savings program.)
- For a list of participating locations, visit our Health Club Savings page.
- To enroll, members show their UCare member ID card when they sign-up at a participating location.

OPTION 2: SILVERSNEAKERS®* FITNESS PROGRAM

- Free basic fitness center membership. Visit www.silversneakers.com for a complete list of participating locations.
- Group exercise classes taught by certified instructors.
- SilverSneakers at home fitness or wellness kit.
- Access to SilverSneakers Online. The SilverSneakers member website is a complete, easy-to-use wellness resource. This secure member community lets members create exercise and nutrition plans; track fitness progress; and find health articles, recipes and more.
- Eligible members receive a SilverSneakers card or participation letter in the mail with their SilverSneakers ID barcode. If a replacement card is needed, members can call UCare Customer Service to request a duplicate card or print a card from the SilverSneakers website at www.silversneakers.com.

Fitness Programs | UCare’s Minnesota Senior Health Options (MSHO), UCare Connect and UCare Connect + Medicare

SILVERSNEAKERS® FITNESS PROGRAM

- Free basic fitness center membership. Visit www.silversneakers.com for a complete list of participating locations.
• Group exercise classes taught by certified instructors.
• SilverSneakers at home fitness or wellness kit.
• Access to SilverSneakers Online. The SilverSneakers member website is a complete, easy-to-use wellness resource. This secure member community lets members create exercise and nutrition plans; track fitness progress; and find health articles, recipes and more.
• Eligible members receive a SilverSneakers card or participation letter in the mail with their SilverSneakers ID barcode. If a replacement card is needed, members can call UCare Customer Service to request a duplicate card or print a card from the SilverSneakers website at www.silversneakers.com.

Fitness Programs | UCare Individual & Family Plans, UCare Individual & Family Plans with Fairview

HEALTH CLUB SAVINGS

• Members must be 18 years or older to qualify.
• A reimbursement of up to $20 per month with a minimum of 12 visits per month at a participating health club.
• Members with family coverage may add one covered dependent (must be 18 years or older) to qualify for a total credit of up to $40 per month.
• For a list of participating locations, visit our Health Club Savings page.
• To enroll, members show their UCare member ID card when they sign-up at a participating location.

Fitness Programs | Prepaid Medical Assistance Program (PMAP - Medical Assistance/MA) and MinnesotaCare

HEALTH CLUB SAVINGS

• Members must be 18 years or older to qualify.
• A reimbursement of up to $20 per month with a minimum of 12 visits per month at a participating health club.
• For a list of participating locations, visit our Health Club Savings page.
• To enroll, members show their UCare member ID card when they sign-up at a participating location.

Community Education Classes

Members get up to a $15 discount on most community education classes in Minnesota. Check a local community education catalog or contact the local school district for class times and locations. Member may get their discount, by showing their UCare member ID card when enrolling in a class.
UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, UCare Individual & Family Plans, and UCare Individual & Family Plans with Fairview include a limit of three discounts in a calendar year (one discount per class enrollment) starting 1/1/2019.

UCare Families & Children (PMAP, MNCare), UCare’s MSHO, UCare Minnesota Senior Care Plus, UCare Connect and UCare Connect + Medicare Plans include unlimited discounts in a calendar year (one discount per class enrollment).

**Connect to Wellness Kit**

Available to UCare Connect and UCare Connect + Medicare members. Each kit includes engaging tools to help improve health and wellness – at no cost! Members may choose one of the following kit options:

- Kit A: Stress Relief
- Kit B: Tai Chi
- Kit C: Sit & Be Fit for a seated fitness option
- Kit D: Latin Dance

One kit per member per calendar year. For more information and to get an order form for the Connect to Wellness Kit, members should call UCare Customer Services at the number on the back of their member ID card. Kit information can also be found on our [Connect to Wellness kit](#) page.

**Dental Programs**

**DENTAL CARE KIT**

Available to MSHO and UCare Connect + Medicare members. Each kit includes a Sonicare electric toothbrush, sensitive teeth toothpaste and dental floss to help members with oral health.

**UCARE MOBILE DENTAL CLINIC**

The Mobile Dental Clinic offers dental check-ups, cleanings and simple restorative care to UCare members who have limited access to quality dental care. All care is provided by faculty-supervised dental, dental hygiene and dental therapy students from the University of Minnesota School of Dentistry, UCare’s Mobile Dental Clinic (MDC) partner.

The clinic is a specially designed, wheelchair-accessible, 43-foot “dentist's office on wheels.” It has three dental chairs, state-of-the-art instruments, chairside digital radiography and an electronic health record system.

Any UCare member with a UCare dental benefit may schedule a visit on the Mobile Dental Clinic. For appointments call 1-866-451-1555 Monday through Friday 8 am - 4:30 pm.

For a complete schedule of the Mobile Dental Clinic visit [UCare.org/mdc](#).

**LivingWell Kid Kit**

Available to UCare’s PMAP and MinnesotaCare members ages 17 years and younger. Members can call Customer Services to request a kit or an order form. Members can select one of four available kits.
- Kit 1: Fitness and activity tools
- Kit 2: De-stress coloring book and fidget toys
- Kit 3: Dental kit for little kids (small, youth size tooth brush)
- Kit 4: Dental kit for tweens/teens (larger, size tooth brush)

One kit per member age 17 or younger per calendar year. Order forms and kit information can also be found on our LivingWell Kid Kit page.

**Management of Maternity Services (MOMS) Program**

UCare wants members to have a great pregnancy and a healthy baby. Our MOMS Program gives members in PMAP, MinnesotaCare, UCare Connect and UCare Connect + Medicare important information to help them stay healthy during and after pregnancy. Eligible members can earn $75 gift cards when they have early prenatal and timely postpartum visits. Members are offered telephonic nurse education. Once the baby is born, breastfeeding members are eligible for lactation services and can request a breast pump at no charge to assist in breastfeeding when members must be separated from their babies due to work or illness (medical order required). Limits apply.

Pregnant smokers who complete an assessment with UCare’s Tobacco Quit Line during their pregnancy or within one year after delivery are also eligible for a $25 gift card.

**Pregnancy and Childbirth Education Classes**

From learning about stages of labor and options for care, to getting the basic information about newborns, childbirth and pregnancy, education classes are a great way to get ready for parenthood. Classes are offered through clinics, hospitals and other health agencies. UCare members in PMAP, MinnesotaCare, UCare Connect and UCare Connect + Medicare can take these classes, and breastfeeding classes, at no charge. No referral from a provider is needed. To find out more about classes, members should contact their OB provider or call UCare Customer Services.

While childbirth education classes are not a covered benefit for UCare Individual & Family Plan and UCare Individual & Family Plan with Fairview members, lactation classes and breastfeeding supplies recommended by Health Resources & Services Administration (HRSA) are a covered preventive benefit.

**Rewards & Incentives**

UCare offers member incentives for a variety of preventive health services. Members should call UCare Customer Services to see if they are eligible. Additional information about the services and vouchers are available on UCare’s Rewards and Incentives page.

**Seats, Education And Travel Safety (SEATS) Program**

Car seats and safety education are available at no charge to UCare members in PMAP, MinnesotaCare, UCare Connect and UCare Connect + Medicare who are pregnant or children up to age 8 through UCare’s SEATS Program. Members can call UCare Customer Services to get the name and phone number...
of a partnering agency in their area who will assist the member. Members are required to attend an education session to learn proper installation and use before receiving car seats. Typical wait time is 2 - 3 weeks. Limits apply.

**Smoking and Tobacco Cessation Programs**

UCare members may access the UCare Tobacco Quit Line at 1-855-260-9713 toll free or TTY users dial 711 toll free, or visit [https://myquitforlife.com/UCare](https://myquitforlife.com/UCare). Counselors at the quit line help members learn to live without tobacco or nicotine at no charge. The counselors provide personalized support and tools. Resources include one-on-one phone coaching; quit guide booklet; quit aids, like nicotine patches and gum; members-only website for online support; text tips and reminders; and medication options that can help fight cravings.

**Strong & Stable Kit**

Available to UCare’s MSHO and Minnesota Senior Care Plus (MSC+) members by requesting it through their care coordinator or case manager, who will order the kit for the member.

The Strong & Stable Falls Prevention Kit has:

- Helpful ideas for staying active, staying safe at home and knowing medications
- Tub grips to install on slippery areas
- A nightlight that stays lit when the power goes off and can be used as a flashlight
- A medication box
- First Step to Active Health strength and balance exercises kit

**UCare Member Perks**

UCare offers additional perks to its members – just for being members. Discounts on food and groceries as well as hearing and navigation services. Please refer to our [UCare Member Perks](https://UCare.org/healthwellness) page on UCare.org/healthwellness for a current listing.

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Behavioral Health

This chapter provides information regarding behavioral health services provided to UCare members.

Provider Assistance

Many of your questions can be answered by accessing the Provider Portal. Within the Provider Portal you will find information on notifications and authorizations entered for your organization, member eligibility and claim status. If you need assistance with the Provider Portal or you have questions that cannot be answered by using the Provider Portal, please contact the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.

To have our monthly newsletter and bulletins sent directly to your email, sign up for provider news and updates.

Please review our frequently asked questions and the content below for assistance with questions you may have regarding UCare’s Behavioral Health program.

Behavioral Health Frequently Asked Questions

Manage Your Provider File

You can access information on updating your provider profile online. Behavioral health providers currently not in the UCare network can also submit a request to join the UCare network. Please visit the Provider Center section of the provider website for information on credentialing, updating your organization information and requesting to join the UCare network.

Behavioral health providers must be set up in the UCare system for electronic claim submission. Please contact our Provider Assistance Center for guidance on being set up in our system at 612-676-3300 or 1-888-531-1493 toll free.

Mental Health Services

The list below is a summary of behavioral health services frequently provided to UCare members. The services listed are not the only behavioral health services or benefits UCare members may access. This list is intended to serve as a resource to providers; coverage and benefits vary significantly among different UCare plans. Please refer to the Member Enrollment and Eligibility section of the provider manual, member handbook or member contracts specific to the member’s UCare plan for more details.
## Mental Health Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Assessment</td>
<td>Dependent on member’s coverage and the State of Minnesota Mental Health/Behavioral Health Scope of Practice guidelines.</td>
<td>Medicare Products (UCare Medicare Plans, EssentiaCare, UCare Medicare with Fairview &amp; North Memorial) State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAF &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>Medicare practitioner and place of service rules must be followed for use of Medicare benefits.</td>
</tr>
<tr>
<td>Psychotherapy</td>
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<tr>
<td>Psychological &amp; Neurological testing</td>
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<tr>
<td>Partial Hospitalization Program</td>
<td>Medicare approved outpatient hospital or Community Mental Health Center (CMHC)</td>
<td>Medicare Products (UCare Medicare Plans, EssentiaCare, UCare Medicare with Fairview &amp; North Memorial) State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAF &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>A minimum of 20 hours per week required. A minimum of 4 to 5 hours of services per day for a child under 18 years of age.</td>
</tr>
<tr>
<td>Day Treatment (adult and children)</td>
<td>Minnesota Department of Human Services (DHS) approved adult day treatment or CTSS children’s day treatment provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAF &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>Children’s Day Treatment for State Public Programs is part of the CTSS benefit. A max of 15 hours per week. *Claims submitted in excess of 15 hours per week are subject to denial of payment.</td>
</tr>
<tr>
<td>Intensive Outpatient Dialectical</td>
<td>Minnesota Department of Human Services</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare)</td>
<td>Includes group and individual IOP DBT.</td>
</tr>
<tr>
<td>Service</td>
<td>Qualified Providers</td>
<td>Products</td>
<td>Special Instructions</td>
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</tr>
<tr>
<td>Behavioral Therapy (IOP DBT)</td>
<td>(DHS) approved IOP DBT Provider</td>
<td>Connect + Medicare, PMAP &amp; MnCare</td>
<td></td>
</tr>
<tr>
<td>Early Intensive Developmental and Behavioral Intervention (EIDBI)</td>
<td>Minnesota Department of Human Services (DHS) approved EIDBI provider</td>
<td>State Public Programs (PMA, MnCare, UCare Connect &amp; UCare Connect + Medicare)</td>
<td>Under age 21 and has autism spectrum disorder or a related condition.</td>
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</tbody>
</table>

### Mental Health Residential Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mental Health Residential Treatment</td>
<td>Minnesota Department of Human Services (DHS) approved Children’s Mental Health Residential Treatment Provider</td>
<td>State Public Programs (PMA, MnCare, UCare Connect &amp; UCare Connect + Medicare)</td>
<td>For State Public Programs, only the treatment associated with this service is covered when determined to be medically necessary by UCare. The room and board is approved by the county of residence. For Exchange, room and board and treatment associated with this service is covered when determined to be medically necessary by UCare.</td>
</tr>
<tr>
<td>Intensive Residential Treatment Services (IRTS)</td>
<td>Minnesota Department of Human Services (DHS) approved I RTS provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, MnCare &amp; PMAP)</td>
<td>Only the treatment associated with this service is covered when determined to be medically necessary by UCare. DHS approved rate used to determine payment.</td>
</tr>
<tr>
<td>Crisis Residential</td>
<td>Minnesota Department of Human Services (DHS) approved Crisis Residential provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAP &amp; MnCare), Individual &amp; Family Plans</td>
<td>Only the treatment associated with this service is covered when determined to be medically necessary by UCare. DHS approved rate used to determine payment.</td>
</tr>
<tr>
<td>Residential Eating Disorder Treatment</td>
<td>Must be a licensed facility in the state in which services are provided</td>
<td>Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>Room and board and treatment associated with this service is covered when determined to be medically necessary by UCare.</td>
</tr>
<tr>
<td>Intensive Treatment in Foster Care (ITFC)</td>
<td>Minnesota Department of Human Services</td>
<td>State Public Programs (PMA, MnCare, UCare Connect &amp;</td>
<td>Between the ages of 0 and 21, room and board and treatment associated with this service is</td>
</tr>
<tr>
<td>Service</td>
<td>Qualified Providers</td>
<td>Products</td>
<td>Special Instructions</td>
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<tr>
<td>Substance Use Disorder Assessment (Comprehensive Assessment or Rule 25 Assessment)</td>
<td>Must be a qualified assessor as defined in Minnesota Administrative Rule Minnesota Administrative Rules 9530.6615 subp.2</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAP &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>Payment for the recommended services is dependent upon the member’s benefit, coverage and UCare’s review. For State Public Programs, UCare’s contractual agreement with the Minnesota Department of Human Services (DHS) may impact payment for recommended services. UCare must receive a copy of the Rule 25, Comprehensive Assessment or Placement Summary. Rule 25 Assessment and Placement Summary. Claim submission for Rule 25 Assessment must include the appropriate HF modifier.</td>
</tr>
<tr>
<td>Medication Assisted Therapy / Treatment (MAT)</td>
<td>Minnesota Department of Human Services (DHS) approved Chemical Dependency / MAT Provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, PMAP &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>A Rule 25, Comprehensive Assessment or summary is required to evaluate substance use, individual risk, enable an appropriate treatment plan and/or access MAT services.</td>
</tr>
<tr>
<td>Outpatient Chemical Dependency Treatment</td>
<td>Medicare practitioner and place of service rules must be followed for use of Medicare benefits.</td>
<td>Medicare Products (UCare Medicare Plans, EssentiaCare, UCare Medicare with Exchange)</td>
<td>For use of Medicare benefits, a Medicare accepted assessment must be used. For State Public Programs and Exchange, a Rule 25,</td>
</tr>
</tbody>
</table>
State of Minnesota Mental Health/Behavioral Health Scope of Practice guidelines. State Public Programs & Exchange must be approved by DHS for Outpatient treatment.

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
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</thead>
<tbody>
<tr>
<td>Peer Recovery Support</td>
<td>Minnesota Department of Human Services (DHS) approved Peer Recovery Support Service Provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, MnCare &amp; PMAP), Individual &amp; Family Plans</td>
<td>A Rule 25, Comprehensive Assessment or Summary is required. Service must be indicated as a needed service on a treatment plan.</td>
</tr>
<tr>
<td>Treatment Coordination</td>
<td>Minnesota Department of Human Services (DHS) approved Treatment Coordination provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, MnCare &amp; PMAP), Individual &amp; Family Plans</td>
<td>A Rule 25, Comprehensive Assessment or Summary is required. Service must be indicated as a needed service on a treatment plan.</td>
</tr>
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</table>

**Substance Use Disorder Residential Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
</tr>
</thead>
</table>
| Chemical Dependency Residential Services | Minnesota Department of Human Services (DHS) approved residential treatment provider | State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, MnCare & PMAP), Exchange UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview | To determine if this level of care is appropriate, UCare must receive a copy of the Rule 25, Comprehensive Assessment or Placement Summary.  
*Rule 25 Assessment and Placement Summary*  
For State Public Programs, after medical necessity has been determined by UCare, the health plan is responsible for the treatment associated with CD residential programs. Room and board should be billed to DHS. |
For Exchange, room and board and treatment associated with this service is covered when determined to be medically necessary by UCare.

### Inpatient Hospital Mental Health and Chemical Dependency (admissions)

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (acute settings)</td>
<td>Must meet the Minnesota Department of Human Services (DHS) eligibility requirements for State Public Programs and Exchange. Providers must meet Medicare requirements for Medicare products.</td>
<td>Medicare Products (UCare Medicare Plans, EssentiaCare, UCare Medicare with Fairview &amp; North Memorial) State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAP &amp; MnCare) Exchange (UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with Fairview)</td>
<td>See the Hospital Services section of the Provider Manual and the Eligibility &amp; Authorizations section of the provider website for additional information <em>see the hospital services section for detox</em></td>
</tr>
<tr>
<td>Mental Health &amp; Chemical Dependency</td>
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### Mental Health Support Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Qualified Providers</th>
<th>Products</th>
<th>Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Rehabilitative Mental Health Services (ARMHS)</td>
<td>Minnesota Department of Human Services (DHS) approved ARMHS provider</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare, PMAP &amp; MnCare)</td>
<td>Must be 18 years or older</td>
</tr>
<tr>
<td>Behavioral Health Home (BHH)</td>
<td>Minnesota Department of Human Services (DHS) certified BHH Provider must be, in UCare’s provider network.</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare Connect + Medicare &amp; PMAP)</td>
<td>BHH providers are required to notify UCare within 30 days of a member starting BHH services. Notification can be completed by faxing the Determination of Eligibility for Behavioral Health Home Services form to UCare.</td>
</tr>
<tr>
<td>Mental Health Targeted Case Management (MH-TCM)</td>
<td>Minnesota Department of Human Services</td>
<td>State Public Programs (MSHO, MSC+, UCare Connect, UCare</td>
<td>Members receiving MH-TCM must meet the criteria established in Minnesota Administrative Rule (Minnesota</td>
</tr>
</tbody>
</table>
Mental Health Targeted Case Management (MH-TCM)

UCare does not require a referral, notification or prior authorization for mental health targeted case management (MH-TCM). Once a member has been assessed and determined to meet the criteria in the Minnesota Administrative Rule for MH-TCM, services can begin. MH-TCM providers are required to follow all assessment and documentation requirements.

Counties assisting members with MH-TCM: You may refer UCare members to your delegate MH-TCM agencies. The agency is not required to be in the UCare provider network.

Primary Care and Community providers assisting members with MH-TCM: You may refer members to the county delegate MH-TCM agency. The agency is not required to be in the UCare provider network. If you are not familiar with MH-TCM agencies, you may call UCare Behavioral Health for assistance.

UCare’s MH-TCM reimbursement rate is 100% of the Minnesota Medical Assistance posted rate or contracted county host rate at the time of service. Providers billing MH-TCM services are expected to file claims to UCare with charge amounts listed at 100% of this rate.

UCare will conduct periodic audits to ensure providers are billing appropriate charge amounts to UCare. UCare reserves the right to collect any overpayments.

Level of Care Determination (Medical Necessity)

To determine if a level of care is medically necessary or meets the community standard of care, UCare adopted criteria created by Medicare, the Minnesota Department of Human Services (DHS), Minnesota Administrative Rules, InterQual Behavioral Health Level of Care and UCare Medical Policies. The type of benefits/coverage the member has determines which level of care criteria is utilized. Providers, members and consumers may request a copy of the criteria used to make level of care decisions.

It is important to remember that the member must have a benefit for the service in order for it to be covered by UCare.

Below are links to the criteria used and how to request a copy of level of care criteria:

- State Public Programs (Minnesota Health Care Programs (MHCP) Provider Manual)
- Medicare Products (Medicare Coverage Database – Centers for Medicare & Medicaid Services)
- Medicare Products (National Government Services)
- Medical Policies (UCare Medical Policies)
• InterQual Behavioral Health Level of Care- request a copy (UCare Medical Necessity Criteria Request form)

Authorization / Notification Requirements

UCare reviews our prior authorization and notification requirements to evaluate if changes are needed. Changes to the prior authorization and notification requirements are based on industry trends, contractual requirements, cost and utilization of the service.

To prevent claim denials, it is important for providers to be aware of authorization and notification requirements. Additional information on authorization and notification standards can be found in the Authorization and Notification Standards section of the UCare Provider Manual.

Authorization and notification requirements for the current and previous year can be found in the Eligibility and Authorization section of the UCare provider website. You will also be able to access authorization and notification forms in this section. Behavioral health requests should be submitted with the authorization and notification form filled out completely and include all required documentation as outlined below. Completing these forms correctly will reduce the need for additional information and prevent delays in UCare’s response.

To comply with HIPAA and internal compliance requirements, providers should fax one prior authorization form at a time. When authorization requests are faxed in bulk, it increases the risk of information being lost or inappropriately filed.

**BEHAVIORAL HEALTH AUTHORIZATION DOCUMENTATION REQUIREMENTS**

The following is a list of clinical records UCare Behavioral Health requires for prior authorization and concurrent review. The documents listed assist the behavioral health clinician in determining medical necessity for the level of care or service requested. Providing the requested documentation in a timely manner can reduce an adverse determination. When sending documentation, please send the most recent assessments dated within the last 12 months, unless other timeline is specified.

<table>
<thead>
<tr>
<th>Service</th>
<th>Required Documentation</th>
</tr>
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<tbody>
<tr>
<td>Day Treatment</td>
<td>Diagnostic Assessment, Functional Assessment, LOCUS (State Public Programs) &amp; Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>Outpatient Chemical Dependency</td>
<td>Rule 25 Assessment, Rule 25 Summary or Comprehensive Assessment dated within 45 days of request for services, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Intake or Diagnostic Assessment, Functional Assessment, LOCUS (State Public Programs), Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>CTSS</td>
<td>Diagnostic Assessment, CASII or ECSII &amp; Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>IOP DBT</td>
<td>Diagnostic Assessment, Functional Assessment, LOCUS (State Public Programs), Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>Service Description</td>
<td>Clinical Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Crisis Residential</td>
<td>Crisis Assessment &amp; Crisis Stabilization Plan, Discharge Plan, Progress (daily) Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>IRTS</td>
<td>Diagnostic Assessment, Functional Assessment, LOCUS Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>ARMHS</td>
<td>Diagnostic Assessment, Functional Assessment, LOCUS Individual Treatment Plan, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>Children’s Mental Health Residential Treatment</td>
<td>Diagnostic Assessment, CASII or ECSII, Individual Treatment Plan, Progress Notes &amp; Discharge Summary <em>county out of home placement screening</em></td>
</tr>
<tr>
<td>Inpatient Mental Health Admission</td>
<td>H&amp;P, Treatment Plan, Medication Administration Record, Social Work, Practitioner &amp; Nursing Progress Notes, Discharge Summary</td>
</tr>
<tr>
<td>Inpatient Chemical Dependency Admission</td>
<td>H&amp;P, Treatment Plan, Medication Administration Record, Social Work, Practitioner &amp; Nursing Progress Notes, Discharge Summary</td>
</tr>
<tr>
<td>Transcranial Magnetic Stimulation</td>
<td>Documentation from treating practitioner that includes: diagnosis, past treatment history, medication history, medical history, compliance history and Individual Treatment Plan, which includes number and frequency of TMS treatment sessions</td>
</tr>
<tr>
<td>EIDBI</td>
<td>Comprehensive multi-disciplinary evaluation (CMDE), Individual Treatment Plan</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td>Neuropsychological Assessment and Treatment Plan</td>
</tr>
<tr>
<td>Chemical Dependency Residential</td>
<td>Rule 25 Assessment, Rule 25 Summary or Comprehensive Assessment dated within 45 days of request for services, Progress Notes &amp; Discharge Summary</td>
</tr>
<tr>
<td>Eating Disorder Residential</td>
<td>H&amp;P, Treatment Plan, Medication Administration Record, Social Work, Practitioner &amp; Nursing Progress Notes, Discharge Summary</td>
</tr>
<tr>
<td>Intensive Treatment in Foster Care (ITFC)</td>
<td>Diagnostic Assessment (within 180 days), CASII, Treatment Plan &amp; Progress Notes</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities (PRTF)</td>
<td>Diagnostic Assessment (within 180 days days), Functional Assessment, LOCUS/Individual Treatment Plan, Progress Notes and Discharge Summary</td>
</tr>
<tr>
<td>Peer Recovery Support</td>
<td>Comprehensive or Rule 25 Assessment within 45 days of request for services</td>
</tr>
<tr>
<td>Treatment Coordination</td>
<td>Comprehensive or Rule 25 Assessment within 45 days of request for services</td>
</tr>
</tbody>
</table>

*Progress notes are required for concurrent review of services or continued stay in the current level of care.*

**2019 MENTAL HEALTH SERVICE CLAIMS EDITS**

The following services have been removed from the behavioral health prior authorization grids, and utilization will be monitored via claims. When a member has received the total number of a service listed below, clinical records may be reviewed by UCare’s Behavioral Health team and a clinical determination on the medical necessity for additional services made to support claim payment.
Providers can submit clinical records for review in two ways: 1. When a member is close to the total number of a service listed below, providers may submit clinical records via electronic claim attachments. Directions on how to submit an electronic claim attachment can be found in the Claims & Payment section of the UCare Provider Manual. Please follow the directions on submitting electronic attachments. Only submit clinical records when the member is close to reaching or has reached the limit of the service listed below. 2. After your claim has denied for medical records, using the Provider Claim Reconsideration Request Form found on the Claims & Billing web page under Forms & Links. Providers must complete the Claim Reconsideration form as an Adjustment Request and attach medical records. The reason for the request is “other.” It is important to complete this form correctly. The table below provides the medical/clinical records the behavioral health team requires for review.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT / HCPC</th>
<th>Claim Edit</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Assessment</td>
<td>90791, 90792</td>
<td>4 sessions per calendar year</td>
<td>Clinical rationale for more than four (4) sessions in a calendar year. Must include diagnosis and treatment history.</td>
</tr>
<tr>
<td>EIDBI CMDE</td>
<td>97151-UB</td>
<td>8 hours per day</td>
<td>Clinical rationale for more than eighty (80) units in a calendar year. Must include diagnosis, treatment history and previous CMDE(s).</td>
</tr>
<tr>
<td>Group &amp; Individual Psychotherapy *includes incorporating biofeedback with psychotherapy</td>
<td>90853, 90832, 90834, 90837, 90875 &amp; 90876</td>
<td>104 sessions per calendar year</td>
<td>Most recent Diagnostic Assessment, Individual Treatment Plan &amp; Progress Notes.</td>
</tr>
<tr>
<td>Family Psychotherapy</td>
<td>90846, 90847, 90849</td>
<td>52 sessions per calendar year</td>
<td>Most recent Diagnostic Assessment, Individual Treatment Plan &amp; Progress Notes.</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>96130, 96131, 96136, 96137, 96138, 96139</td>
<td>8 hours per calendar year</td>
<td>Children: Pediatric evaluation, developmental screening, parental interview. All patients: clinical rationale for more than 8 hours in a calendar year.</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>96146</td>
<td>1 session per day</td>
<td>Children: Pediatric evaluation, developmental screening, parental interview. All patients: clinical rationale for more than 1 session per day.</td>
</tr>
</tbody>
</table>
*Sessions/units/hours are cumulative and include all providers in the calendar year. Member must have the benefit for the service provided.

**Peer to Peer Review**

In the event coverage guidelines or medical necessity has not been established for the level of care or service requested, UCare’s Behavioral Health Utilization Review clinicians will consult with our Behavioral Health Medical Director. UCare’s Behavioral Health Medical Director will review the case and make a determination. If the Behavioral Health Medical Director decision results in an adverse determination, the ordering or treating provider has the opportunity to discuss the plan of care and clinical basis for the level of care or service requested in a peer to peer review with the Medical Director. If an adverse determination has already been administered, the member or member’s representative maintains their right to file an appeal. Please contact UCare’s Behavioral Health department at 612-676-6705 or 1-877-447-4384 toll free if you would like to request a peer to peer review.

**Behavioral Health Clinical Practice Guidelines**

UCare adopted five behavioral health clinical practice guidelines to support good decision-making by patients and clinicians, improve member health outcomes and meet NCQA accreditation standards. Adult guidelines are adopted from the American Psychiatric Association (APA). Child and adolescent guidelines are adopted from the Journal of the American Academy of Child Adolescent Psychiatry. See the Clinical Practice Guidelines for Medical and Behavioral Health section of the Provider Manual for more information.
Child & Teen Checkups

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in Minnesota as the Child and Teen Checkup (C&TC) program, is a required Medicaid service. C&TCs are comprehensive well-child exams. All UCare members from birth through the age of 21 are eligible to receive this service from their primary care clinic.

If you have questions regarding C&TC, please call the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.

Two-Character Referral Code

When you are billing for a C&TC screening, you must append a two-character referral code to the C&TC procedure code to report that a complete C&TC was performed. This code allows the county to conduct additional follow up with the patient regarding these referrals to ensure they are receiving the services they need. If this code is not included, it will not be reported as occurring. In addition, the claim will be denied. You must use one of the following two-character referral codes to append to the C&TC procedure code:

<table>
<thead>
<tr>
<th>HIPAA Compliant Referral Condition Code</th>
<th>Use this referral condition code for billing when a C&amp;TC screening results in one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU (no referral – not used)</td>
<td>• No referral(s) given (“NU”).</td>
</tr>
<tr>
<td></td>
<td>• If only a verbal dental referral was made for preventive dental health care.</td>
</tr>
<tr>
<td>ST (new diagnosis or treatment service requested)</td>
<td>• One or more referrals were made (“ST”).</td>
</tr>
<tr>
<td></td>
<td>• Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).</td>
</tr>
<tr>
<td></td>
<td>• Patient is scheduled for another appointment with the screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).</td>
</tr>
<tr>
<td>AV – refused referral (referral recommended, but it was refused)</td>
<td>One or more referrals were made, and the patient refused one or more of the referrals (“AV”).</td>
</tr>
<tr>
<td>S2 (continue current services/treatment)</td>
<td>The patient is currently under treatment for a diagnostic or corrective health problem(s).</td>
</tr>
</tbody>
</table>
When a C&TC screening is attempted, but not completed, you may still bill UCare the C&TC procedure code along with the referral code as if the C&TC had been completed. You must document the reason(s) why the component(s) was not completed in the patient’s chart when the attempt was made. Please review the section of the MHCP Provider Manual for correct billing for C&TC.

Chart documentation must show that the visit took place with a PCP or OB/GYN, which must include documentation of the date when the visit occurred and evidence of all of the following:

A. A health history
B. A physical exam
C. A physical developmental history
D. A mental developmental history
E. Health education/anticipatory guidance

The payment amount shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M.

**Well Child Care Coding for Quality Measurement and Payment**

Billing for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) should always include the following codes to ensure visits are able to count towards national and state quality benchmarks.

<table>
<thead>
<tr>
<th>CPT</th>
<th>99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
<td>G0438, G0439</td>
</tr>
<tr>
<td>ICD 10</td>
<td>Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2</td>
</tr>
</tbody>
</table>

**S0302**

If HCPCS code S0302 is submitted on a claim for any subscriber other than an MHCP subscriber, it will be denied as provider liability.

Code S0302, should **ONLY** be submitted when a COMPLETE well child or child and teen checkup is performed for an MHCP subscriber (PMAP or MNCare).
Every Visit Is an Opportunity

Did you know that every visit a child makes to your clinic offers an opportunity to complete a C&TC screening? Here are examples of opportunities to turn these appointments into C&TC screenings:

- Camp physicals
- Sports physicals
- Head Start physicals
- Acute-only or sick visits
- Chronic conditions (e.g., repeat asthma visits)

Lead

You should make sure kids have two tests for lead poisoning – one at age 1 and the second at age 2. Kids are eligible between their 9 and 24-month birth dates for the lead test, and up to age 6 if not tested at the 24-month visit. Please see the MDH Periodicity Schedule for further details.

Resources

DHS C&TC Program Information

Minnesota Department of Health – Lead Screening

Minnesota Department of Health information on C&TC and immunization

UCare C&TC Clinic Tools

C&TC information for providers

UCare Member C&TC Schedule and Rewards

UCare Rewards and Incentives

UCare Provider Manual: Interpreter Services Section

UCare Provider Manual: Transportation Services Section

Useful Tools for C&TC Providers

Created by the C&TC Metro Action Group and available on the Dakota County Public Health website.
Notifying UCare Members of Medicare Coverage Termination

The Centers for Medicare and Medicaid Services (CMS) requires that comprehensive outpatient rehabilitation facilities (CORFs) provide an advance notice of Medicare coverage termination to UCare enrollees no later than two days before coverage of their services will end.

The correct notice must be used for the member's specific UCare plan because the content of the member appeals section differs.

Denial & Discharge Notices | UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare

NOMNC – Notice of Medicare Non-coverage

- Issued by CORF staff when ongoing services will be terminated.
- Must be given two days prior to discharge or service termination.

NDMCP – Notice of Denial of Medical Coverage/Payment

- Issued by UCare or delegates when CORF services are denied at or prior to the start of services.

DENC - Detailed Explanation of Non-coverage

- Issued by CORF staff when the member does not agree with service termination and wants a fast appeal using the Quality Improvement Organization (QIO).

Discharge Notification Guidelines

The Notice of Medicare Non-Coverage Form (NOMNC) is used when ongoing CORF services are being denied. The NOMNC is also known as the “Advance Notice” and informs the member of the date that coverage of services will end. The NOMNC describes what should be done if the member wishes to appeal the decision or needs more information.

1. The provider of the service is responsible for delivering the NOMNC to the member no later than two days before the end of coverage. Even if a provider does not agree with the decision that covered services should end, the provider must deliver the notice.
   - If the total span of services is expected to be fewer than two days, the NOMNC should be delivered to the member upon admission or start of services.
• If there is more than a two-day span between services, the NOMNC should be issued on the next to last time services are furnished. This notice should be delivered as soon as the service termination date is known.

2. The provider must carry out valid delivery of the NOMNC, meaning that all patient-specific information required in the notice is included, and the member (or authorized representative) must sign and date the Medicare Office of Management Budget (OMB)-approved notice to acknowledge receipt.

3. If a member’s authorized representative has been appointed, the representative must receive all required notifications. The notice must be mailed to the representative on the same day as the telephone notification.

4. Authorized representatives may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the contents of the notice, and the date, time and phone number of the call must be documented.

5. The provider may document the valid delivery of the NOMNC on UCare’s NOMNC Valid Delivery Documentation Form, available on UCare’s website or in the member’s medical record.

6. If the member decides to appeal the end of coverage, they must contact the QIO no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform UCare and the provider of the request for review.

   • The provider is responsible for providing the QIO and member with a Detailed Explanation of Non-Coverage (DENC) Form, (also known as the “Detailed Notice”), which explains why services are no longer necessary.
   • The QIO must make a decision by close of business of the day coverage is to end. The provider and UCare must cooperate with the QIO in providing information for the review. The provider must obtain appropriate signatures from the member and/or the member’s representative. The QIO for Minnesota and Wisconsin members is Livanta.
   • Personal Health Information provided to the QIO must be handled in accordance with HIPAA.

7. Providers must issue the advanced or detailed notices to UCare members when directed to do so by UCare or by a UCare delegated entity. The provider must follow the direction of UCare or UCare’s delegated entity and must not delay the delivery of the notice.

8. The provider must use the most current version of the denial notice from UCare’s website each time, rather than saving and reusing a previous version. Notices cannot be altered in any way and a CORF cannot create its own notice.

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**Denial Forms | UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare**

Denial forms for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare are found at the bottom of the following page of UCare's provider website: [Denial Notices for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities](#).
UCare’s Federally Qualified Health Center (FQHC) - Rural Health Clinic (RHC) Payment Carve-Out Process

On July 1, 2019, the process outlined in Section 256B.0625 of Minnesota Statutes for Medical Assistance Covered Services, Subd. 30 (i) that required the Minnesota Department of Human Services (DHS) to change claims processing between FQHC and RHC providers, managed care organizations (MCOs) and DHS was updated.

For beneficiaries enrolled in Minnesota Health Care Programs (MHCP), DHS partially, fully or not at all “carves out” some services for payment by managed care plans. The FQHC-RHC Payment Carve-Out process impacts medical (837P), dental (837D) claims and pharmacy claims.

Below are charts that show the type of service, program and provider type and how each are impacted by the July 1, 2019, update to the FQHC-RHC Payment Carve-Out process.

### Professional Services Billed by FQHCs: July 1, 2019

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Carve-out</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PMAP</td>
<td>PROVIDER -&gt; DHS</td>
<td>• Provider bills DHS directly.</td>
</tr>
<tr>
<td>• MSC+ Non-dual</td>
<td></td>
<td>• DHS pays provider encounter rate.</td>
</tr>
<tr>
<td>• UCare Connect</td>
<td></td>
<td>• If provider sends claim to UCare, UCare denies and instructs provider to bill other payer (DHS).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Non-duals</td>
</tr>
<tr>
<td><strong>No Carve-out</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MinnesotaCare</td>
<td>PROVIDER -&gt; UCARE</td>
<td>• Provider sends claim to UCare.</td>
</tr>
<tr>
<td>• MSC+ Duals</td>
<td></td>
<td>• UCare pays claims directly according to UCare-Provider contract.</td>
</tr>
<tr>
<td>• UCare Connect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SNBC) Duals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MSHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UCare Connect +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dental Services Billed by FQHCs: July 1, 2019

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Carve-out</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PMAP</td>
<td>PROVIDER -&gt; DHS</td>
<td>• Provider bills DHS directly.</td>
</tr>
<tr>
<td>• MSC+ Non-dual</td>
<td></td>
<td>• DHS pays provider encounter rate.</td>
</tr>
<tr>
<td>• MSC+ Duals</td>
<td></td>
<td>• If provider sends claim to UCare, UCare denies and instructs provider to bill other payer (DHS).</td>
</tr>
</tbody>
</table>
- UCare Connect Non-duals
- UCare Connect Duals
- UCare Connect + Medicare
- MSHO

| No Carve-out | PROVIDER -> UCARE | • Provider sends claim to UCare.
|             |                  | • UCare pays claims directly according to UCare-Provider contract. |

**Medicaid-covered Pharmacy Services Billed by FQHCs: July 1, 2019**

Note: there are three FQHCs that have pharmacies

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **Full Carve-out** | PROVIDER -> DHS | • Provider bills DHS directly.  
| • PMAP |  
| • MSC+ Non-dual |  
| • UCare Connect Non-duals |  
| **For Medicaid-covered drugs** |  
| • MSC+ Duals |  
| • UCare Connect Duals |  
| • MSHO |  
| • UCare Connect + Medicare |  
| **Full Carve-out** | PROVIDER -> DHS | • Provider bills DHS directly.  
| • PMAP |  
| • MSC+ Non-dual |  
| • UCare Connect Non-duals |  
| **For Medicaid-covered Service** |  
| • MSC+ Duals |  
| • UCare Connect Duals |  
| • MSHO |  

| No Carve-out | PROVIDER -> UCARE | • Provider sends claim to UCare.  
|             |                  | • UCare pays claims directly according to UCare-Provider contract. |

**Medicaid-covered Chiropractic Services Billed by FQHCs: July 1, 2019**

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **Full Carve-out** | PROVIDER -> DHS | • Provider bills DHS directly.  
| • PMAP |  
| • MSC+ Non-dual |  
| • UCare Connect Non-duals |  
| **For Medicaid-covered Service** |  
| • MSC+ Duals |  
| • UCare Connect Duals |  
| • MSHO |  

---

2019 UCare Provider Manual 24-2
- UCare Connect + Medicare

| No Carve-out | PROVIDER -> UCARE | • Provider sends claim to UCare.  
• UCare pays claims directly according to UCare-Provider contract. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• MinnesotaCare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Professional Services Billed by RHCs: July 1, 2019

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Partial Carve-out  
• PMAP  
• MSC+ Non-dual  
• UCare Connect Non-duals | PROVIDER -> UCARE -> DHS | • Provider sends claim to UCare.  
• UCare “pays” $0 and forwards claim to DHS.  
• DHS pays provider encounter rate. |
| No Carve-out  
• MinnesotaCare  
• MSC+ Duals  
• UCare Connect (SNBC) Duals  
• MSHO  
• UCare Connect + Medicare | PROVIDER -> UCARE | • Provider sends claim to UCare.  
• UCare pays claims directly according to UCare-Provider contract. |

### Dental Services Billed by RHCs:

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Partial Carve-out  
• PMAP  
• MSC+ Non-dual  
• MSC+ Duals  
• UCare Connect Non-duals  
• UCare Connect Duals  
• UCare Connect + Medicare  
• MSHO | PROVIDER -> UCARE -> DHS | • Provider sends claim to UCare.  
• UCare “pays” $0 and forwards claim to DHS.  
• DHS pays provider encounter rate. |
| No Carve-out  
• MinnesotaCare | PROVIDER -> UCARE | • Provider sends claim to UCare.  
• UCare pays claims directly according to UCare-Provider contract. |

### Medicaid-covered Chiropractic Services Billed by RHCs:

<table>
<thead>
<tr>
<th>Carve-out Type</th>
<th>Claim Path</th>
<th>Notes</th>
</tr>
</thead>
</table>
### ANSI Codes on Remittance Advice/Explanations of Payment

The **UCare ANSI Code Grid** shown below identifies the Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) UCare uses on 820 Remittance Advice transactions and Explanations of Payment (EOPs) for claims processed under the carve-out process.

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>CARC</th>
<th>RARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCare “paid” claims at $0 and forwarded to DHS for encounter payment.</td>
<td>256 – Service not payable per managed care contract.</td>
<td>N193 – Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>UCare “paid” replacement claim at $0 and forwarded to DHS for encounter payment.</td>
<td>256 – Service not payable per managed care contract.</td>
<td>N193 – Specific federal/state/local program may cover this service through another payer.</td>
</tr>
<tr>
<td>UCare Denied claim - DHS TCN missing so cannot forward replacement to DHS.</td>
<td>16 – Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.</td>
<td>M47 – Missing/incomplete/invalid/ internal or document control number.</td>
</tr>
<tr>
<td>Provider Initiated Void Claim processed by UCare and forwarded to DHS to Void claim.</td>
<td>B11 – The claim/service has been transferred to the proper payer/processor for processing.</td>
<td>N193 – Specific federal/state/local program</td>
</tr>
<tr>
<td>UCare Initiated Void – Voided Claim not forwarded to DHS.</td>
<td>16 – Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.</td>
<td>N463 – Missing support data for claim.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Provider sends claim to UCare that should have been submitted to DHS.</td>
<td>109 – Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.</td>
<td>N193 – Specific federal/state/local program may cover this service through another payer.</td>
</tr>
</tbody>
</table>

If you have a question on a remittance advice (RA)/835 received from UCare, call **UCare’s Provider Assistance Center (PAC) at 612-676-3300 or 1-888-531-1493**. When you call PAC be sure to tell the representative you are calling about a claim related to the RHC Payment Carve-Out process.

If you have a question on a RA/835 received from DHS, call **MHCP’s Provider Call Center at 651-431-2700 or 1-800-366-5411**.

**References**

- [DHS Provider Manual - Federally Qualified Health Center and Rural Health Clinics](#)
Home & Community Based Services - Waiver Services

The purpose of home and community-based services (HCBS) or “waiver services” is to allow individuals who meet specific criteria to remain in their home and to avoid admission to an institutional setting. HCBS waiver services—also known as Managed Long Term Supports and Services (MLTSS)—promote community living and independence based on the individual needs and choices of the member. Examples of HCBS include but are not limited to: Adult Day Service (ADS), chore services, companion services, Consumer-Directed Community Supports (CDCS), Customized Living, home-delivered meals and homemaker services.

HCBS waivers are for services normally not covered by Medicaid. Services covered through HCBS waivers that are also covered under regular Medicaid, such as extended home health and extended skilled nursing services, are those that exceed the amount, scope and duration of regular Medicaid state plan services.

Providers of HCBS waiver services are separated into three distinct service tiers:

- **DHS Enrollment Required Services (formerly known as Tier 1):**
  - As of Jan. 1, 2014, providers of these services must be enrolled with DHS as Minnesota Health Care Programs (MHCP) providers.

- **Lead Agency Approval Option Services:**
  - Direct Delivery Services (formerly known as Tier 2): Comprises four basic services typically directed to a broad community market, such as Chore Services, Environmental Accessibility Adaptations/Home Modification/Installations, Homemaker/Cleaning and Transitional Services/Elderly Waiver-Related Supports. Provider enrollment with DHS, while encouraged at Tier 2 and Tier 3, is optional. Lead agencies or their financial representatives may exercise administrative oversight over the provision of service by qualified non-enrolled Tier 2 and Tier 3 providers.
  - Purchased Items Services (formerly known as Tier 3): Furnish items rather than “services” in the traditional sense. Receipt Service HCBS waiver/AC supplies and goods are available through a wide range of local, regional and national providers.

DHS Enrollment Required Services providers must enroll with DHS, and while not mandatory, it is recommended that Direct Delivery Services and Receipt Services providers enroll through DHS as well.

UCare members eligible to receive HCBS services must use providers who are enrolled with DHS for HCBS/waiver services. A complete list of enrolled providers is available on DHS’s MnHelp website. Provider lists are also available by accessing the [DHS licensing look-up website](https://www.mn.gov) or the [MDH Provider Directory](https://mdh.state.mn.us).

UCare contracts directly for some extended waiver services, such as transportation, personal care assistants (PCA) and home health services covered through the waiver as "extended" services. PCA, Home Health Care or DME provider lists are available through the Search Network tool on [UCare’s website](https://www.ucare.org).
Providers must obtain a UCare provider number and use this when billing for waiver services. Providers must limit the waiver services they deliver to services for which they are qualified and contracted to provide. Providers who had a contract with UCare that included Elderly Waiver Services must still follow the re-enrollment process that DHS created to provide services to UCare members.

**UCare Plans that Include Coverage Under the Elderly Waiver**

- UCare’s Minnesota Senior Health Options (MSHO)
- Minnesota Senior Care Plus (MSC+)

**UCare Products that DO NOT Include Coverage of HCBS Waiver Services**

- Prepaid Medical Assistance Program (PMAP)*
- MinnesotaCare
- UCare Connect and UCare Connect + Medicare*
- UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare
- UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview*

*Note that UCare Connect, UCare Connect + Medicare and a small number of PMAP members may be eligible for other HCBS waiver programs. These members have their HCBS waiver services coordinated through the county and paid for through Medical Assistance fee-for-service (DHS). These waivers include:

- Community Access for Disability Inclusion (CADI) Waiver
- Brain Injury (BI) Waiver
- Developmental Disabilities (DD) Waiver
- Community Alternative Care (CAC) Waiver

**Elderly Waiver**

The Elderly Waiver (EW) funds HCBS for people age 65 and older who are eligible for Medical Assistance and require the level of care provided in a nursing facility, but choose to reside in the community. The Minnesota Department of Human Services (DHS) operates the EW program under a federal waiver to Minnesota’s Medicaid State Plan. Counties, tribal entities and health plans administer EW services.

**HCBS WAIVER REQUESTS**

HCBS waiver requests should be directed to the member’s care coordinator/case manager. These services may be requested by the member, a member’s representative, the member’s primary care physician or care coordinator/case manager. Members must meet financial eligibility criteria to qualify for EW services. Financial eligibility must be verified prior to the start of waiver services.
The role of the care coordinator/case manager for EW services is to:

- Conduct the requisite assessment to determine member eligibility.
- Develop a plan of care including the waiver service plan.
- Assist with accessing waiver services.
- Monitor the ongoing provision of waiver services.

The care coordinator/case manager must document the need for waiver services in the member’s care plan. Waiver services must meet the definitions outlined in the MHCP Provider Manual for each type of waiver.

Services not covered by the EW include:

- Room and board, including room and board in a Customized Living facility.
- Items for comfort and convenience.
- Payments directly or indirectly to the member.
- Costs of facility maintenance, upkeep and improvement.
- Upkeep and improvements that are not of direct medical or remedial benefit to the recipient.
- Services provided to the member’s immediate family.
- Services that have not been approved by the care coordinator/case manager.

Costs for waiver services are limited by the member’s individual case mix classification. UCare expects care coordinators to manage waiver services within the case mix budget.

UCare covers the cost of eligible EW services for MSHO and MSC Plus members. UCare does not cover the following:

- Services or items purchased prior to the LTCC screening or eligibility begin date.
- Services not approved by the care coordinator/case manager.
- Services provided or billed for when the member is no longer eligible for coverage.
- Essential Community Support (ECS) Services, care coordinator assesses the need for, authorizes and monitors services but the provider bills DHS for payment of services.

**Review of Requests for Waiver Services**

Requests for waiver services are not categorized as medical necessity reviews, and decisions for approval must be made within 14 calendar days of the request.

**Denial of Waiver Service Requests**

- Denials of requests for waiver services are not subject to physician review.
- Notification of the attending health care professional in the event of a denial, termination or reduction (DTR) of a waiver service is not required.
- A DTR form is required even when the member initiates the termination or reduction of waiver services. The care coordinator/case manager must:
- Document within the care plan the member initiated termination/reduction of specific waiver services.
- Inform and document the notification to the service provider of a termination/reduction of waiver services.

- When members in a skilled nursing facility (SNF) stay are hospitalized, a DTR for waiver services is not issued as long as the member’s waiver span remains open.
- If a member becomes ineligible for waiver services for any reason, including a nursing facility (NF) stay of more than 30 days, a DTR must be sent to the member.

For members enrolled in hospice while receiving waiver services:

- Waiver services continue while the member is in hospice.
- Services related to the terminal condition are paid by Medicare (hospice) if the member is eligible for Medicare.

Waiver services may not be provided outside the state of Minnesota except when:

- The provider is located within the member’s local trade area in North Dakota, South Dakota, Iowa or Wisconsin.
- The member is temporarily traveling outside Minnesota but within the U.S.A., and services are limited to direct care staff services determined necessary and authorized in the care plan.

Providers are expected to work with the assigned care coordinator/case manager for any waiver service.

Providers should contact UCare’s Care Management Intake line at 612-676-6622 or 1-877-447-4384 for assistance in determining the care coordinator/case manager assigned to the member.

Members approved for HCBS waiver services receive service coordination from their assigned care coordinator/case manager. The care coordinator/case manager monitors and makes changes to the member’s plan of care as needed. Providers are reimbursed according to guidelines established by Minnesota DHS. Care coordinators/case managers may negotiate provider payment rates in the event there is no specified rate listed on the DHS fee schedule. Rates are also negotiated for certain services when DHS has provided a rate, and the rate is not to exceed the DHS published maximum allowable service rate. Rates may be negotiated lower than the maximum rate. In some cases, the approval obtained from the member’s care coordinator/case manager may list the specified code and approved rate. Providers should visit the DHS website for coding and rate information.

Extended transportation is a type of waiver service that may be offered in addition to medical transportation. Extended transportation is intended to enable members to gain access to services, activities and resources as specified in the care plan.

Home modifications as a waiver service may include adaptations or improvements to a member’s home that are of general utility and not of direct medical or remedial benefit to a member. Costs may be averaged over the span of a service agreement (up to 12 months) as long as the member remains on the waiver for the full span of the service agreement.
Waiver Service Approval Form

UCare requires care coordinators/case managers to submit a [waiver service approval form](#) to UCare Clinical Services for all EW services.

Coding Information for Waiver Service Providers

Coding examples for waiver providers:

- John Doe attended adult day services all day on April 11, 2016.
  Submit claim using S5102 with 1 unit as code, which is defined as adult day care services, adult; per diem.

- A homemaker is at Jane Doe’s home for one hour on April 14, 2013.
  Submit claim using S5130 with 4 units as the code, which is defined as homemaker service, NOS; per 15 minutes.

- Jane Doe has been transported to the adult day services center. Extended transportation is listed under the member’s plan of care.
  Submit claim using T2003 with a UC modifier with 2 units for a round trip, as the code is defined as per one-way trip.

Submission of Units

It is very important to submit the correct number of units for each service in order to be reimbursed accordingly.

Each code on the claim must have a unit (number) associated with it, which is entered in box 24G of the CMS 1500 (08-05) form.

The number of units entered will depend on the specific code(s) definition found in the Healthcare Common Procedure Coding System Level II (HCPCS) manual.

Definitions differ in that some indicate time, per item, or per day or visit.

Providing more services than authorized by the care coordinator may result in claim denial.

Elderly Waiver Billing Information

All claims for EW services for eligible UCare MSHO and MSC+ members are submitted directly to UCare for claim adjudication rather than the state’s system, MMIS.

As a reminder, all claims must be submitted electronically. To submit a claim adjustment, please follow the guidelines outlined in the MN Administrative Uniformity Committee (AUC) Best Practice, “Claims Attachments.”
When you submit claims for waiver services:

- Use the Professional (837P) claim.
- Bill only for services already provided.
- Bill only for services approved on the authorization. **Note:** Services that require a service authorization (SA) cannot be billed on the same claim as services that do not require a SA.
- Submit your usual and customary charges for the service (except for CDCS, specialized supplies and equipment, environmental accessibility adaptations and assistive technology services when a dollar amount is approved on SA instead of a rate per unit).
- Provider must enter a diagnosis code when submitting claims for all waiver services. Providers are required to use the most current, most specific diagnosis code when submitting their claims.
- Use the information listed on your service authorization when submitting claims for reimbursement through the waiver.
- Use date spans only for monthly code(s) when you have provided services for all dates in the span; otherwise each date must be billed on a separate line. **Note:** A week is considered Monday-Sunday when an authorization lists the number of UOS per week.

### Elderly Waiver Identification Information

The claims submitted to UCare should contain the provider number that DHS identifies you with; in turn, the clearinghouse you are using should have that same information. If DHS identifies you with an UMPI, that is what you should provide to UCare and the clearinghouse. If DHS identifies you with an NPI, you should enroll with UCare and the clearinghouse with that information. This is important to help in processing of your claims correctly.

Should any information about your facility be changed with DHS – UCare should be advised of those same changes as soon as possible.

Providers do not need to be contracted with UCare for EW services, only enrolled with DHS to provide such services. To obtain a UCare provider number for EW services, complete the facility add form (on the Manage Your Provider Profile page under Add or Update a Facility or Location) and indicate this service type on the form. This step must be completed for UCare to recognize provider information submitted on claims.

### Waiver Obligations - Important Notice for EW Providers

A waiver obligation is similar to a deductible for waiver services. Some members must pay a dollar amount (designated by DHS) out of pocket each month for waiver services, before the health plan pays providers for services. The waiver obligation is deducted from the first provider bill for EW services received by UCare each month. Once the waiver obligation is satisfied, UCare will pay providers as they bill.
Waiver providers are responsible to bill members directly when a member has a waiver obligation. The provider must first submit the claim to UCare for services rendered. The provider will then receive an Explanation of Payment (EOP).

If the EOP has an explanation code of “WO: Waiver Obligation Applied – Member Responsibility for Balance,” the member should be billed directly for this amount.

This is the ONLY amount that can be billed directly to the member. Balance billing members is prohibited per Minnesota Statute, section 236D.03.

**Additional Information Regarding Waiver Services**

See also the [DHS Provider Manual](#). Select a chapter, such as home care services, HCBS waiver services or billing policy.
Home Care Services

Included in this chapter:

- Criteria that must be met for Medicare-certified home care services
- Billing information for Medicare-certified home health contracted services
- Billing information for home infusion services
- Billing information and standards for Personal Care Attendant (PCA) services

Home care providers may not subcontract to another entity to provide covered services for UCare members without the prior written approval from UCare. Such approval is at UCare’s sole discretion.

Home Care Services Criteria

UCARE MEDICARE PLANS, UCARE MEDICARE WITH FAIRVIEW & NORTH MEMORIAL AND ESSENTIACARE

UCare follows Medicare criteria for coverage of home care services. Services must be delivered by a Medicare-certified home health agency. Members must meet Medicare criteria.

Medicare home health services DO NOT include coverage for custodial care, general household services such as laundry, meal preparation, shopping or other home care services furnished mainly to assist in meeting personal, family or domestic needs.

MINNESOTA SENIOR HEALTH OPTIONS (MSHO) AND UCARE CONNECT + MEDICARE

UCare’s MSHO and UCare Connect + Medicare combine Medicare and Medicaid benefits; therefore, UCare follows both Medicare and Medicaid criteria for coverage.

Medicare standards are reviewed first. If a request for home care does not meet Medicare criteria, it is reviewed using Medicaid criteria.

For Medicaid criteria for home care services, refer to the Medical Necessity Criteria section of this manual.

MINNESOTA SENIOR CARE PLUS (MSC+), UCARE CONNECT, PREPAID MEDICAL ASSISTANCE PROGRAM (PMAP), MINNESOTACARE

UCare follows Medicaid criteria for MSC+, UCare Connect, PMAP and MinnesotaCare (refer to the Medical Necessity Criteria section of this manual).

Some members of MSC+ and UCare Connect also have Medicare coverage, which is not administered by UCare. In this circumstance, UCare is the secondary payer. Check for additional coverage on the UCare Provider Portal, by calling our Provider Assistance Center at 612-676-3300 or 1-888-531-1493 or checking the Minnesota Department of Human Services MN-ITS system.
Medicaid services may be covered if the following member and provider conditions are met:

- The member is eligible for the services provided.
- Physician-ordered services are provided to recipients in their own residence.
- All home health services require a start of service face-to-face visit, regardless of the need for prior authorization. Services include skilled nurse visits, home health aide visits and home care therapies (occupational, physical, respiratory and speech language therapies).
  - At the start of the home health services, a face-to-face visit must:
    - Be for the primary reason the person requires home health services
    - Occur within 90 days before or 30 days after the start of services
    - Be completed by a qualified provider
- Services also may be provided in a private foster care setting with no more than four residents, in assisted living if services are not part of customized living services, or in a group home licensed by the Commissioner of Health.
- Services must be documented in a written service plan and reviewed by the member’s physician at least once every 60 days for home health agency or home care nursing* services.
- Provider is responsible for maintaining member-signed record of each encounter.

*Home care nursing (formerly Private Duty Nursing) may be covered for UCare Connect and PMAP members. Contact the member’s county of residence or the Minnesota Department of Human Services (DHS) to determine approval authority for home care nursing. Providers of home care nursing must be Medicare-certified.

Please refer to the medical authorization and notification requirements on the Eligibility & Authorizations page to verify home care nursing requirements.

**UCARE INDIVIDUAL & FAMILY PLANS AND UCARE INDIVIDUAL & FAMILY PLANS WITH FAIRVIEW**

Home Health Services are eligible and covered only when they are:

- Medically Necessary, and
- Provided as rehabilitative care, terminal care or maternity care, and
- Ordered by a physician and included in the written home care plan.

Home Health Care Services are limited to 120 visits per year all visits combined (Skilled Nurse visits, Home Health Aide, PT, OT, SLP).

**HOME CARE SERVICES | TRANSITION OF PROVIDER**

If a home care provider is unable to continue providing care to a UCare member in one of our Medicaid plans, the provider must notify the recipient, responsible party and Minnesota DHS at least 30 days before terminating services. The provider must also help the recipient transition to another home care provider. If the termination is a result of sanctions on the provider, the provider must give each recipient a copy of the home care bill of rights at least 30 days before terminating services. Information can be found in LEG-10-01:2010 Legislative Changes Ch. 352, art 1, sec 8.
BILLING HOME HEALTH SERVICES

Billing for skilled home health care services depends on the member's plan.

UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare (Preferred Provider Organization)

- Members must meet Medicare coverage criteria and providers must bill Medicare rates.
- Providers must bill specific G-codes along with revenue codes for Medicare reimbursement.
- Bill units in visits, not in 15-minute units.
- Use the UB-04 or 837I (electronic institutional claim form).

UCare's MSHO (Dual Special Needs Plan), UCare Connect + Medicare

- For Medicare billing, members must meet Medicare coverage criteria and providers must bill Medicare rates.
- Providers must bill specific G-Codes along with the Revenue Codes when billing Medicare reimbursement.
- Bill units in visits, not in 15-minute units.
- If members of UCare’s MSHO and UCare Connect + Medicare do not meet Medicare criteria, they must meet Medicaid criteria. Providers must bill the specific Medicaid rates.
- Providers must bill specific T-codes along with revenue codes for Medicaid reimbursement.
- Must be billed on the 837I form.

Prepaid Medical Assistance, Minnesota Senior Care Plus, UCare Connect and MinnesotaCare (MHCP plans)

- Members must meet Medicaid home health criteria.
- Providers must bill the Medicaid rates.
- Providers must bill the appropriate T-code along with the revenue code.
- Must be billed on the UB-04 form or 837I claim.
- UCare Individual & Family Plans members must meet the criteria listed immediately above.
- Provider must bill the specific G-Codes (Medicare codes) along with the revenue code.
- Must be billed on a UB-04 form or 837I claim.

BILLING MULTIPLE VISITS ON THE SAME DAY

When billing for more than one visit on the same day for the same services, such as skilled nurse visit, physical therapy, occupational therapy, speech therapy or home health aide (more than one state plan home health aide visit per day is non-covered according to state law), the second visit must be billed using a 76 modifier, or else the second visit will be denied as a duplicate claim.

ENROLLEE RIGHTS AND PROVIDER RESPONSIBILITIES

UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, MSHO and UCare Connect + Medicare members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their plan’s decision that Medicare coverage of home health services should end. See Denial Notifications in the following section.
Regulations

Home health agencies must provide an advance notice of Medicare coverage termination (NOMNC) to UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, MSHO and UCare Connect + Medicare members no later than two days before coverage of their services will end. If the member does not agree that covered services should end, the member may request an expedited review by the QIO in that state. The provider must furnish a detailed notice explaining why services are no longer necessary or covered. The review process will be completed within 48 hours of the member’s request for a review.

Download the customized denial forms from the Denial Notices for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities page each time you need to use the form to ensure use of the most current version.

The member (or authorized representative) must acknowledge receipt of the NOMNC and contact the QIO (within specified timelines) if they wish to obtain an expedited review.

The QIO contacts UCare and the provider if a member requests an expedited review. The QIO makes a determination no later than the day Medicare coverage is projected to end.

WHEN TO DELIVER THE NOMNC

Based on the determination by UCare or our delegated approval authority regarding when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to last less than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (such as in the home health setting), the NOMNC should be issued on the next-to-last time services are furnished. Providers should deliver the NOMNC as soon as the service termination date is known. You need not agree with the decision that covered services should end, but you are responsible under your Medicare provider agreement to issue the notice.

HOW TO DELIVER THE NOMNC

The provider must deliver the NOMNC. The member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. The authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative the same day.

EXPEDITED APPEAL PROCESS

If a UCare member decides to appeal the end of coverage, he or she must contact the QIO no later than noon on the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform UCare and the provider of the request for a review. The provider is then responsible for providing the QIO and member with a second notice, the Detailed Explanation of Non-Coverage (DENC). The provider may need to present additional information needed for the QIO to make a decision. Providers must cooperate with the QIO’s requests for assistance in gathering required information. The QIO decision should take place by close of business on the day coverage is to end.
TIMELY NOTIFICATION

Providers should structure their notice delivery and discharge patterns to ensure arrangements for follow-up care are in place; scheduling equipment to be delivered (if needed) and writing orders or instructions in advance.

MORE INFORMATION

Further information on this process, including frequently asked questions and the required notices and related instructions can be found on the Centers for Medicare & Medicaid Services (CMS) website. The regulations are at 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the Managed Care Manual includes information on the process.

Personal Care Attendants (PCA) | Standards for Agencies in the UCare Network

To ensure that UCare members have access to PCA services from qualified providers, a provider of PCA services must meet the following standards to be eligible for participation in UCare’s network:

The PCA provider agency must perform a background study on each individual PCA.

The PCA must have a passed status before providing services to UCare members. The agency must provide documentation upon UCare’s request.

The PCA provider agency must have professional liability coverage at all times. UCare requires a minimum of $1 million per incident and $3 million aggregate.

The PCA provider agency must have general liability coverage at all times. UCare requires a minimum of $1 million per incident and $3 million aggregate.

The PCA provider agency must have surety bond coverage in the amount of $50,000 or 10% of the provider’s payments from Medicaid in the previous year, whichever is greater.

The PCA provider agency must have fidelity bond coverage in the amount of $20,000.

The PCA provider agency must have proof of workers compensation insurance.

The PCA agency must support UCare’s efforts in promoting self-care and independence for all UCare members.

PCA provider agencies that serve members who also need ongoing skilled nursing services must be Medicare-certified. Physical therapy, occupational therapy, speech therapy, skilled nursing visits and home health aides must be provided by the Medicare-certified home health service provider.

PCA provider agencies that also provide private duty nursing services must be Medicare-certified.

PCA provider agencies must employ only individuals who have the personal background and experience that demonstrates the capacity to serve UCare members safely and competently as a PCA. Agencies must follow all requirements listed under Minnesota Statute 256B.0659 when hiring individual PCAs.
The PCA provider agency must present its internal PCA written policies and procedures as stated under Minnesota Statute 256B.0659 to UCare upon our request.

The PCA provider agency must not solicit UCare members or engage in case finding or misrepresentation of its relationship with UCare and/or its relationship with potential clients.

The use of the UCare name or logo in any marketing efforts by a PCA agency is strictly prohibited without prior approval from UCare.

All time cards must be signed by the UCare member or their responsible party. A member’s name, handwritten by the PCA, will not be accepted and may be cause for further investigation. The PCA provider agency is responsible for retaining member signed time card records as documentation of each encounter.

The PCA provider agency will follow Minnesota Statute 256B.0659 requirements for initial enrollment of personal care assistance provider agencies.

PCA provider agencies cannot provide PCA services in homes owned or controlled by the provider of PCA services.

PCA provider agencies must provide PCA supervision for all members receiving PCA services.

PCAs must not work more than 275 hours per month. Provider agencies must coordinate weekly work schedules with other agencies that employ the individual to ensure the PCA’s combined scheduled hours do not exceed this limit.

PCA provider agencies must provide each UCare member, or their authorized representative, a printed copy of the home care bill of rights at the time the recipient agrees to services or before services are started, whichever is earlier. Agencies must keep documentation of notice in the recipient’s file.

Providers must use locked filing cabinets and secure computers to prevent personnel without a legitimate business need from obtaining UCare member information. Agencies must follow all applicable Health Insurance Portability and Accountability Act (HIPAA) laws and regulations pertaining to member privacy.

PCA provider agencies must have a dedicated business phone number and fax number specific to their PCA provider agency. Voicemail greetings must include business information.

PCA provider agencies must inform UCare immediately of any ownership changes to your agency, including co-owner information.

Providers are required to keep a copy of each UCare member’s service plan on file.

To ensure a member does not exhaust PCA hours before the authorization expires, PCA provider agencies are responsible to develop month-to-month care plans for use of PCA hours and to monitor use of PCA services in accordance with Minn. Stat. 256B.0659 subd. 15.

Agencies are required to carefully monitor the planned use of PCA hours when flexible use occurs. UCare will send notices when a recipient is at risk of overuse of hours.

The agency must have a signed agreement between two clients who voluntarily choose shared care, as determined at the time of assessment.
A PCA provider agency must request a PCA reassessment from UCare at least 60 days before the end of the service authorization.

PCA provider agencies must follow all requirements listed under Minnesota Statute 256B.0659 at all times.

The PCA provider agency cannot require PCAs to sign an agreement not to work with any particular PCA recipient or for another PCA provider agency after leaving the agency, and may not take action on any such agreements regardless of the date signed.

**PCA INDIVIDUAL AND AGENCY TRAINING REQUIREMENTS**

**Individual PCA Training requirements**

DHS requires all individual PCA providers to register for and pass a one-time Individualized Personal Care Assistance Training online test. All PCA provider agencies must provide individual training to their employed PCAs. PCA training must include successful completion of the following training components:

- Meeting the requirements of the 2009 legislation
- Basic first aid
- Vulnerable adult/child maltreatment
- OSHA universal precautions
- Basic roles and responsibilities of an individual PCA

Upon completion of the training components, the PCA must demonstrate the competency to provide assistance to recipients. A copy of completion of training must be provided upon UCare’s request. Individual PCAs may be subject to monitoring by UCare. If a violation occurs, the agency is required to implement a corrective action plan or take disciplinary action. UCare requires all agencies to make sure all individual PCAs successfully complete the training. For more information regarding the individual PCA standardized training, please refer to the DHS enrolled provider home page and training for Individual PCA Standardized Training.

**PCA Provider Agency Training Requirements**

Minnesota Legislation requires PCA provider agency owners, managing employees and Qualified Professionals to complete the three-day Steps for Success training. Once a certificate of completion is provided to each required personnel member within the agency, the agency must submit copies to UCare upon request. Find more information about the [Steps for Success training program on the DHS website](https://www.dhs.state.mn.us/InnovateServices/Programs-Initiatives/Training/Steps-for-Success-Training).  

Individual PCA providers must register for and pass a one-time [Individual Personal Care Assistant (PCA) Training](https://www.dhs.state.mn.us/InnovateServices/Programs-Initiatives/Training/Individual-Personal-Care-Assistant-Training) online test. Individual PCAs may take the training and test as often as needed. After the individual PCA passes the one-time test, the PCA will be able to print a certificate. The individual PCA is responsible for keeping a copy of the certificate for his or her own records. The individual PCA must give a copy of the completion certificate to the employer agency/agencies for the agency to keep on file.

If an individual PCA loses the certificate, the PCA is responsible for obtaining a new copy or retaking the test to obtain a new copy.
Any new owners and new managing employees are required to complete mandatory training as a requisite of hiring. All Qualified Professionals (QP) must attend Steps for Success within six months of the date hired by a PCA provider agency. Employees in management and supervisory positions, owners who are active in day-to-day operations of an agency, and QPs who have completed the required training do not need to repeat the required training if hired by another agency within three years of completing the training. PCA provider agencies certified for participation in Medicare as a home health agency are exempt from the training.

Billing training is also required for PCA provider agencies through DHS. PCA agencies must designate and report one person as the person responsible for billing their PCA services. This person must register and attend the one-day PCA Provider Agency Billing Lab and provide the certificate of completion to UCare upon our request.

**PCA AUTHORIZATION PROCESS**

Authorization is required for payment of all PCA services as outlined in Minnesota Statute 256B.0652 subdivision 6 and 256B.0659. PCA provider agencies must follow the specified authorization procedures and cooperate with all phases of the authorization process. Requests for services can be made directly to the members UCare assigned care coordinator or faxed to 612-884-2094.

**MEMBER ELIGIBILITY**

(Ref: Minnesota Rules 9505.0335 Personal Care Services Subpart 1 [H])

“Qualified recipient” means a recipient who needs personal care services to live independently in the community, is in a stable medical condition and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section 148.171, subdivision 15. Member eligibility should be verified monthly via MN-ITS or the UCare Provider Portal.

**MEMBER PROGRAMS WITH PCA BENEFITS**

UCare covers PCA services for members enrolled in UCare MSC Plus and UCare’s MSHO Plans. There is no PCA benefit for the members in the following plans: UCare Medicare Plans; for adult, non-pregnant MinnesotaCare members; UCare Individual & Family Plans; UCare Individual & Family Plans with Fairview; UCare Medicare with Fairview & North Memorial.

For UCare Connect, UCare Connect + Medicare, UCare PMAP and MinnesotaCare Expanded Benefit set (Pregnant women and children under 21), please contact the county of the member’s residency or Minnesota DHS. (UCare Connect and UCare Connect + Medicare members, UCare PMAP and MinnesotaCare Expanded Benefit set [Pregnant women and children under 21] may be eligible for PCA services; however, UCare and its delegates are not the approval authorities for these services.)

**STARTING PCA SERVICES**

A PCA assessment is required to begin PCA services for an eligible UCare member.

- The member, member’s family, member’s representative, primary care clinic or physician must contact the members UCare care coordinator or UCare to request the assessment.
- UCare and/or the UCare care coordinator will accept the request by phone, fax or mail.
Initial Assessment

1. Role of the UCare care coordinator
   - State Statute requires use of the Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS- DHS- 3428D) for the PCA Assessment. Ref: Minnesota Statutes 256B. 0659 subdivision 3a.
   - The Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan is the tool that establishes the need for and level of PCA services.
   - The assessment must be performed by the UCare care coordinator or county waiver case manager.
   - Upon completion of the assessment, the care coordinator will submit to UCare and provide a copy of the service plan to the member.

2. Role of the PCA provider agency
   - Contact UCare for approval before providing service.
   - Request reassessment for PCA from the UCare care coordinator or UCare at least 60 days prior to the current authorization expiration.
   - Allow 30 days from request date for the completion of the PCA Assessment.

3. Role of UCare
   Upon receipt of the completed assessment, the authorizing entity will review the assessment recommendations and provide a written response within 14 calendar days or 10 business days.

4. UCare will send a copy of the service plan to the PCA agency.

TEMPORARY START OF PCA SERVICES

(Minnesota Statutes 256B. 0652 subdivision 9)

A temporary start of PCA services requires authorization prior to or at the start of service. The agency nurse, independently enrolled private duty nurse or county public health nurse must:

- Request authorization from the UCare care coordinator or UCare for a temporary start of care.
- Provide documentation to support the immediate need for the service.

Upon care coordinator approval UCare will:

- Issue an approval for up to 45 days. The level of services authorized under this provision shall have no bearing on future authorizations.

REQUEST FOR INCREASE IN PCA SERVICES

A request for increase in services may be made when a member has a temporary, long-term or permanent change in medical status, as described below:

- Temporary changes are those that last 45 days or less.
- Long-term changes are those that are longer than 45 days and up to 365 days.
- Permanent changes are those that are chronic or lifetime in nature.
Or medical or caregiver status changes that include, but are not limited to:

- A change in the member’s health or level of care
- Change in physician request for services
- Recent facility placement
- A change in the primary caregiver’s availability

**CHANGE OF AGENCY**

A request for a change of agency must be received via fax at UCare and must include:

- Member demographics, including member UCare ID
- Name of current PCA agency
- Member or responsible party signature

**TRANSITION OF CARE/SERVICES**

Request for continued authorization of services previously approved by another health plan:

- Agency must fax a copy of the previous health plan or DHS service agreement, or
- Copy of member’s current PCA assessment (DHS-3244/3428D)

**PCA Authorization Transfer form**

**PCA BILLING GUIDELINES**

When billing for PCA services, please use the correct agency provider identification number. Your agency could be set up in our system with either a National Provider Identifier (NPI), or will be set up with a 6-digit UCare provider legacy number along with a 4-digit UCare Group Practice number.

Billing PCA Services:

- Bill on an 837P EDI Format.
- Bill NPI in loop 2010AA (if you have an NPI).
- If you do not have a NPI, bill the 4-digit UCare group practice number in loop 2010BB.
- Bill the Unique Minnesota Provider Identifier (UMPI) (individual PCA number provided by DHS) in loop 2310B (rendering provider loop).
- Date span billing is no longer allowed for PCA services. You must line-item bill for each day a PCA service is rendered.
- If you are billing for more than one PCA on the same day, separate the claim and bill each individual PCA on a different claim for each day along with each of their UMPI numbers.

**MAKING CHANGES TO INDIVIDUAL PCA UMPI NUMBERS (ADDITIONS/CHANGES/DELETIONS)**

PCA numbers are not automatically updated in our systems for individual PCAs. If you have a new PCA with a new UMPI number, it is your responsibility to provide that information to UCare.

When there are additions, changes or deletions to your PCA UMPI listing, notify UCare by completing the online Personal Care Assistant and Entity UMPI Information Form. Once submitted, you will receive
a confirmation number. If you need to know the status of the request, you may contact the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free. They will need the confirmation number that you received when you submitted the form. Please allow 60 days for your request to be reviewed and completed.

When sending updated or new UMPI numbers to UCare, please do not send your entire PCA UMPI roster/listing. Send only the information for new or updated PCAs.

**Qualified Professional (QP) Supervision Standards**

All PCAs must be supervised by a qualified professional. Authorization is required for all supervision services.

Definition: A Qualified Professional is a registered nurse, mental health professional or licensed social worker, or a qualified developmental disabilities specialist who is responsible for supervision of PCA services.

Qualified Professionals must:

- Pass an initial background check upon hire to provide supervision of PCA services.
- Complete the DHS Steps for Success training upon initial agency enrollment or within six months of date of hire.

Provide direct observation, at a minimum, for new PCA services and for a change in PCA for a member with established PCA services.

Provide supervision at the frequency cited Minnesota Statute 256B.0659, subd. 14:

- Evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services.
- At least every 90 days thereafter for the first year.
- Every 120 days after the first year of a recipient's service or whenever needed in response to a recipient's request for increased supervision of the PCA staff.
- After the first 180 days of a recipient’s service. UCare requires that QP supervision visits be conducted in person/face to face.

**QUALIFIED PROFESSIONAL RESPONSIBILITIES**

1. Ensure and document that the PCA meets the required qualifications and is:
   - Capable of providing the required personal care services.
   - Knowledgeable about the plan of personal care services before performing those services.
   - Knowledgeable about the essential observations of the member’s health.
   - Knowledgeable about any conditions that should be immediately reported to the Qualified Professional or physician.
2. Develop the recipient’s care plan as follows:
   - With the recipient and/or responsible party.
• Within the first week after start of services with an agency.
• Update the care plan as needed when the recipient needs a change in PCA services.
• Monitor the care plan monthly.
• Develop a new care plan at the time of the recipient’s annual reassessment.

3. Perform all required supervisory functions at each evaluation visit, including:
   • Directly observe the PCA’s work.
   • Record in writing the results of the observations.
   • Identify any deficiencies in the work of the PCA.
   • Record all actions taken to correct any deficiencies in the work of the PCA.

4. Review the plan of personal care services with the member.
   • Work with the member to revise, as necessary, the plan of personal care services.
   • Ensure that the PCA and the member are knowledgeable about any change in the plan of personal care services.
   • Ensure records are kept that show the services provided and the time spent providing those services by the PCA.
   • Determine that a qualified member is capable of directing his or her own care or resides with a responsible party.
   • Determine with a physician that a recipient is a qualified recipient.
   • Assess the satisfaction level of the recipient with PCA services.
   • Review month-to-month plan for use of PCA services.
   • Documentation of PCA services provided.
   • Assess whether the PCA services are meeting the goals of the service as stated in the PCA care plan and services plan.
   • Revision of the PCA care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

**Note:** “Plan of personal care services” means a written plan of care specific to personal care services.

5. Provide for the member’s cultural and linguistic needs.
   • Identify and provide interpretation services when necessary.
   • Refrain from use of family members and the PCA as interpreters for evaluation visits and assessments.
   • Use a UCare-contracted agency for all interpretation needs.

UCare will monitor compliance with these requirements. The PCA agency is required to enforce compliance, to implement a corrective action plan if deficiencies occur or to take immediate disciplinary action if directed by UCare to do so.
Hospital Services

This section provides information regarding the hospital admission notification process for all UCare health plans. For information regarding Swing Beds admission notification process see the Nursing Facility Services section. For information regarding fiscal and intermediary letter (rate sheet) for Critical Access Hospitals, Federally Qualified Health Centers and Rural Health Clinics, see “Fee Schedules” in the Claims section.

This section also includes information regarding the Important Message from Medicare and the Detailed Notice of Discharge (DND) for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, Minnesota Senior Health Options and UCare Connect + Medicare members.

Hospital Admission Notification | All UCare Members

HOSPITAL RESPONSIBILITY

Hospitals should verify member eligibility prior to providing service.

Inpatient admissions: Fax daily inpatient admissions report to the Clinical Intake line at 612-884-2499 or email (secured) to UCareadmissions@UCare.org. Refer to the authorization requirements grid on the Eligibility & Authorizations page of the UCare provider website (www.UCare.org/providers) or call 1-877 447-4384 toll free-610-7215 within one business day from the date of admission. Please include the member’s name, UCare ID number, date of birth, ICD-10 diagnosis and admission date.

Observation admissions: All hospitals that contract with UCare are expected to be compliant with the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The Act requires all hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation of the notification to individuals receiving observation services in an outpatient status for more than 24 hours. The Medicare Outpatient Observation Notice (MOON) was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. In accordance with the statute, the notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted. Please ensure that your organization is properly notifying patients in observation stays. The CMS guidance, instructions and MOON templates are available at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Obstetric/newborn admissions: The delivery date and delivery type, birth weight, and level of care are required. Find the Birth Notification Form on the Provider Manual web page, under Resources for Hospitals. Fax it to Clinical Intake at 612-884-2499 or 1-866-610-7215 toll free.

Behavioral health admissions: UCare Behavioral Health processes all Mental Health and Chemical Dependency admissions for UCare members. Contact UCare Behavioral Health at: 612-676-6705 or 1-
Detoxification in a hospital is not a behavioral health admission. Detoxification for members needing medical stabilization is a medical service, providers should follow the inpatient admission process listed above. When the member is ready for chemical dependency treatment, contact UCare Behavioral Health.

**Acute Inpatient Rehab and Long Term Acute Care (LTAC) admissions:** UCare requires prior authorization for Acute Inpatient Rehab and LTAC hospital admissions. Requests are reviewed for medical necessity in advance and concurrently throughout the admission and through discharge.

*Please note, for 2019 Acute Inpatient Rehab and Long Term Acute Care (LTAC) admissions for UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview require notification of admission to the facility.*

UCare uses utilization triggers for utilization management and case management. Hospitals are expected to:

- Promptly provide adequate clinical information for any stay upon request.
- Provide for reasonable access to hospital utilization review staff.
- Notify UCare when needs for case management or discharge planning support are identified.

*Note: All admissions for Acute-In-Patient Rehab or LTAC are processed by UCare Clinical Services at 612-676-6705 (choose "option 2") or 1-877-447-4384 toll free; or by fax at 1-866-610-7215 toll free or 612-884-2499.

**DAILY ADMISSION REPORT**

Daily Admission Reports are produced and shared with facilities each day by UCare to verify the admission notifications received by UCare for a facility. New reports are created seven days per week/365 days a year and are uploaded to UCare’s secure website for retrieval by hospitals and delegated care coordination agencies.

Individual hospitals that wish to receive electronic admission reports can contact UCare at 612-676-6705 or 1-877-447-4384 toll free with an email address for a designated staff member. Once registration is complete, they will receive an email notice when a report has been uploaded, which also includes access instructions.

Hospitals must designate a department to receive and process the report. The hospital should verify their record of admissions with the Daily Admission Report. The hospital should promptly communicate any omissions, errors or other issues to UCare at 612-676-6705 or 1-877-447-4384 toll free. Unreported errors may lead to denied or delayed payment for the services.

Below is the information available on the Daily Admission Report:

1. Notification/certification number - This number is assigned by UCare and can be used to reference the notification or for tracking
2. UCare member ID number
3. Member last name
4. Member first name
5. Birth date
6. Benefit/Product description:
   RISK = Medicare Risk (UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare)
   MSHO = UCare's Minnesota Senior Health Options
   PMAP = Prepaid Medical Assistance Program
   MNCARE = MinnesotaCare
   MSC+ = Minnesota Senior Care Plus
   CONNECT = UCare Connect and UCare Connect + Medicare
   IFP = UCare Individual & Family Plans/UCare Individual and Family Plans with Fairview (Exchange product)
7. Date of admission
8. ICD-10 diagnosis codes
9. Care coordinator entity or system - This information is included, when applicable, for purposes of communicating and coordinating discharge care plans.

Example of Daily Admission Report

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**Notice of Discharge and Medicare Appeal Rights for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, Minnesota Senior Health Options and UCare Connect + Medicare Members**

When a UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, Minnesota Senior Health Options or UCare Connect + Medicare member is admitted to a hospital, the facility must provide the member inpatient hospital discharge appeal rights. “An Important Message from Medicare About Your Rights (IM),” a statutorily required notice, explains members’ rights as a hospital inpatient, including discharge appeal rights.

**Use of Standardized Notice.** Hospitals must use the standardized IM form (CMS-R-193), (Exp. 03/31/2020). The notices are also available at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html. Hospitals may not deviate from the content of the form except where indicated. The Office of Management and Budget (OMB) control number must be displayed on the notice.
Delivery Timeframe. If the IM is not given prior to admission, hospitals must deliver the IM to the enrollee at or near admission, but no later than two calendar days following the date of the enrollee’s admission to the hospital. The hospital may deliver the IM within seven days of admission but only in those cases where an enrollee has a scheduled inpatient visit, such as elective surgery. Hospitals may not deliver the IM to an enrollee who is in an outpatient or observation setting on the chance that the patient may end up receiving inpatient care.

Follow-up Important Message from Medicare. A “follow-up” copy of the signed IM must be delivered to the member using the following guidelines: If the member is being discharged more than two calendar days after receiving the IM at admission, hospitals must deliver the follow-up copy as far in advance of discharge as possible, but no more than two calendar days before the anticipated/planned date of discharge. Thus, when discharge seems likely within one to two calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice, so that the member has a meaningful opportunity to file an appeal if the member does not agree with the plan for discharge.

When UCare or the attending physician determines that a member no longer meets inpatient hospital criteria and is being discharged to a non-covered, custodial level of care, the follow-up copy of the IM should be given. However, for members who are to be moved to the covered, skilled level of care (swing bed or a skilled nursing facility), the IM should not be delivered until a bed is available.

Detailed Notice of Discharge (DND). A member in a Medicare inpatient hospital stay has a right to request an immediate review by the Quality Improvement Organization (QIO). If UCare or the hospital determines that inpatient care is no longer medically necessary and the member files an appeal, the QIO will contact UCare and request the DND to be delivered to the member. The DND provides the member with a detailed explanation about why UCare or the hospital decided that inpatient care should end. If UCare made the decision that inpatient care should end, the DND will be completed by UCare staff and faxed to hospital staff for delivery to the member. The DND must be delivered to the member as soon as possible, but no later than noon of the day after the QIO notification. Hospital staff must keep documentation of delivery time of the DND.

Use of Standardized Notice. Hospitals must use the Detailed Notice of Discharge (CMS-10066). (Exp. 10/31/2019)

In-Person Delivery. The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee’s representative.

Notice Delivery to Representatives. CMS requires that notification of the enrollee’s Medicare appeal rights to be made to the enrollee’s representative when the enrollee is not competent or able to receive or comprehend the information. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the enrollee’s legal guardian, or someone appointed in accordance with a properly executed “durable medical power of attorney”).

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for him or her, but who has not been named in any legally binding document, may be a representative for purpose of receiving the notices described in this section. Such representatives should have the enrollee’s best interests at heart and must act in a manner that is protective of the enrollee and the enrollee’s rights. Therefore, a representative should have no relevant conflict of interest.
Regardless of the competency of an enrollee, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the enrollee’s rights as a hospital inpatient, including the right to appeal a discharge decision.

When direct phone contact cannot be made, the hospital should send the notice to the representative by certified mail, return receipt requested or any method in which delivery may be tracked and verified (e.g., UPS, FedEx, etc.). The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date received. The hospital should place a copy of the notice in the enrollee’s medical file and document the attempted telephone contact with the member’s representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call and the telephone number called.

If both the hospital and the representative agree, hospitals may send the notice by fax or e-mail. However, hospitals must meet the HIPAA privacy and security requirements when transmitting the IM by e-mail or fax.

Ensuring Enrollee Comprehension. Notices should not be delivered during an emergency. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee’s signature. This includes explaining the notice to the enrollee if necessary and providing an opportunity for the enrollee to ask questions. The hospital should answer all the enrollee’s questions orally to the best of its ability. The enrollee should be able to understand that he or she may appeal a discharge decision without financial risk, but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal.

These instructions do not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Enrollee Signature and Date. The IM must be signed and dated by the enrollee to indicate that he or she received the notice and understands its contents. If you are unable to obtain a signature from the enrollee, record on the IM form why a signature was not obtained.

Refusal to Sign and Annotation. If an enrollee refuses to sign the notice, hospitals may annotate the notice to indicate the refusal and the date of refusal is considered the date of receipt of the notice. The annotation may be placed on the unused patient signature line, in the “Additional Information” section on page 2 of the notice, or another sheet of paper may be attached to the notice. Any insertions on the notice must be easy for the enrollee to read (i.e., in at least 10 point font) in order for the notice to be considered valid.

Notice Delivery and Retention. Hospitals must give the patient a copy of the signed or annotated notice and retain a copy of the signed notice for its own records. The hospital may determine whether to retain the original notice or give it to the enrollee. Providers may also determine the method of storage that works best within their existing processes, for example, storing a copy in the medical record or electronically.

For more information regarding CMS requirements for member notification, please see Chapter 13 of the Medicare Managed Care Manual.
Care Transitions

For UCare members in acute inpatient, skilled nursing facilities, nursing facilities, rehabilitation settings and customized living facilities, the organization is responsible for facilitating safe transitions for members from one setting to the next.

All members of UCare’s MSHO and MSC+ products are automatically assigned a care coordinator/case manager. Members enrolled in UCare Medicare Plans, UCare Medicare Plan with Fairview & North Memorial, EssentiaCare, UCare Individual & Family Plans, UCare Individual & Family Plans with Fairview, UCare Connect (SNBC) and UCare Connect + Medicare (SNBC) are assigned a care coordinator/case manager based on specific criteria including acute complex medical need and identified diagnoses. The care coordinator/case manager is responsible for facilitating safe transitions for members from one setting to the next. Case managers/care coordinators must make themselves available to members, family members, facilities, providers or others to assist with both planned and unplanned transitions. Care coordinators/case managers coordinate care when members move from one setting to another, such as when a member is discharged from a hospital to home or from a hospital to a skilled nursing facility (SNF). In some cases members may also need assistance after an outpatient procedure.

While the care coordinator/case manager is ultimately responsible for ensuring that care transition tasks are completed, UCare requires providers and facilities to work collaboratively with the care coordinator/case manager and the member and their family to ensure care is coordinated as members transition from one setting to another, such as when they are discharged from an acute setting to a community setting.

- For both planned and unplanned transitions, the sending facility should share the member’s plan of care with the receiving facility within one business day of the transition. This can be done in several ways, such as sending a complete facility transfer form or copy of the discharge instructions, or by communicating verbally with the receiving facility.
- For both planned and unplanned transitions from any setting to another setting, the facility/provider should communicate with the member or members’ responsible party about the transition process and any changes to the member’s health status and plan of care.

UCare requires that facilities such as hospitals, skilled nursing facilities, rehabilitation units or customized living centers communicate with the member’s primary care provider regarding both planned and unplanned transitions.
Interpreter Services

This section explains how to access interpreter services, professional standards for interpreters and how to work with interpreters. It also provides guidance for UCare’s contract interpreter service agencies on claims and reporting.

Access to Interpreter Services

All UCare members may contact our health plan to access interpreter services, when working with UCare. However, UCare provides interpreters in a medical or dental setting for non-English-speaking members of our Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MnCare), Minnesota Senior Care Plus (MSC Plus), UCare Connect, UCare Connect + Medicare, and UCare’s Minnesota Senior Health Options (MSHO) plans. UCare Provider Relations and Contracting (PRC) Department continually evaluates its interpretation network to ensure appropriate geographic, language and cultural competency coverage. PRC consults with UCare’s Customer Service department, Diversity and Cultural Competency Committee and primary care providers as well as the Minnesota Department of Human Services to ensure members have access to high-quality interpreters.

ARRANGING INTERPRETER SERVICES AT YOUR CLINIC

It is our desire to enhance access to medical services at your clinic through the interpreter services program.

Providers may access interpreter services for UCare members in the following ways:

- **Calling a UCare contracted interpreter agency.** Providers can call the agencies listed below to schedule interpreter services. Members can also obtain the names and phone numbers of UCare contracted agencies by calling UCare Customer Service.
  Things to remember when working with an interpreter agency:
  A. When using contracted interpreters, clinic staff will need to review and sign interpreter work orders.
  B. Schedule any follow up appointments or specialty/ancillary services the member needs while the interpreter is present.
  C. Clinics are required to notify UCare immediately if they observe any unprofessional and/or inappropriate conduct by a contracted interpreter.
- **UCare’s contracted phone interpreters.** UCare contracts with an interpreter services vendor. If an in-person interpreter is not available to interpret, a contracted UCare provider who provides services to a UCare enrollee may call the interpreter services vendor at 1-888-413-2915.
- **UCare primary care clinic with in-house interpreter service.** Several primary care clinics employ in-house interpreters. The primary care clinic must obtain an addendum to their current primary care contract or an interpreter contract in order to provide services. Staff interpreters can have priority for providing interpreter services at their clinic site.
- **UCare’s primary and specialty network.** The primary care and specialty network is diverse and includes many providers who speak languages other than English. An enrollee may choose to see a provider in their native language, if available, eliminating the need for an interpreter.
When the information is available, [Find A Doctor](#) will display the language(s) spoken by a specific provider.

**INTERPRETER SERVICE EXPECTATIONS**

1. UCare will reimburse sign and oral language interpreter agencies for services provided at authorized UCare providers.
2. The interpreter service agency or interpreter is required to perform clinic appointment reminder calls to patients and to accompany patients to prescription pick-ups after a clinic visit.
3. The interpreter is not required to provide transportation to UCare members.
4. The interpreter is expected to arrive 10 minutes before the scheduled appointment.
5. The interpreter is required to remain at the clinic 30 minutes past their arrival time to ensure their availability if the patient or physician is late. The interpreter may leave prior to the 30 minutes wait time if the clinic determines and documents that the appointment has been canceled and the patient has been contacted and notified by the interpreter. A work order must be completed and signed by clinic staff for the wait time.
6. Interpreters are, except on rare occasions which will be clearly communicated, to be available for a minimum of 60 minutes. If the interpreter needs to leave during the appointment, they must inform the provider/staff a minimum of 15 minutes before they leave to give the provider/staff the opportunity to notify the interpreter service agency and find a replacement interpreter.
7. UCare requires that interpreters wear identification badges at all times while providing services to UCare members. The identification badge must include a picture ID, name of the agency and full name of the interpreter identifying the interpreter as a medical interpreter.
8. UCare requires that the interpreter completes a work order for each interpreter service. Clinic staff must review the work order for accuracy. The completed work order must be signed and dated by a clinic staff person at the end of the appointment. The printed name of the clinic staff person and their title must appear on the work order. If there are discrepancies on the work order, the clinic staff may refuse to sign the work order or must make the changes on the work order. If there are changes made by clinic staff on the work order, their initials are required next to the changes. The completed work order must be signed at the end of the appointment; it cannot be signed before the appointment ends, another time or at a later date.
9. Individual interpreters must not solicit UCare members at any clinic site, unless the clinic indicates that there is a need to have an interpreter readily available.
10. Gender appropriate interpreters must be provided, if requested by the patient or the clinic.
11. The sign and oral language interpreter services UCare will not reimburse include, but are not limited to:
   - Services provided in patient hospitals and long term care facilities.
   - Interpreter’s mileage, parking fees, meals, wait time, transportation, voicemail services and weekend or after-hours premium fees.
   - Services provided to any family member or friend of the agency’s staff, including but not limited to all interpreters working on behalf of agency (family members are defined as the interpreter's parents, spouse, domestic partner, children, grandparents, sibling, mother-in-law, father-in-law, brother-in-law or sister-in-law).
• Services if the primary caregiver and/or other clinic staff speak the patient’s language.
• Services provided for worker’s compensation or auto injury-related services.
• Cancellations or no shows by the interpreter.

For additional interpreter performance expectations, please read the Professional Standards for Interpreters section.

**UCare Contracted Interpreter Service Agencies**

Below is a list of interpreter agencies that are contracted with UCare as of when this manual was last updated. To verify the agencies in the UCare network, call the UCare Customer Service number on the member’s ID card.

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<tr>
<td>A-Z Friendly Languages</td>
<td>Albanian, Amharic, Arabic, Armenian, Azerbaijani, Bassa, Belarusian, Bengali, Body, Bosnian, Bulgarian, Cambodian (Khmer), Cantonese Croatian, Czech, Edo, Ewe, Farsi, French, Georgian, German, Gio (Geo), Grebo, Greek, Hindi, Hmong, Hungarian, Igbo, Japanese, Kisii, Korean, Kpelle, Krahn, Kru, Laotian, Latvian, Liberian, Lithuanian, Lorma, Mandarin, Mandingo, Mano, Mina, Moldovan, Oromo, Oromiffa, Pashto, Polish, Portuguese, Pulaar, Punjabi, Romanian, Russian, Sapo, Sebuano, Somali, Spanish, Susu, Swahili, Tagalog, Telugu, Thai, Tibetan, Tigrinya, Toisanese, Turkish, Twi, Ukrainian, Urdu, Vietnamese, Yoruba, Zulu</td>
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<td>1113 E. Franklin Ave., Ste. 210A</td>
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<tr>
<td>Minneapolis, MN 55404</td>
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<tr>
<td>763-566-4312</td>
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<td>ARCH Language Network</td>
<td>Afar, Afghani, Amharic, Anuak, Arabic, Armenian, Belarus, Bosnian, Burmese, Cambodian, Cantonese, Chinese, Dioula,</td>
<td>Anoka, Blue Earth, Carver, Dakota, Dodge, Hennepin, Kandiyohi, Le Sueur, Lyon, McLeod,</td>
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<tr>
<td>125 Little Canada Road West, Suite 200</td>
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<tr>
<td>Little Canada, MN 55117</td>
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<td>651-789-7897</td>
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<tr>
<td>1-877-789-7818</td>
<td>Farsi, French, German, Hindi, Hmong, Igbo, Italian, Karen, Korean, Kuchi, Laotian, Malinke, Mandarin, Mandingo, Nuer, Oromo, Pashto, Pidgin English, Portuguese, Punjabi, Russian, Serbian, Somali, Spanish, Swahili, Tagalog, Thai, Trigrinya, Turkish, Ukraininan, Urdu, Vietnamese, Yoruba</td>
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<tr>
<td>CareInt 4033 Abbott Avenue South Minneapolis, MN 55410 612-922-0587</td>
<td>Russian</td>
<td>Hennepin, Ramsey</td>
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<tr>
<td>Intercultural Mutual Assistance Association 2500 Valleyhigh Dr. NW Rochester, MN 55901 507-289-5960 <a href="http://www.imaa.net">www.imaa.net</a></td>
<td>Amharic, Anuak, Arabic, Bosnian, Dinka, Filipino, French, German, Greek, Hindi, Hmong, Italian, Karen, Kannada, Khmer, Laolue, Laotian, Laotinh, Lotoko, Luganda, Mai (Somali), Mende,</td>
<td>Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca,</td>
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<td>All MN Counties, and these WI Counties: Barron, Buffalo, Burnett, Chippewa, Clark, Crawford, Douglas, Dunn, Eau Claire, Jackson, Juneau, La Crosse, Marathon, Monroe, Pepin, Pierce, Polk, Richland, Rusk, Sawyer, St. Croix, Taylor, Trempealeau, Vernon, Washburn, Wood</td>
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<td>Amharic, Anuak, Arabic, Armenian, Belarusian, Berber, French, Georgian, Khmer, Moldovan, Oromo, Romanian, Russian, Spanish, Somali, Sudanese, Swahili, Ukrainian</td>
<td>Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright</td>
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<td>American Sign Language (ASL), Amharic, Arabic, Bassa, Bosnian, Cambodian, Cantonese, Dinka, Farsi, French, Hindi, Hmong, Italian, Japanese, Kiswahili, Korean, Kpelle, Kurdish, Laotian, Lingala, Mandarin, Oromo, Russian, Serbo-Croatian, Somali, Spanish, Swahili, Tibetan, Vietnamese, Yoruba</td>
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<td>The Bridge World Language Center, Inc.</td>
<td>Amharic, Anuak, Arabic, Belarus, Bengali, Bulgarian, Burmese, Cambodian, Cantonese, Chinese, Creole, Croatian, Farsi, French Gujurati, Hindi, Hmong, Indonesian, Italian, Japanese, Javanese, Kissi, Korean, Krahn, Kurdish, Laotian, Nuer, Oromo, Polish, Portuguese, Punjabi, Russian, Sapo, Serbo-Croatian, Spanish, Somali, Swahili, Tagalog, Thai, Tigrinya, Ukrainian, Urdu, Vietnamese, Yoruba</td>
<td>Anoka, Benton, Carver, Clay, Crow Wing, Dakota, Douglas, Hennepin, Isanti, Kandiyohi, Koochiching, Lyon, Meeker, Nobles, Olmsted, Pope, Ramsey, Rice, St. Louis, Scott, Sherburne, Stevens, Todd, Washington, Wright</td>
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<td>The Language Banc, Inc.</td>
<td>Akan, Albanian, Amharic, Arabic, Armenian, Bashto, Bassa, Belorussian, Bengali, Bhutan, Bosnian, Bulgarian, Cambodian, Cantonese,</td>
<td>All counties in Minnesota</td>
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<td><a href="http://www.wcinterpreters.com">www.wcinterpreters.com</a></td>
<td>Arabic, Karen, Kiswahili, Somali, Spanish</td>
<td>West Central Interpreting &amp; Consulting Services LLC&lt;br&gt;316 Becker Avenue SW, Suite 315&lt;br&gt;Willmar, MN 56201&lt;br&gt;320-235-0165&lt;br&gt;320-235-0105 (Fax)&lt;br&gt;<a href="http://www.wcinterpreters.com">https://wcinterpreters.com/</a></td>
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**PROFESSIONAL STANDARDS FOR INTERPRETERS**

Quality interpreting requires that the interpreter adheres to a code of ethics and follows professional standards of practice. UCare expects all spoken language interpreters to follow the National Council on Interpreting in Health Care (NCIHC) National Standards for Interpreters in Health Care and the NCIHC National Code of Ethics for interpreters in Health Care. These documents may be found at [http://www.ncihc.org/](http://www.ncihc.org/).
American Sign Language (ASL) interpreters are expected to adhere to the Registry of Interpreters for the Deaf (RID) Code of Professional Conduct, which can be viewed at [http://www.rid.org/](http://www.rid.org/). In addition, the ASL interpreter must be RID certified.

**Guidelines for Health Care Professionals in Working with Interpreters**

Use qualified interpreters to interpret.

The most basic requirement is that you have access to an experienced and qualified interpreter who can truly aid communication rather than getting in the way or distorting the messages that you and the patient want to communicate. Being bilingual in English and the patient's language is only a prerequisite for being able to interpret (just as speaking English is only a prerequisite for teaching it; being a native speaker doesn't make you a language teacher). A qualified, professional interpreter has the special skills needed to fully understand anything another person wants to say and to make that person's message clear to another person in a different language. In addition, like any professional, a qualified interpreter knows their role, their limitations and their responsibilities as an interpreter for others.

Don't depend on children or other relatives and friends to interpret. Do not ask children or relatives or friends of the person you are going to meet with to interpret. Do not call upon staff members or others unskilled in interpreting even if they speak both languages. If bilingual staff with other responsibilities does the interpreting, they must not try to do two things at once, e.g., interpreting and counseling.

Have a brief pre-interview meeting with the interpreter. Plan to meet with the interpreter for a couple of minutes before the interview to explain the situation and any background needed for understanding what you plan to talk about. Agree with the interpreter in advance on such things as how the interview will start and where the interpreter should sit.

Establish a good working relationship with the interpreter. If possible, try to work with the same interpreter over time so that you can establish a comfortable working relationship. Although your roles are quite different, you need to be able to work together as a team.

Plan to allow enough time for the interpreted session. Schedule enough time for the interview, remembering that an interpreted conversation requires every statement or question to be uttered twice.

Address yourself to the interviewee, not the interpreter. Speak directly to the patient, not to the interpreter, addressing the patient rather than the interpreter as "you." Your eye contact should be with the patient, not with the interpreter – because it is the patient you are talking to, not the interpreter.

Don't say anything that you don't want the other party to hear. Expect everything you say to be translated as well as everything the patient says. But remember that what can be said in a few words in one language may require a lengthy paraphrase in another.

Use words, not just gestures, to convey your meaning. The words are easier for the interpreter to deal with and the patient won't be hearing your words at the same time as your gestures.
Speak in a normal voice, clearly, and not too fast. Speak in your normal voice, not louder or slower (unless the interpreter asks you to slow down). Sometimes it is easier for the interpreter to interpret speech produced at normal speed with normal rhythms, rather than artificially slow speech.

Avoid jargon and technical terms. Avoid idioms, technical words or cultural references that the interpreter either might not understand or might have difficulty translating. (Some concepts may be easy for the interpreter to understand but extremely difficult to translate.)

Keep your utterances short, pausing to permit the interpretation. For consecutive interpreting, you should speak for a short time – one longer sentence or three or four short ones, and then stop in a natural place to let the interpreter pass your message along. Be aware of the length or complexity of your speech so as not to unduly tax the interpreter’s memory. Short simple sentences are obviously easier. Do not pause for interpretation in the middle of a sentence, since the interpreter may need to hear the whole sentence before he/she can even start to interpret it.

Ask only one question at a time. If you link questions together, you may not be able to match the questions with the answers.

Expect the interpreter to interrupt when necessary for clarification. Be prepared to have the interpreter interrupt when necessary to ask you to slow down, to repeat something they didn’t quite get, to explain a word or concept they might not be familiar with, or to add an explanation for something the patient may not be able to understand without some background information.

Expect the interpreter to take notes if things get complicated. Don't be surprised if the interpreter takes notes to facilitate recall. This is an aid to memory, not an interruption.

Be prepared to repeat yourself in different words if your message is not understood. If mistranslation is suspected (for example, if the response doesn't seem to fit with what you said), go back and repeat what you said in different words.

Have a brief post-interview meeting with the interpreter. Meet with the interpreter again after the interview to assess how things went, to see if the interpreter is satisfied or has questions or comments about the process of communication.

If your interpreter has a limited command of English or limited interpreting skills, you may need to do some of the following: Make sure the interpreter understands her role before you begin. Urge her to speak directly to you and the other party, using the first person pronoun to refer to the speaker. Instruct her not to add or delete anything, and especially not to add her own comments about what is said, or to offer advice, suggest questions or answers to your questions to the patient, etc. Use the simplest vocabulary that will express your meaning.

Speak in short and simple sentences. Check to see if the message is understood. For important messages, such as instructions, directions, etc., ask the interpreter to repeat the message back to you in English, so you can make sure they understood it and encourage them to ask for clarification of anything they don’t fully understand before they attempt to interpret your message to the patient. You can also ask the patient to confirm his or her understanding of what you said if this would not unduly embarrass the patient.
When interpreting is used, you will be communicating THROUGH the interpreter but TO the patient. Dealing with cultural differences and the personality of the patient is primarily your job, not the interpreter's.

Here are some things to keep in mind with regard to the linguistic and cultural differences between you and the patient.

EXAMPLE: There may be less eye contact on the part of the patient than you would normally expect, and the eye contact may be with the interpreter rather than with you.

EXAMPLE: A smile or nod on the part of the patient may not mean what it would mean if done by you or someone from your culture.

Remember that if the patient comes from a different culture, then so do you. Remember that if the patient has trouble grasping your way of thinking and the concepts and metaphors involved, you are probably having the same trouble dealing with the patient's way of thinking and the abstractions and metaphors of another culture. If the patient has language problems when talking to you, then you have language problems, too. The patient probably knows more of your language than you do of his or hers. Remember that the interpreter is not there (just) to interpret for the patient or to interpret the patient's language. The interpreter is there to interpret for two individuals who don't know each other's languages, you and the patient. The interpreter is there to facilitate communication between the two of you. The interpreter is there to render each speaker's utterances in the other person's language, in such a way that the meaning of each utterance can be understood.

Source: Bruce T. Downing Program in Translation and Interpreting, University of Minnesota

**Interpreter Services Requirements and Performance Expectation**

The following are requirements and expectations of interpreters and interpreter service agencies. Failure to follow them is a breach of the UCare participation agreement and may result in network termination.

1. The interpreter service agency, clinic, hospital or care system through which the interpreter is working is required to perform a criminal background check through the Minnesota Bureau of Criminal Apprehension, with the cost incurred by either the individual or the employer. Additionally, the interpreter’s employer must check the interpreter’s status using the Office of Inspector General Exclusion (OIG) at [http://exclusions.oig.hhs.gov/](http://exclusions.oig.hhs.gov/) and System for Award Management (SAM) at [https://www.sam.gov/SAM/](https://www.sam.gov/SAM/).

Verification of the Minnesota Bureau of Criminal Apprehension, OIG and SAM must be completed before the interpreter is hired and interpreter services are provided to UCare enrollees. Failure to complete all three verifications will result in nonpayment for services rendered to UCare members. Verification must be completed annually for each interpreter.

An interpreter with a felony charge is prohibited to provide service to UCare enrollees. Plus, an
An interpreter who is listed on the OIG or SAM system is prohibited to provide service to UCare enrollees.

All verification must be recorded and documented as part of the interpreter’s credentials in the interpreter service agency’s or clinic’s files. Interpreter service agency, clinic, hospital or care system must provide results upon UCare’s request.

2. The interpreter, the interpreter service agency, and the clinic, hospital or care system through which the interpreter is working must comply with immunization and tuberculosis (TB) testing standards. Health care organizations are required to ensure compliance with national standards with regard to immunizations, verification of immune status and TB testing among all health care workers. For immunization, the interpreter, interpreter service agency, clinics, hospitals or care systems must comply with the standards that have been established by the Centers for Disease Control and Prevention (CDC) under the guidelines for healthcare workers. For TB testing, the interpreter, interpreter service agency, or clinic, hospital or care system must comply with the Minnesota Department of Health under the guidelines for healthcare workers. The interpreter service agency will provide documentation certifying interpreters have no active TB infection and are immune to Hepatitis B, measles (rubeola), rubella (German measles) and varicella (chicken pox) upon UCare’s request.

3. The interpreter service agency, clinic, hospital or care system must make sure the following credentials are recorded and maintained in the Interpreter Service Agency’s application, interview notes and subcontract/employment files:
   - The interpreter is proficient in the patient’s native language and in the English language.
   - The interpreter understands and respects the culture of the patient and that of the medical professional.
   - The interpreter shall have a working knowledge of medical terminology and experience in medical interpretation.
   - The interpreter shall provide timely, reliable and competent interpreter services.
   - The interpreter will receive orientation to and follow guidelines based on the National Council on Interpreting in Health Care Code of Ethics and Professional Standards of Interpreters.
   - Participant will comply with Minnesota Statute 256B.0625, Subdivision 18 a., Section 144.058, which requires interpreters to enroll in the Minnesota Roster of Spoken Language Healthcare Interpreters.

4. The interpreter service agency must furnish and require the use of identification badges that include a picture ID, name of the agency and full name of the interpreter who is identifying them as a medical interpreter. The interpreter service agency will inform interpreters that they must wear their badge in a visible manner at all times while on health care facility premises and providing interpretation service to UCare members.

5. The interpreter service agency must furnish to UCare training materials they use to train newly hired and/or contracted interpreters upon request to UCare. Training must be documented in the employed and/or contracted interpreter’s individual file. UCare will provide 10 business days for interpreter service agency to comply with request.
6. The interpreter service agency must furnish any additional trainings that are provided to interpreters after initially hired and/or contracted upon request to UCare. These trainings must be documented in the employed and/or contracted interpreter’s individual file. UCare will provide 10 business days for interpreter service agency to comply with request.

7. The interpreter service agency may only employ or directly subcontract with individual interpreters. The interpreter service agency may not subcontract with any other interpretation agency and may not assign UCare enrollee interpretation services to any agency not directly contracted with UCare.

8. The interpreter service agency must inform interpreters that direct solicitation of interpreter services to UCare members or to any Minnesota Health Care Programs recipient is strictly prohibited. The agency is responsible for enforcing the policy.

9. The interpreter service agency is responsible to coordinate and schedule all appointments. The interpreter is strictly prohibited from scheduling direct appointments with clinics, health care providers or members. This excludes, follow-up appointments scheduled at the end of a medical appointment with the clinic and enrollee present. Follow-up appointments scheduled by the interpreter must be reported and coordinated through the interpreter service agency.

10. The interpreter service agency must document all appointments through their schedule and tracking systems.

11. The interpreter service agency must have provisions or policies to ensure that individual interpreters are billing services under the interpreting agency originally contacted to perform the service.

12. The interpreter service agency will monitor and assess the quality of interpreter’s performance. The interpreter service agency agrees that if there are performance issues with specific interpreters, the agency is required to implement a corrective action plan or disciplinary action. In addition, UCare or the clinic reserves the right to deny future assignments to that interpreter.

Examples of possible performance issues include, but are not limited to:
- Late arrival to appointments without a valid reason or notice.
- Missing an appointment without a valid reason or notice.
- Lack of English or targeted language fluency.
- Leaving the appointment prior to completion of assignment without the agreement or permission of staff.
- Failure to wear photo ID badge in a visible manner or to provide identification to staff when requested.
- Soliciting business from clinic clients or staff.
- Fraudulent documentation.
- Abuse of interpreter services.
- Failure to follow code of ethics and standards of practice.
- Failure to follow the interpreter service agency’s polices and/or procedures.
- Schedule appointment that was not requested by the member, clinic or health plan.
- Unethical conduct and/or inappropriate behavior.
13. The interpreter service agency must supply the work order for the individual interpreters. The work order must have the following information:
   • Agency’s name and logo
   • Agency’s address and phone number
   • Arrival and departure time
   • The member’s name and address
   • The member’s UCare ID number
   • The date of service
   • Appointment time (not applicable to pharmacy claims)
   • Name of clinic or place of service
   • Address of clinic or place of service
   • Comment or Note section
   • Interpreter's MDH Roster ID number (does not apply to ASL interpreters)
   • Interpreter’s name, signature and date
   • Clinic staff’s name, signature and date. The clinic staff’s name must also be printed and legible.

The work order must be signed by the clinic or health care provider’s staff at the end of the appointment, not before the appointment ends. Interpreter is not allowed to return to the clinic at a later time or date to have the work order signed. The interpreter service agency is responsible to review and confirm the work order for accuracy. Any corrections made by the clinic, interpreter service agency or interpreter must be initialed and dated by the individual party who made the changes. The agency must review the corrections and sign the work order acknowledging that the corrections are valid. Services will not be paid if work orders are submitted without the clinic staff name, which is to include a signature as well as a legible printed name.

14. Verification of UCare enrollee eligibility must be done by the interpreter service agency and not the individual interpreters.

15. The interpreter service agency must, at all times, record and maintain a written record of all interpreter services. Records must be kept at least 10 years. The agency must provide the written records to UCare upon request.

16. The interpreter service agency must submit a quarterly report to UCare. The report is due by the end of the month, following the last month of the quarter (April 28, July 28, October 31 and January 31). It must include all claims billed to UCare within that quarter. It must be in Microsoft Excel format and include the following information, in this column order:
   A. Interpreter First Name
   B. Interpreter Middle Name
   C. Interpreter Last Name
   D. Interpreter MDH Roster ID Number
   E. Language Interpreted
F. UCare Member Last Name
G. UCare Member First Name
H. UCare Member ID Number
I. Date of Service
J. Appointment Start Time
K. Appointment End Time
L. Service Provider Name
M. Service Provider Address (including City, State & ZIP code)
N. Type of Appointment/Service (face to face, ASL, cancellation, no show, phone, mileage)
O. Units Billed
P. Amount Billed

The required Interpreter Quarterly Report template is available on the Provider Manual web page under Transportation & Interpreters. (Click the link above and download the report and then open the Excel document. You can save a copy to your own computer for your use.)

17. The interpreter service agency must submit a current roster list of their interpreters to UCare prior to the effective date of the agreement between UCare and the interpreter service agency. The roster list must be maintained. On a yearly basis, it must be submitted to UCare at the beginning of each year by January 31. The interpreter roster list must be in Microsoft Excel format and include the following information, in this column order:
A. Interpreter First Name
B. Interpreter Middle Name
C. Interpreter Last Name
D. Interpreter MDH Roster ID Number
E. Language Interpreted
F. Language Interpreted
G. Language Interpreted
H. Home Address
I. City
J. State
K. ZIP code
L. Social Security Number
M. Date of Birth
N. Gender
O. Date of Hire
P. Date of Orientation
Q. Signed Date of Code of Ethics
R. Education (Ongoing)
S. Date of Criminal Background Check
T. OIG Last Verified
U. EPLS/SAM Last Verified
V. Immunizations Current
W. Date of Individual Training/Certification

X. MN Roster Expiration

Any changes to the agency's interpreter roster should be sent within 30 days to UCare. This includes new hires and interpreters who are no longer with the interpreter service agency. This must be reported to UCare on the Interpreter Change Form. Another way to report interpreter change is to submit a Microsoft Excel spreadsheet to UCare by fax or secure email. See the Add, Update or Remove an Interpreter Form Example on the Provider Manual web page, under Transportation & Interpreters.

18. The use of the UCare name or logo in any marketing efforts by the interpreter service agency is strictly prohibited without prior approval from UCare.

19. The interpreter service agency is responsible to make sure a gender appropriate interpreter is being provided if requested by the patient or clinic.

20. The interpreter service agency or interpreter is required to perform a clinic appointment reminder call to each client within 24 hours prior to the appointment.

21. The interpreter must be available for a minimum of 60 minutes for each appointment.

22. The interpreter is required to arrive 10 minutes early for an appointment.

23. The interpreter is required to remain at the clinic 30 minutes past the appointment time to ensure their availability if the patient or physician arrives late. The interpreter may leave prior to the 30 minutes wait time if the clinic determines and documents that the appointment has been canceled and the patient has been contacted and notified. A work order must be completed and signed for the wait time.

24. The interpreter must assist the enrollee with checking in and scheduling follow-up appointment, as necessary.

25. If the interpreter needs to leave prior to the 60 minutes or before the appointment ends, the interpreter must give the clinic or provider’s staff a minimum of 15 minutes advance notice. This is to allow the provider’s staff the opportunity to notify the interpreter service agency to send a replacement for an interpreter, if needed. The attending interpreter cannot leave until the interpreter service agency has confirmed with the provider’s staff that a replacement has been filled and an estimated arrival time is provided. The interpreter service agency must accommodate the provider, as necessary, until the new interpreter arrives to ensure there is not a lack of communication between the provider and member.

26. The interpreter must stay for the complete duration of the appointment; this includes but is not limited to appointments for clinics, X-ray, labs and pharmacy.

27. The interpreter service agency must respond to requests with one or more days’ notice as well as to urgent (same-day) requests.

28. The interpreter service agency must provide the following for:
   - Same-day requests: Call the requesting clinic as soon as appointment is filled with an accurate estimated time of arrival for interpreter (keeping in mind traffic and parking delays).
   - Future requests (next day and beyond): Provide verbal confirmation to the requesting clinic by 4 p.m. on the day the request is made.
29. The interpreter service agency must respond to requests during daytime operations (6 am to 6 pm on weekdays) as well as after hours (6 pm to 6 am evenings, weekends and holidays).

30. The interpreter service agency must respond to emergency situations. An unplanned event requiring an immediate response is considered an emergency. Examples include, but are not limited to:
   - Member’s arrival in the Emergency Room
   - Mental health situations
   - Member’s health could be compromised if not seen immediately

31. The interpreter service agency must respond to emergency requests within 15 minutes. A return phone call from the agency will let the requester know whether or not you can fill the request and provide an accurate estimated time of arrival.

32. If the interpreter service agency is unable to fulfill a particular request for interpreter services or needs to cancel an arranged interpreter and cannot find a replacement, the agency must notify the requesting party and UCare immediately.

33. The interpreter service agency must supply the interpreter with the following information prior to the appointment:
   - Client name
   - Location
   - Date
   - Time
   - Estimated duration of visit
   - Language required

34. If an interpreter request cannot be filled for a future scheduled appointment, the interpreter service agency must give the requesting party and UCare a minimum advance notice of 48 hours.

35. The interpreter service agency must have written documentation to support their business operations and relationship with interpreters, including policies and procedures.

36. The interpreter service agency must cooperate with site visits or document requests from UCare to ensure all requirements and expectations are being met.

Reimbursement and Claims Processing Guidelines for Interpretive Services

The following are reimbursement and claims processing guidelines applicable to interpreter agencies:

1. For Minnesota Health Care Program (MHCP), face-to-face sign and oral language interpretation services will be reimbursed only for covered services provided in the following settings:
   - Medical Clinic
   - Outpatient Hospital
   - Ambulatory Surgery Center
   - Emergency Room
   - Urgent Care
• Dialysis Facility
• Home Care
• Pharmacy
• Dental

2. Face-to-face oral and sign language services will be reimbursed only for covered services listed in the member’s Certificate of Coverage or Evidence of Coverage.

3. UCare will reimburse for actual time, on site, face-to-face interpreting only. “Actual time” is from the beginning to end time of communication between the member, interpreter and provider, which may include:
   • Assisting the enrollee with checking in for the medical appointment.
   • Talking with the receptionist about required paperwork prior to the appointment.
   • Interpreting during the medical appointment.
   • Scheduling follow-up appointments.

4. A no-show is when the interpreter is present at the medical facility, as scheduled, without advance notification from the enrollee, physician or health care professional that the appointment has been canceled. UCare will reimburse for a no-show if the physician, health care professional or UCare member did not arrive for the appointment. The interpreter must arrive at the clinic or appointment place and remain at least 30 minutes past the appointment start time to be reimbursed for the no-show. The work order must be signed and dated by clinic staff for reimbursement.

Late cancellation is when the interpreter service agency or interpreter is notified by the enrollee, clinic and health care professional that the appointment has been canceled less than one hour from the appointment time. UCare will not reimburse for late cancellation even if the interpreter is in transit to the appointment.

5. UCare follows the MHCP billing code(s). 1 unit equals 15 minutes. To be reimbursed for 1 unit, the number of minutes must be 8 or more. Less than 8 minutes should not be billed and will not be reimbursed.

UCare follows interpreter guidelines for best practices developed by the Minnesota Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group (TAG). More information is available in the following section.

6. Claims must be submitted on the 837P format through a clearinghouse that works directly with UCare for electronic data interchange (EDI) claim transmission. Attachments associated with a claim, such as a work order or adjustment form, must be faxed to UCare with the AUC Claim Attachment Cover Sheet and include an attachment control number (ACN). Please see the Claims section for details.

7.
**MINNESOTA DEPARTMENT OF HEALTH (MDH) ROSTER ID**

A MDH Roster ID is required for all claims submitted to UCare for Interpreter Services. Interpreter claims that do not contain this information are subject to deny.

<table>
<thead>
<tr>
<th>Loop/Segment</th>
<th>What to Enter</th>
<th>Place on the Claim Image</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loop 2300, segment REF01</td>
<td>G1</td>
<td>Box 23</td>
</tr>
<tr>
<td>Loop 2300, segment REF02</td>
<td>MDH Roster ID</td>
<td>Box 23</td>
</tr>
</tbody>
</table>

**Exception:** A Roster ID number is not required for American Sign Language interpreters.

8. A work order must accompany each claim and have all of the following information completed on the work order for payment:
   - Interpreter service agency’s information, including name, address, city, state, ZIP code and phone number
   - Interpreter’s arrival and departure time
   - Member’s first and last name
   - Member’s address including city, state, ZIP code
   - Member’s identification numbers
   - Date of service (appointment date)
   - Language provided
   - Appointment time (not needed for a pharmacy visit)
   - Name of clinic or place of service
   - Address of clinic or place of service, including city, state and ZIP code
   - Interpreter’s name, signature and date
   - Interpreter’s MDH Roster ID number (does not apply to ASL interpreters)
   - Clinic or health care provider staff name, signature and date

If one or more of these pieces of information is missing or incomplete, the claim is not valid for reimbursement.

9. UCare’s standard claim submission timeline for new claims is 12 months from the date of services. Please refer to your contract as this information may vary.

10. UCare’s standard claim adjustment timeline is 12 months from the initial date of when the claim was processed (paid or denied). Please refer to your contract as this information may vary.

11. Face-to-face oral language interpreter services during dialysis treatments are reimbursable for the duration of the initial appointment only. Face-to-face oral interpreter services may be reimbursable, as needed, when a change in the patient’s medical treatment or status requires additional explanation. In the event interpreter services are required during routine dialysis treatments, services should be provided via telephone conference calls.

12. Face-to-face oral language interpreter services during sleep studies are reimbursable for the duration of initial patient orientation only. Upon request of the facility or member, face-to-face interpreter services for the following morning is reimbursable. In the event the patient wakes during the night and requires interpreter services, services will be provided via telephone conference calls.
13. Interpreter service for American Sign Language (ASL) should be referred to the provider’s contract for covered services and reimbursement requirements.

14. Face-to-face oral language interpreter services during outpatient surgery at a hospital outpatient facility or ambulatory surgery center are **reimbursable for the preparation time prior to the surgery and recovery time after the surgery.**

15. UCare will reimburse for interpreter services during medical telephone conference calls only when a health care professional is involved in the call. Reminder phone calls and calls to schedule appointments or transportation service are not covered as part of a medical telephone conference.

16. All interpreter claims are subject to post-payment audits, which require the provider’s cooperation.

17. UCare does not reimburse for associated charges related to interpreter services, including but not limited to:
   - Services provided at inpatient hospitals and long-term care facilities.
   - Interpreter’s mileage, parking fees, meals, wait time, transportation, voice mail services, and weekend or after-hours premium fees.
   - Services provided to any family member or friend of the agency’s staff, including but not limited to all interpreters working on behalf of agency (family members are defined as the interpreter’s parents, spouse, domestic partner, children, grandparents, sibling, mother-in-law, father-in-law, brother-in-law or sister-in-law).
   - Services if the primary caregiver and/or other clinic staff speak the patient’s language.
   - Services provided for worker’s compensation or auto injury-related services.
   - Cancellation or no show by interpreter.
   - Appointments not scheduled or coordinated by the interpreter service agency.
   - Appointment not requested by the member, clinic or health plan.
   - Other provisions specifically included in the Interpreter Services Provider Agreement.

18. On a case-by-case basis, to ensure enrollee access in rural areas, mileage will be reviewed for payment by UCare. The reimbursement for mileage must be requested prior to the date of service for approval by completing and submitting an Interpreter Service’s Mileage Request Form. If another interpreter service agency has a local or closer interpreter in the area where the appointment is, UCare reserves the right to contact that agency to ask if they can cover the appointment before we make a final decision.

19. Request for mileage is prohibited in the following metro counties: Anoka, Dakota, Carver, Hennepin, Ramsey, Scott and Washington. The traveling distance must be 30 miles or more one way. If mileage is approved, we will deduct 25 miles from each segment for payment. The reimbursement for mileage is at the current IRS mileage rate.

20. UCare will not be charged when the interpreter leaves the appointment prior to the agreed-upon completion time without the consent or agreement of the respective clinic or health care provider staff. In the event the interpreter has to leave prior to the appointment ending and the necessary requirements are met as described in the previous section under “Interpreter Services Performance Expectations,” the interpreter services will be reimbursed for actual time.
21. UCare will not pay for services that are rendered in a manner inconsistent with the “Interpreter Services Performance Expectations” described in the previous section.

22. Interpreter services provided by the same interpreter to multiple enrollees/members at the same location on the same date of service or same enrollee with multiple appointments on the same date of service will be reimbursed as follows:
   • The first appointment of the day will be reimbursed at the one-hour minimum or actual time, whichever is greater.
   • Appointment(s) following the first appointment must have at least 1 ½ hours between the end of the last appointment and the start time of the next appointment to be reimbursed at the one-hour minimum or actual time, whichever is greater. Time between appointment(s) that is less than 1 1/2 hours will be reimbursed for actual time.

23. Interpreter services provided by the same interpreter to multiple enrollees/members simultaneously must be billed as a single visit flat fee. Time in addition to the one-hour minimum will be reimbursed at the quarter-hour unit rate.

Clinic Staff Interpreters | Reimbursement and Claims Processing Guidelines

The following are reimbursement and claims processing information for interpreter services provided by clinic staffs:

1. Clinics, hospitals or care systems must have a contract or amendment to provide interpreter services and must only bill for face-to-face interpreting time provided within their facility only. If the patient fails to show for the appointment, UCare will not reimburse for no show time.
2. Reimbursement will only be made for clinic visits and outpatient hospital services.
3. Interpretation services must be provided by an employee of the clinic or hospital and must be hired to work as an interpreter for the clinic. The clinic or hospital cannot use a bilingual staff member to provide interpretation services and bill for it.

For example: A Certified Medical Assistant (CMA) who speaks the patient’s language and provided the interpretation during the doctor’s visit. The interpretation service should not be billed to UCare.

4. Internal clinic/hospital staffs are subject the same performance and expectation guidelines as the interpreters working with an interpreter service agency.
5. Interpreter service provided by an outside agency is not billable and will not be reimbursed.
6. Reimbursement will not be made for inpatient hospital services.
7. UCare follows the MHCP billing guidelines and codes for interpreter services.

Questions regarding claims should be directed to the Provider Assistance Center at 612-676-3300 or toll free at 1-888-531-1493.
MINNESOTA COMMUNITY CODING PRACTICE/RECOMMENDATION FOR INTERPRETER SERVICES

The following information was developed by the Minnesota Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group (TAG) for interpreter services.

T1013 – Face-to-face oral language interpreter services per 15 minutes
T1013-U3 – Face-to-face sign language interpreter services per 15 minutes
T1013-GT – Telemedicine interpreter services per 15 minutes
T1013-U4 – Telephone (conference call) interpreter services per call

Interpreter services provided to multiple patients in a group setting, at the same time.
T1013-UN – two patients at the same time
T1013-UP – three patients at the same time
T1013-UQ – four patients at the same time
T1013-UR – five patients at the same time
T1013-US – six or more patients at the same time
T1013-52 – drive time, wait time, no show/cancellation per 15 minutes

**Note:** Drive time, wait time is not covered by UCare. Modifier 52 is only to be used for “no show” by a patient or physician.

If patient has more than one visit on the same day and the service was provided by the same interpreter service agency, report each visit on a separate service line with the 59 modifier:
T1013 – first appointment
T1013-59 – second appointment and additional appointment within the same day
99199 – Mileage for interpreter services

Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported. Report one unit per mile.

**Note:** Rounding rules apply to all services. A minimum of eight minutes must be spent in order to report one unit.

**Note:** A MDH Roster ID is required for all claims submitted to UCare members for Interpreter Services. Interpreter claims that do not contain this information are subject to deny.

Find these and other resources on UCare.org/providers/ on the Provider Manual web page, under Transportation & Interpreters.

**Place of Service Codes**
**Interpreter Quarterly Report Sample**
**Interpreter Change Form**
**Interpreter Mileage Request Form**
Nursing Facility Services

This chapter describes UCare’s authorization requirements, coverage details and denial notification requirements for both skilled level care and custodial care provided in a nursing facility. UCare does not cover skilled nursing facility or swing bed stays for members of the following plans: Pre-paid Medical Assistance Program (PMAP) or MinnesotaCare. Contact the Minnesota Department of Human Services for additional information.

Definitions

Skilled Care (also known as Medicare Part A extended hospital coverage): A level of inpatient nursing home care available for qualifying UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare (Preferred Provider Organization), UCare’s Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members who require skilled nursing or rehabilitative care following an injury, illness or exacerbation of a chronic condition. These services must meet each of the following criteria:

- Provided under physician orders
- Require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists and speech-language pathologists or audiologists
- Provided directly by, or under the general supervision of, these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result

Skilled Nursing Facility Care: A level of inpatient nursing home care available for qualifying UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview members who require daily skilled services for post-acute treatment and rehabilitative care of illness or injury following a hospital confinement.

Custodial Care (non-skilled care): Care that is primarily for the purpose of assisting the individual in activities of daily living, such as assistance in getting out of bed, walking, bathing, dressing, feeding and supervision of medication that ordinarily would be self-administered, or in meeting personal rather than medical needs. This type of care is not specific therapy for an illness or injury, is not skilled care, and does not require the continuous attention or supervision of trained, licensed medical personnel. Custodial care/non-skilled care is available for qualifying members of UCare’s Minnesota Senior Health Options, UCare Connect + Medicare, Minnesota Senior Care Plus and UCare Connect.

Skilled Nursing Facility (SNF): A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related health services. Such services can only be performed by, or under the supervision of, licensed nursing personnel.

Nursing Facility (NF): A facility or part of a facility certified by the Minnesota Department of Health to provide long-term care or custodial care. Long-term care facilities provide medical and supportive services for residents who have lost some capacity for self-care due to a chronic illness or condition and who are expected to need temporary or prolonged care.
Skilled Nursing Facility Coverage | Medical Necessity Criteria

The following basic services are covered during a skilled nursing facility stay:

- Room and board, when skilled care is required
- Daily skilled nursing services
- Restorative rehabilitation services
- Drugs and blood transfusions administered in the facility
- Medical supplies and durable medical equipment required during the admission to the skilled nursing facility stay

Services that are not covered as skilled care:

- Respite, non-rehabilitative or custodial care
- A private room, unless it is determined to be medically necessary and approved by UCare.

Coverage for skilled nursing facility care is subject to the following limitations:

- The member must have available skilled nursing facility benefits.
- The nursing facility must participate in Medicare.
- The member must meet medical necessity requirements for admission to a skilled nursing facility as defined by Medicare, with the exception of a preceding three-day inpatient hospital stay (UCare does not require a three-day inpatient hospital stay but does review each skilled nursing facility authorization request for medical necessity).
- Daily skilled care must be furnished pursuant to a physician’s order, be reasonable and necessary for the treatment of the member’s illness or injury both in duration and quantity, and require the skills of professional health personnel such as registered nurses, physical therapists, occupational therapists and speech pathologists.
- The skilled care must be provided directly by or under supervision of the skilled nursing and/or rehabilitation personnel.

Skilled care coverage may be considered medically necessary when all of the following criteria are met:

- Services require a skilled nursing facility level of care and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech-language pathologists or audiologists.
- Services are provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
- Services are provided under a plan of care established and periodically reviewed by a physician.
- Services are appropriate for the treatment of the illness or injury with the expectation that the condition of the patient will improve in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program. One or more of the following types of skilled services are required:
o Skilled nursing services: Services necessary when the member’s condition continues to require skilled assessment, treatment and management/modifications on a daily basis, or is potentially or acutely unstable and requires frequent and ongoing monitoring and assessment. The skilled nursing services must be provided daily (seven days per week).

OR

o Rehabilitative services: Therapies performed to increase or enhance the member’s functional mobility or status. These may include physical therapy, occupational therapy and speech therapy. Rehabilitative services must be provided at least five days per week.

Nursing facility care is not considered skilled level care and/or not medically necessary for the following situations, including but not limited to:

- Services that do not meet medical necessity criteria as defined by Medicare and/or as previously described.
- Services solely provided to allow respite for the member’s caregivers or family.
- Care of a custodial nature.
- Care for the sole purpose of subcutaneous daily injections of maintenance medications, such as insulin.
- Administration of oral medications, including oral antibiotics for urinary tract or upper respiratory infections.
- Care of stable or chronic wounds.
- Care of stable medical conditions or conditions with an established plan of care.
- Administration of medical gases (oxygen).

**AUTHORIZATION REQUIREMENTS FOR SKILLED NURSING FACILITY STAYS**

Find authorization requirements for medical services on the Eligibility and Authorization page of the UCare provider website (www.UCare.org/providers).

Skilled nursing facility stays require authorization prior to admission or within one business day of admission. Medicare medical necessity criteria must be met for approval.

All skilled nursing facility admissions are subject to concurrent review. They must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay/concurrent review:

- Documentation of progress toward long- and short-term goals.
- Expected length of treatment.
- Examples of documentation that may be requested:
  - Nursing assessments and progress notes
  - Rehabilitation therapy assessments and progress notes
  - Physician orders and progress notes

**QUALIFYING EVENTS**

UCare waives the three-day hospital stay requirement for skilled nursing facility coverage for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, UCare’s MSHO and
UCare Connect + Medicare members. (The three-day hospital stay requirement does apply to UCare SeniorSelect members, and UCare does not waive the three-day hospital stay.) UCare does not follow the Medicare presumption of coverage upon discharge from a hospital stay regardless of the length of hospitalization. UCare looks directly at medical necessity and at the qualifying event leading to the need for skilled level of care, whether or not there was a hospital stay immediately prior.

To be eligible for skilled nursing facility coverage, the member must have available Medicare Part A days, the stay must meet Medicare skilled level coverage criteria, and the stay must be authorized by UCare or its approval authority. One of the following conditions must be met:

- The member resides in the community or in long-term care and is discharged from an inpatient hospital stay OR presents to a clinic, emergency room or urgent care setting. All of the following must be true:
  - The member has an injury, illness or acute exacerbation of a chronic condition, AND
  - The member requires ongoing skilled care, observation, monitoring or rehabilitation therapy that cannot be appropriately provided in the home setting, AND
  - The member meets skilled nursing facility coverage/eligibility criteria.
- Alternatively, a resident of a long-term care facility or nursing facility who experiences an acute illness, injury or exacerbation of a chronic condition that would meet criteria for an inpatient hospital admission may be authorized for skilled nursing facility care if the skilled care can be provided safely in a skilled nursing facility. When a member moves from NF to skilled nursing facility level of care, the physician or nurse practitioner must evaluate the member in person within 24 hours of exacerbation. Communication with nursing personnel either by telephone or in person is required at least every 24 hours thereafter.

“In-Lieu-of Days” include days for which the Enrollee is treated by Participant in lieu of hospitalization. A significant change of the Enrollee’s condition must occur. The condition must be of a nature that could have justified hospitalization and for which a physician or nurse practitioner is involved in the direct management of the medical needs of the Enrollee. In order for UCare to pay this additional rate, this must be reviewed and authorized by UCare.

**UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare Coverage Details**

**BENEFIT PERIODS | UCARE MEDICARE PLANS, UCARE MEDICARE WITH FAIRVIEW & NORTH MEMORIAL AND ESSENTIACARE**

- UCare covers up to 100 days of skilled nursing facility level of care per benefit period, including days used under fee-for-service Medicare or Medicare contracts.
- A “benefit period” is a period of consecutive days that begins with the first day of admission to a hospital, skilled nursing facility or intermediate care facility.
- A new benefit period begins following a period of 60 consecutive days during which the member has not been an inpatient at any hospital or received skilled care in a skilled nursing facility.
SEPARATION PERIODS | UCARE MEDICARE PLANS, UCARE MEDICARE WITH FAIRVIEW & NORTH MEMORIAL AND ESSENTIACARE

- A separation period is 60 or more consecutive days when the member has not been inpatient at any hospital or received skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility but not receiving skilled level of care, the non-skilled days count toward the 60-day separation period.
- If the member is hospitalized for any reason, regardless of the type of care received in the hospital, upon discharge, the 60-day separation period starts over. A member may have more than one benefit period if the separation criteria are met.

SWING BED AUTHORIZATION REQUIREMENTS | UCARE MEDICARE PLANS, UCARE MEDICARE WITH FAIRVIEW & NORTH MEMORIAL AND ESSENTIACARE

Authorization is required for swing bed stays prior to admission or within one business day of admission. Medicare medical necessity criteria must be met for approval.

All swing bed admissions are subject to concurrent review and must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay concurrent review:

- Documentation of progress toward long- and short-term goals
- Expected length of treatment

Examples of documentation UCare may request:

- Nursing assessments and progress notes
- Rehabilitation therapy assessments and progress notes
- Physician orders and progress notes

Medical necessity for swing bed admission follows Medicare skilled level of care criteria. Hospital providers of extended care services are expected to identify skilled nursing facilities within their geographic region and determine the availability of skilled nursing facility beds prior to requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities; if no transfer agreement exists, the geographic region defined by Medicare is 50 miles. Hospital providers must transfer the member to a skilled nursing facility as soon as a bed becomes available. The typical duration of a swing bed authorization is three to five days. The admission will be concurrently reviewed for continued coverage.
UCare SeniorSelect Coverage Details

Medicare covers up to 100 skilled care days for eligible services in a Medicare-certified facility, including swing beds. The first 20 days are paid in full by Medicare. The coinsurance for days 21-100 is paid in full by UCare SeniorSelect.

- Under the basic plan, there is no additional coverage beyond 100 days.

The member MUST use a facility contracted specifically with UCare SeniorSelect to be eligible for coinsurance coverage.

**BENEFIT PERIODS | UCARE SENIORSELECT**

- UCare covers coinsurance for days 21-100 of skilled nursing facility care per benefit period, including days used under fee-for-service Medicare or other Medicare contracts.
- A “benefit period” is a period of 60 consecutive days that begins with the first day of admission to a hospital, skilled nursing facility or intermediate care facility.
- A new benefit period may begin following a period of 60 consecutive days during which the member has not been inpatient at any hospital or received skilled care in a skilled nursing facility.

**SEPARATION PERIODS | UCARE SENIORSELECT**

- A separation period is 60 or more consecutive days and the member has not been inpatient at any hospital or received skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility, but not receiving skilled level of care, the non-skilled days count toward the 60-day separation period.
- If the member is hospitalized for any reason, regardless of the type of care received in the hospital, upon discharge, the 60-day separation period starts over. A member may have more than one benefit period if the separation period criteria are met.

**SWING BED AUTHORIZATION REQUIREMENTS | UCARE SENIORSELECT**

- There are no authorization or notification requirements for UCare SeniorSelect member admissions to skilled nursing facilities or swing beds, regardless of the length of stay.
- Admission to skilled nursing facilities or swing beds are subject to Medicare medical necessity criteria.

UCare’s MSHO Coverage Details

UCare covers 180 days of nursing facility.

UCare coverage applies when a UCare member is residing in the community (including assisted living) when first enrolled with UCare. Minnesota’s Department of Human Services (DHS) is responsible for nursing facility liability days that are not assigned to UCare.
The 180-day liability begins at the time the member is admitted to a nursing facility. Days counted toward the 180-day liability include:

- Medicare skilled nursing facility days
- Swing Bed days
- Medicaid custodial/long-term care NF days (These may include Medicaid bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medicaid standard is 36 therapeutic leave and 18 hospital leave bed hold days.)

**SKILLED NURSING FACILITY BENEFIT PERIODS | UCARE’S MSHO**

- UCare covers up to 100 days of skilled nursing facility coverage per Medicare benefit period.
- A “benefit period” is a period of consecutive days that begins with the first day of admission to a hospital, skilled nursing facility or intermediate care facility.
- A new skilled nursing facility benefit period may begin following a period of 60 consecutive days during which the member has not been an inpatient at any hospital or received skilled care in a skilled nursing facility.

**SKILLED NURSING FACILITY SEPARATION PERIODS | UCARE’S MSHO**

- A separation period is 60 or more consecutive days when the member has not been an inpatient at any hospital or receiving skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility, but not receiving skilled level of care, the non-skilled custodial care days count toward the 60-day separation period.
- If the member is hospitalized for any reason, regardless of the type of care received in the hospital, upon discharge the 60-day separation period starts over. A member may have more than one Medicare benefit period if the separation period criteria are met.

**SWING BED AUTHORIZATION REQUIREMENTS FOR MEDICARE SKILLED LEVEL COVERAGE | UCARE’S MSHO**

Authorization is required for swing bed stays prior to admission or within one business day of admission. Medicare medical necessity criteria must be met for approval.

All swing bed admissions are subject to concurrent review and must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay concurrent review:

- Documentation of progress toward long- and short-term goals
- Expected length of treatment

Examples of documentation UCare may request:

- Nursing assessments and progress notes
- Rehabilitation therapy assessments and progress notes
- Physician orders and progress notes
Medical necessity for swing bed admission follows Medicare skilled level of care criteria. Hospital providers of extended care services are expected to identify skilled nursing facilities within their geographic region and determine the availability of skilled nursing facility beds prior to requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities; if no transfer agreement exists, the geographic region defined by Medicare is 50 miles. Hospital providers must transfer the member to a skilled nursing facility as soon as a bed becomes available. The typical duration of a swing bed authorization is three to five days. The admission will be concurrently reviewed for continued coverage.

UCare is liable for a total of 180 days of nursing facility days for UCare’s MSHO members, of which 100 days may be Medicare skilled days. UCare notifies the Department of Human Services when the health plan liability has been exhausted, and further custodial days are the liability of Medicaid. UCare will continue to cover Medicare skilled care days, up to 100 days per 60-day separation period.

For additional information see MSHO/MSC+ Nursing Home Authorization Information.

**Minnesota Senior Care Plus**

UCare covers 180 days of nursing facility care.

UCare applies this coverage to members who are residing in the community (including assisted living) when they become UCare members. The Minnesota Department of Human Services (DHS) is liable for nursing facility liability days that are not assigned to UCare.

The 180-day liability will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 180-day liability include:

- Medicare skilled nursing facility days (billed to Medicare)
- Swing bed days (billed to Medicare)
- Medicaid custodial/long term care nursing facility days (These may include Medicaid bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medicaid standard is 36 therapeutic leave and 18 hospital leave bed hold days.)

UCare is liable for a total of 180 nursing facility days. Up to 100 of these days may be Medicare skilled level care days. UCare notifies the Department of Human Services when the health plan liability has been exhausted, and all further custodial days will be paid by Medicaid.

For additional information see MSHO/MSC+ Nursing Home Authorization Information.

**UCare Individual & Family Plans/UCare Individual & Family Plans with Fairview**

UCare covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness and injury, following a hospital confinement.
Skilled nursing facility services are limited to 120 days per admission.

**AUTHORIZATION REQUIREMENTS FOR SKILLED NURSING FACILITY COVERAGE**

Skilled nursing facility stays require authorization prior to admission or within one business day of admission. Medicare medical necessity criteria must be met for approval.

All skilled nursing facility admissions are subject to concurrent review. They must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay/concurrent review:

- Documentation of progress toward long- and short-term goals
- Expected length of treatment

Examples of documentation that may be requested:

- Nursing assessments and progress notes
- Rehabilitation therapy assessments and progress notes
- Physician orders and progress notes

**UCare Connect (SNBC)**

UCare covers 100 days of nursing facility care, including days used under fee for service Medicare or other Medicare contracts.

UCare applies this coverage to members who are residing in the community (including assisted living) when they become UCare members. The Minnesota Department of Human Services (DHS) is liable for nursing facility liability days that are not assigned to UCare.

The 100-day liability will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 100-day liability include:

- Medicare skilled nursing facility days (billed to Medicare)
- Swing bed days (billed to Medicare)
- Medicaid custodial/long-term care nursing facility days (These may include Medicaid bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medicaid standard is 36 therapeutic leave and 18 hospital leave bed hold days.)

UCare notifies the Department of Human Services when the health plan liability has been exhausted, and all further custodial days will be paid by Medicaid.

For additional information see [UCare Connect (SNBC) Nursing Home Authorization Information](#).

**UCare Connect + Medicare (SNBC)**

UCare covers 100 days of nursing facility.
UCare applies this coverage to members who are residing in the community (including assisted living) when they become UCare members. The Minnesota Department of Human Services (DHS) is liable for nursing facility liability days that are not assigned to UCare.

The 100-day liability will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 100-day liability include:

- Medicare skilled nursing facility days
- Swing bed days
- Medicaid custodial/long-term care nursing facility days (These may include Medicaid bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medicaid standard is 36 therapeutic leave and 18 hospital leave bed hold days.)

**SKilled Nursing Facility Benefit Periods | UCare Connect + Medicare**

UCare covers up to 100 days of skilled nursing facility coverage per Medicare benefit period.

- A “benefit period” is a period of consecutive days that begins with the first day of admission to a hospital, skilled nursing facility or intermediate care facility.
- A new skilled nursing facility benefit period may begin following a period of 60 consecutive days during which the member has not been an inpatient at any hospital or received skilled care in a skilled nursing facility.

**Skilled Nursing Facility Separation Periods | UCare Connect + Medicare**

- A separation period is 60 or more consecutive days when the member has not been an inpatient at any hospital or receiving skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility, but not receiving skilled level of care, the non-skilled custodial care days count toward the 60-day separation period.
- If the member is hospitalized for any reason, regardless of the type of care received in the hospital, upon discharge the 60-day separation period starts over. A member may have more than one Medicare benefit period if the separation period criteria are met.

**Swing Bed Authorization Requirements for Medicare Skilled Level Coverage | UCare Connect + Medicare**

Authorization is required for swing bed stays prior to admission or within one business day of admission. Medicare medical necessity criteria must be met for approval.

All swing bed admissions are subject to concurrent review and must meet medical necessity criteria and continued stay criteria. The following information and/or documentation may be requested as part of the continued stay concurrent review:

- Documentation of progress toward long- and short-term goals
- Expected length of treatment
Examples of documentation UCare may request:

- Nursing assessments and progress notes
- Rehabilitation therapy assessments and progress notes
- Physician orders and progress notes

Medical necessity for swing bed admission follows Medicare skilled level of care criteria. Hospital providers of extended care services are expected to identify skilled nursing facilities within their geographic region and determine the availability of skilled nursing facility beds prior to requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities; if no transfer agreement exists, the geographic region defined by Medicare is 50 miles. Hospital providers must transfer the member to a skilled nursing facility as soon as a bed becomes available. The typical duration of a swing bed authorization is three to five days. The admission will be concurrently reviewed for continued coverage.

UCare is liable for a total of 100 days of nursing facility days for UCare Connect + Medicare members, of which 100 days may be Medicare skilled days. UCare notifies the Department of Human Services when the health plan liability has been exhausted, and further custodial days are the liability of Medicaid. UCare will continue to cover Medicare skilled care days, up to 100 days per 60-day separation period.

### Denial and Discharge Notices

Denial and discharge notices for skilled nursing facility services are issued as follows for UCare members.

**UCARE MEDICARE PLAN / ESSENTIACARE | DENIAL FORMS**

Find the customized forms on our Denial Notices for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities page.

**NOMNC – Notice of Medicare Non-Coverage**

- Issued by skilled nursing facility staff when ongoing services will be terminated.
- Must be delivered two days prior to discharge or service termination.

**DENC – Detailed Explanation of Non-Coverage**

- Issued by skilled nursing facility staff when the member does not agree with service termination and wants to appeal via fast track, using the Quality Improvement Organization.

**NDMCP – Notice of Denial of Medical Coverage or Payment Issued by Skilled Nursing Facility staff when:**

- Admission to skilled nursing facility is denied prior to or at admission.
- A member exhausts the 100 day skilled benefit in a facility.
- There is a denial, reduction or termination of a Medicare service that does not include a skilled Medicare stay.
UCARE’S MSHO (DUAL SPECIAL NEEDS PLAN) AND UCARE CONNECT + MEDICARE | DENIAL FORMS

Find the customized forms on our Denial Notices for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities page.

Note: For UCare’s MSHO and Connect + Medicare, if a service is denied under Medicare but is covered under Medicaid, the Medicare denial notice is not needed.

NOMNC – Notice of Medicare Non-Coverage

- Issued by skilled nursing facility staff when ongoing services will be terminated.
- Must be delivered two days prior to discharge or service termination.

DENC – Detailed Explanation of Non-Coverage

- Issued by skilled nursing facility staff when the member does not agree with service termination and wants to appeal via fast track, using the Quality Improvement Organization.

SKILLED NURSING FACILITY RESPONSIBILITIES REGARDING DENIAL NOTICES

Use the Notice of Medicare Non-Coverage (NOMNC) when ongoing services in a skilled nursing facility are denied. The NOMNC, also known as the advance notice, informs the member of the date coverage of services will end. The form describes what should be done if the member wishes to appeal the decision or needs more information.

The facility is responsible for delivering the NOMNC to the member no later than two days before the end of coverage. The facility need not agree with the decision that covered services should end but must deliver the notice.

If the total span of services is expected to be fewer than two days, the NOMNC should be delivered to the member upon admission or start of services.

If there is more than a two-day span between services, the NOMNC should be issued on the next to the last time services are furnished. This notice should be delivered as soon as the service termination date is known.

The facility must carry out valid delivery of the NOMNC, meaning that all patient-specific information required by the notice is included, and the member (or authorized representative) must sign and date the NOMNC Valid Delivery Documentation Form. If a member representative has been appointed, the representative must receive all required notifications. Authorized representatives may be notified by telephone if personal delivery is not immediately available.

- The authorized representative must be informed of the contents of the notice.
- The date, time and phone number of the call must be documented.
- The notice must be mailed to the representative on the same day as the telephone notification.
- The provider may document the valid delivery of the NOMNC notice using UCare’s NOMNC Valid Delivery Documentation Form.
If a member decides to appeal the end of coverage, he or she must contact the Quality Improvement Organization (QIO) no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review.

The QIO will inform UCare and the provider of the request for a review.

- The QIO for Minnesota and Wisconsin is Livanta. (This information is already on the UCare-specific denial forms for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, UCare’s MSHO and UCare Connect + Medicare.)
- The provider is responsible for providing the QIO and member with a Detailed Explanation of Non-Coverage (DENC), also known as the detailed notice, which explains why services are no longer necessary.
- The QIO must make a decision by close of business on the day coverage is to end.
- The provider and UCare must cooperate with the QIO in providing information for the review.
- The provider must obtain appropriate signatures from the member and/or the member’s representative.
- Information provided to the QIO must be in accordance with HIPAA guidelines.

Facilities must issue all notices to UCare members when directed to do so by UCare or by the delegated approval authority. The facility must follow the direction of UCare or the delegated approval authority and must not delay the delivery of the notice.

The facility must use the most current UCare version of the denial notice for UCare Medicare Plans, UCare Medicare with Fairview & North Memorial, EssentiaCare, UCare’s MSHO and UCare Connect + Medicare whenever a notice is delivered to a member. (Find the customized forms on our Denial Notices for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Rehab Facilities page.)

The facility must ensure that the notice and delivery are valid. Notices cannot be altered in any way.
Obstetrics & Gynecology

This chapter provides information about obstetric and gynecologic services and UCare’s Management of Maternity Services (MOMS) program.

Direct Access to Obstetric and Gynecologic Services

Under Minnesota Statutes, section 62Q.52, health plans must allow direct access without a referral or prior authorization for the following obstetric and gynecologic services:

- Annual preventive health examinations and any subsequent obstetric or gynecologic visits determined to be medically necessary by the examining provider
- Maternity care
- Evaluation and necessary treatment for acute gynecologic conditions or emergencies

Family Planning Services

UCare members have open access for family planning services. Members may obtain covered family planning services from any qualified provider, including those outside of the UCare network. Treatment for medical conditions that cause infertility is not an open access service and must be obtained from a UCare contracted provider.

Sterilization

Sterilization is a family planning service. UCare members may obtain covered family planning services from any qualified provider, including those outside the UCare network. The Code of Federal Regulations (42 CRF 441.250-441.259) outlines requirements the member must meet for sterilization to be covered:

- At least 21 years old at the time the consent form is signed
- Mentally competent
- Not institutionalized
- Informed consent must be given voluntarily and a consent form acceptable under federal regulations must be properly signed and witnessed by the patient, a witness and the surgeon. The informed consent must be given not less than 30 days or more than 180 days prior to the completion of the surgical procedure, except in cases of premature delivery or emergency abdominal surgery, in which case informed consent must be given no less than 72 hours prior to completion of the surgical procedure. In addition, in the case of premature delivery, consent must have been obtained 30 days prior to the expected due date.
The consent cannot be obtained when the member is:

- In labor or childbirth.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or other substance that affects the member’s state of awareness.
- In a situation that the provider believes that the member is unable to given informed consent.

The signed consent form must be retained in the member’s medical record.

## Abortion Services | Minnesota Health Care Programs

UCare does not provide coverage for abortion services or make coverage decisions for MHCP members, except under certain circumstances.

1. All induced abortion and abortion-related services should be billed to the Minnesota Department of Human Services (DHS). Abortion-related services include:
   - Hospitalization when the abortion is performed in an inpatient setting
   - The use of a facility when the abortion is performed in an outpatient setting
   - Counseling related to the abortion
   - General anesthesia or conscious sedation provided in conjunction with the abortion. Local and regional anesthesia, including nerve blocks, administered by the attending physician, is considered integral to the procedure and not separately billable.
   - Drugs provided during or directly after the abortion
   - Uterine ultrasound following an abortion
   - Abortion services codes (surgical induced abortion and medical abortion service codes)
   - Supplies (trays, Laminaria, etc.)
   - Treatment of infection or other complications as a result of the abortion (including treatment for an incomplete abortion)
   - Drugs (anti-anxiety, narcotics, anesthetics, antibiotics, etc.)

2. Non-abortion-related services and services performed for the pregnancy prior to the induced abortion should be billed to UCare. Non-abortion related services include:
   - A history and physical exam
   - Tests for pregnancy and venereal disease
   - Blood tests
   - Rubella titre
   - Gonadotropin levels (hCG)
   - Hemoglobin and hematocrit
   - GAM (TM)
   - Pap smear
   - Laboratory examinations for the purpose of detecting fetal abnormalities
   - Family planning services provided as a separate service
• Uterine ultrasound to confirm pregnancy
• RhD drugs
• Drugs used in conjunction with pregnancy or post-pregnancy state

Other non-induced abortion procedures, such as a pregnancy with fetal demise, missed abortion or spontaneous abortion, are not subject to this process and should be billed to UCare.

**Abortion Services | UCare Medicare Plans**

Members are allowed access without referral to UCare providers who perform abortion services. Services are covered under the standard Medicare benefit if they meet certain circumstances.

Medicare Advantage (UCare Medicare Plans, UCare Medicare with Fairview & North Memorial and EssentiaCare) members have coverage for abortion services in the following situations:

1. A member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless an abortion is performed; or
2. The pregnancy is the result of an act of rape or incest.

**Abortion Services | UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview**

Members are allowed access without referral to UCare providers who perform abortion services. Services are covered if they meet certain circumstances.

UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview members have coverage for abortion services in the following situations:

1. A member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless an abortion is performed; or
2. The pregnancy is the result of an act of rape or incest.
UCare’s Management of Maternity Services (MOMS) - Prepaid Medical Assistance Program (PMAP), Minnesotacare, UCare Connect, UCare Connect + Medicare, UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview Members

UCare’s MOMS program is designed to increase the number of pregnant members enrolled in prenatal care during the first trimester, decrease the rate of low birth weight and increase the number of members who obtain postpartum visits. The program identifies the following focus areas: early prenatal care; risk factors such as age, high blood pressure and diabetes; risk behaviors such as maternal use of tobacco, alcohol or street drugs; birth control discussion; and postpartum care. UCare’s efforts are directed toward integration of services and increasing communication among those providing care to our members. Services and processes UCare has implemented to address the focus areas:

1. Early prenatal care. UCare members receive excellent prenatal care once initiated. UCare’s efforts to increase identification of our pregnant members and encourage early care-seeking behavior assure they receive the best clinical care. We designed several processes to encourage early prenatal care.
   - A $75 gift card incentive to members for initiating care in the first trimester or within 42 days of joining UCare.
   - Customer Service sensitively asks callers if anyone in the home is pregnant.
   - Outreach for assessment, education and referral:
     - A telephonic outreach program attempts to reach all identified pregnant members aged 19+ for assessment, education and referral.
     - Public Health home visits are available to all pregnant members including those under age 19.

2. Assessment and referral for risk behaviors. Throughout each pregnancy, UCare’s efforts focus on risk factors the member can mitigate.
   - The telephonic outreach/Public Health home visit program assesses members regarding smoking behavior, nutritional needs, mental health, chemical or alcohol use, medical risk factors and unmet social service needs.
   - The call/visit includes an immediate referral to appropriate services.
   - Follow-up calls determine if the member has completed the referral.
   - For pregnant smokers, UCare offers a $25 gift card incentive to complete an assessment with UCare’s Tobacco Quit line.

3. Preparing for childbirth and caring for the new infant. Pregnant members enrolled in UCare Connect, UCare Connect + Medicare, PMAP or MnCare can take childbirth preparation and
infant care classes at no charge. Classes must be offered through UCare contracted providers. The following classes are included (and are billable):

- Childbirth Preparation, regular and refresher
- Cesarean Preparation and Vaginal Birth After Cesarean (VBAC) Classes
- Infant Care (does NOT include Infant CPR)

4. Postpartum visit. We believe that postpartum visits assure members receive needed follow-up education and assessment, as well as encouragement to seek routine well-baby checkups.
   - A $75 gift card incentive to members for completing the postpartum visit.
   - Public Health postpartum home visits are offered to all newly delivered members within several weeks of delivery.

5. Breastfeeding Education and Support. UCare offers breastfeeding education and support to pregnant and lactating members.
   - Classes - Pregnant members can take breastfeeding classes at no charge. Classes are billable and must be offered through UCare contracted providers.
   - Lactation Consultation – Lactating members can receive inpatient and/or outpatient breastfeeding assistance from a UCare-contracted certified lactation consultant.

**BREAST PUMPS - BREAST PUMP COVERAGE**

Members who are breastfeeding and must be separated from their infant due to work or other reasons can order a breast pump at no cost. A medical order is required and some limits apply.

UCare covers three categories of breast pumps:

- **Hospital Grade Rental Pumps (E0604)** – Hospital grade electric pumps are available to members when they are unable to breastfeed their infants due to a medical condition (mother or infant). For example, if the infant is in the Newborn Intensive Care Unit and is unable to nurse, the hospital grade rental pump is the best choice as it will enable to the mother to establish and/or maintain her milk supply. A medical order is required. Available through hospitals and/or UCare-contracted Durable Medical Equipment (DME) providers.
  - **Note:** Use of a hospital grade rental pump does not count towards the one pump per three years limit. This limit applies only to the purchased electric pump.

- **Dual Electric Pumps (E0603)** – Dual electric pumps are available through UCare-contracted DME providers. These are purchased (not rental). A medical order is required. There is a limit of one electric pump every three years.

- **Manual Pumps (E0602)** – Manual pumps are available through UCare contracted DME providers. These are purchased (not rental). A medical order is required.

**Note:** Breast pumps are covered for members only after their babies are born. Breast pumps are not covered for pregnant members. Diagnosis codes must be one of the postpartum codes.

**Billing information:**

- Claims for breast pumps must be filed under the mother’s UCare number.
• Claims must include procedure code (E0604, E0603 or E0602), Diagnosis Code (Z39.0, Z39.1, Z39.2) and the correct modifier indicating whether the claim is for a rental pump (RR) or a purchased pump (NU).
• If the mother is ineligible due to having no insurance coverage, billing may occur under the infant's UCare number.

**MOMS BILLING INFORMATION**

Reimbursement for services will be provided in accordance with your UCare provider contract.

Bill charges on the CMS 1500 claim form. Billing should include any of the enhanced services provided for the at-risk member.

You may bill for enhanced services if the UCare member has risk factors.

- H1001 At-Risk Antepartum Management
- H1004 Postpartum Follow-up Home Visit
- H1002 Care Coordination
- H1005 Enhanced Package

H1003 Prenatal Health Education I and II and Prenatal Nutrition Education (submit this code with the appropriate amount of units when billing for more than one of these services on the same date of service).

**DESCRIPTION OF ENHANCED SERVICES**

1. At-Risk Antepartum Management: Primary care provider (MD/CNM) will be eligible for a reimbursement if the pregnant woman is determined to be at risk.
2. Care Coordination: Includes development, implementation and ongoing evaluation of a plan of care for the at-risk pregnant women.
3. Prenatal Health Education I: Teaches general information on pregnancy and prenatal care; covers at-risk medical conditions and behaviors that can be improved through education such as comfort measures, self-care, self-detection and prevention of preterm labor, and childbirth process.
4. Prenatal Health Education II: Supplements Prenatal Health Education I for women who require more time and specialized education for at-risk behaviors such as smoking, alcohol and drugs. Provides support and education for stress management, communication, self-esteem and parenting skills.
5. Prenatal Nutrition Education: Ongoing assessment of nutritional status and educational efforts to support a healthy pregnancy and infant. Referrals to food assistance programs such as WIC.
6. Postpartum Follow-up Home Visit: Home visit to be made within the first two weeks of the mother’s hospital discharge that includes assessment of mother’s and infant’s health, family planning, parenting support and referrals to appropriate health and social services.
7. Enhanced Package: All of the above prenatal care services are provided.
Rewards, Incentives & Resources

UCare’s Management of Maternity Services (MOMS) booklet is available in English and Spanish. Members who speak Somali may receive a DVD in Somali, as well as the English booklet.

See the Health Promotions section for additional information about UCare’s Prenatal Care Incentive Program.

Nurse Advice Line

UCare offers an after-hours nurse line when the member’s primary care clinic is closed. The nurse advice line is staffed by registered nurses who provide fast access to health information and illness or injury treatment decision support. There is no charge for use of this service. The nurse advice line can be reached by calling 1-800-942-7858 or, for hearing-impaired members, 1-877-728-3311 TTY.

Contacts

Clinical Services: 612-676-6705 or 1-877-447-4384 toll free

24-hour nurse line: 1-800-942-7858 toll free

UCare Behavioral Health: 612-676-3300 or 1-888-531-1493 toll free, follow the prompts

Health Promotion: 612-676-3351 or 1-866-243-5157 toll free
Public Health

There is often confusion about what public health is. The American Public Health Association website says, “Public health promotes and protects the health of people and the communities where they live, learn, work and play.”

This chapter includes a broad range of information and resources to help you connect to public health-related resources.

Tips for Providers

- **Faster claims processing for new Public Health Nurses**
  A friendly reminder that individual Public Health Nurses providing services at Public Health Agencies must be enrolled with UCare before claims can be paid. To notify UCare of a new Public Health Nurse at your agency, please go to the UCare Manage Your Provider Profile web page, under the “Add or Update a Non-Credentialed Practitioner,” and complete the “Add a non-credentialled practitioner” form.

- **Convenient way for providers to view claims**
  UCare wants to remind providers that you can review submitted claims information via the UCare Provider Portal.

  Link to Provider Login web page: [https://provider.UCare.org/pages/login.aspx](https://provider.UCare.org/pages/login.aspx)

  If you do not have access to view claims, contact:
  UCare Provider Assistance Center
  612-676-3300
  1-888-531-1493 toll free

- **Important UCare news at your fingertips**
  Sign up for UCare’s Health Lines provider newsletter.
  Read the latest [News for Providers](#).

Quick Links to UCare Resources Related to Public Health Services

- [Prior Authorization Requirements](#)
- [Child & Teen Checkups](#)
- [Cultural Competence Resources](#)
- [Interpreter Services](#)
- [UCare Incentives and Health Promotion Programs](#)
- [Home and Community Based Services (Elderly Waiver)](#)
- [UCare Quality Programs and Initiatives](#)
- [UCare County Resources](#)
AUTHORIZATION FOR PUBLIC HEALTH SERVICES/HOME CARE/PCA SERVICES

- To refer a member for public health services, providers should contact the local county public health agency. Contact information is available on the [Minnesota Department of Health website](https://www.health.state.mn.us/index.html).
- UCare does not require authorization for health promotion or public health counseling services.
- UCare does not limit the number of public health nurse home visits provided to meet a member’s identified needs.

PERSONAL CARE ASSISTANT (PCA) SERVICES REQUIRE PRIOR AUTHORIZATION FOR MSHO AND MSC+. CHILD & TEEN CHECKUPS

- Child and Teen Checkups (C&TC) is Minnesota's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is a federal program required in every state to provide quality well-child care for children eligible for Medicaid. It is administered by the Minnesota Department of Human Services with technical and clinical assistance from the Minnesota Department of Health. (Source: [Minnesota Department of Health website](https://www.health.state.mn.us/index.html))
- C&TC visits are a covered benefit for all eligible UCare members. There is no copay or charge for these visits.
- See the [Child & Teen Checkups](https://www.health.state.mn.us/index.html) section for more information, including important information about use of Referral Codes when submitting claims for C&TC visits.

CULTURALLY COMPETENT CARE

Culturally responsive care, or cultural competence in health care, is defined as the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families and communities. Learn more about [Culturally Competent Care](https://www.health.state.mn.us/index.html).

INTERPRETER SERVICES

UCare provides interpreters for non-English-speaking members enrolled in our MHCP products. Learn more about [UCare’s Interpreter Services](https://www.health.state.mn.us/index.html).

HEALTH PROMOTION PROGRAMS

UCare is committed to helping keep our members healthy and safe. Learn more about the [health promotion programs and resources](https://www.health.state.mn.us/index.html) available to eligible UCare members.

VACCINES FOR CHILDREN PROGRAM

The [Minnesota Vaccines for Children (MnVFC) program](https://www.health.state.mn.us/index.html) is an enhanced version of the federally funded Vaccines for Children (VFC) program. Its goal is to ensure affordable vaccines for all children within their own sites.
**FLUORIDE VARNISH APPLICATION (FVA)**

UCare reimburses primary care clinics and county public health agencies for fluoride varnish.

**HOME & COMMUNITY BASED SERVICES (HCBS) – ELDERLY WAIVER (EW) SERVICES**

UCare is responsible for coverage of EW services for our MSHO and MSC+ enrollees eligible for these services.

**TUBERCULOSIS (TB) CASE MANAGEMENT AND DIRECTLY OBSERVED THERAPY**

(See Clinic Services in the MHCP Provider Manual.)

TB case management services are covered if provided by a certified public health nurse employed by a community health board.

Directly observed therapy must be provided by a public health nurse employed by a community health board, or by a community outreach worker, licensed practical nurse or registered nurse trained and supervised by a certified public health nurse employed by a community health board.

Case Management Services are face-to-face services furnished to assist persons infected with TB in gaining access to needed medical services and include, at a minimum:

- Assessing the need for medical services to treat TB.
- Developing a plan of care addressing those needs.
- Assisting in accessing medical services identified in the care plan.
- Monitoring compliance with the care plan to ensure completion of TB therapy.
- Directly observed therapy (consists of physically watching the beneficiary take the drugs prescribed for TB).

**PUBLIC HEALTH NURSING CLINIC (PHNC) AND HOME VISITS**

UCare follows the MHCP Provider Manual and covers the services of certified public health nurses or registered nurses who practice in public health nursing clinics that are a department of, or that operate under the direct authority of, a unit of government, if the service is within the scope of practice of the public health or registered nurse's license as a registered nurse, as defined in Minnesota Rule, section 148.171.

Public health nursing clinics must be a department of, or operate under the direct authority of, a unit of government. Examples of a unit of government include county, city or school district. Services must be performed at a main clinic site, satellite clinics, mobile clinic sites that are open to the public or the recipient’s home.

Services that may be provided by county public health agencies for members enrolled in UCare’s Minnesota Health Care Program products include:
Clinic Visits

- **Health Promotion and Counseling:** Education and counseling to alleviate or prevent health problems. This service does not include in-depth nutritional counseling normally performed by a licensed dietician, nor does it include structured diabetic education programs. (See the [Physician's Services section](#) of the MHCP Provider Manual: Nutritional Counseling and Diabetic Education sections for coverage information and requirements for in-depth Nutritional Counseling and Diabetic Education.)
- **Medication Management:** Review of current medications and adherence to the prescribed medication regime. Education on proper medication use and contact with the prescribing physician when necessary.
- **Nursing Assessment Treatment and Diagnostic Testing:** A health history or examination that includes an evaluation of health behaviors and risk factors and is performed within the scope of practice of a licensed registered nurse.

Home Visits

PHNC services that are typically provided in the clinic setting may also be performed in the recipient’s home on an intermittent basis, when necessary to ensure that the recipient receives the necessary care.

PHNC visits may not be used as a substitute for traditional home care, such as the type of home care that is reimbursable by Medicare. **If a recipient needs traditional home care, the recipient should be referred to a Medicare Certified Home Care Agency.**

Additional covered services that can be provided by public health nurse clinics include:

- Safety assessments
- Infectious disease assessment and/or follow-up
- Senior health classes
- Public health services as follow-up from refugee health screenings services

**UCARE QUALITY IMPROVEMENT PROGRAM**

UCare is committed to the delivery of optimal and cost-effective health care to our members. We aim for continuous improvement in the quality of health care services and the health status of the populations we serve. A comprehensive quality improvement program directs our efforts. See the [Quality Improvement](#) section and UCare’s [Quality Initiatives](#) web page for more information.

**COMMUNICATION BETWEEN PUBLIC HEALTH AGENCIES AND PRIMARY CARE PROVIDERS (PCPS)**

It is important for public health agencies to communicate with their patients’ primary care clinics regarding services they have provided so this information can be incorporated into the patient’s medical record and plan of care. Please take the time to provide this information to the member’s PCP.

**COMMUNITY RELATIONS**

Are you interested in having UCare involved in an event in your community? Contact us at mgossett@UCare.org.
Transportation Services

Additional Resources and Links (external links)

Minnesota Statutes § 256B.0625, subd. 17
Minnesota Statutes, section 174.29 (Coordination of Special Transportation Service)
Minnesota Statutes, section 174.30 (Operating Standards for Special Transportation Service)
Minnesota Rules, part 8840 (Transportation Rules)
Minnesota Department of Transportation (MnDOT) Special Transportation Services Page

Definitions

Below are the terms and their definitions that are referenced in this section and UCare’s transportation provider agreements.

Assisted Transportation: Transportation provided to ambulatory UCare members who require assistance including escort to the desk of the medical service and/or through the door of the member’s destination. See Special Transportation. This is Nonemergency Medical Transportation (NEMT) Mode 4.

Certificate of Need (CON) Form: A CON is a form required by UCare that certifies an individual member’s need for assisted transportation/special transportation services. This form must be completed by the member’s primary care provider and returned to UCare for processing before being considered valid. This form is required before a UCare member receives NEMT Modes 4-7.

Common Carrier (CC) Transportation: Transportation of a UCare member by public transit, taxi cab or other certified commercial carrier. This is also referred to as Access Transportation Services (ATS). Common Carrier Transportation includes NEMT Modes 2-3. UCare uses this term interchangeably with Modes 2-3 to describe these services.

Elderly Waiver (EW) Transportation: Transportation services offered to members to gain access to EW services as specified in the care plan. See Elderly Waiver Services. EW Transportation cannot be billed under a transportation provider’s nonemergency transport legacy/provider number.

Emergency Ambulance Transportation Services: The transport of a UCare member whose medical condition or diagnosis requires medically necessary services before and during transport.

Lift-Equipped/ Ramp Transportation: Transportation services provided to a UCare member who is dependent on special durable medical equipment that require a nonemergency medical transportation provider to use a vehicle containing a lift or ramp. This is NEMT Mode 5.

Member: Any person enrolled in UCare and eligible for benefits under an Evidence of Coverage.
Nonemergency Ambulance Transportation Services: Transportation services provided by an Ambulance Transportation provider approved by UCare to provide to UCare members who qualify for this level of service. Drivers must provide passenger assistance including escort to the desk of the medical service and/or through the door of the member’s destination.

Nonemergency Medical Transportation (NEMT): Transportation services provided to a UCare member who does not require emergency ambulance services to obtain covered services. There are 7 Modes of NEMT:

- Mode 1: Client Reimbursement – This mode is NOT covered by UCare.
- Mode 2: Volunteer Transport
- Mode 3: Unassisted Transport
- Mode 4: Assisted Transport
- Mode 5: Lift Equipment or Ramp Transport (Wheelchair)
- Mode 6: Protected Transport
- Mode 7: Stretcher Transport

Modes 2-3 are also referred to as “Common Carrier” or “Access Transportation.” Modes 4-7 are also referred to as “Special Transportation Services.”

Protected Transportation Services: It is intended to be used by a UCare member who received a transportation level of service assessment and whose assessment determined other forms of transportation are not appropriate. The UCare member must require transport by a provider who meets both the following criteria:

1. Has a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder and a transparent thermoplastic partition between the passenger and the vehicle driver.
2. Is certified by MnDOT as a protected transport provider.

Mental health crisis teams certify the recipient for protected transportation services using Department of Human Services (DHS) criteria. Certification is based on the specific situation and the needs of the client at the time of the protected transportation request. Certification is for a single date and a single transport. This is NEMT Mode 6.

Public Transportation: Transportation service provided to the public on a regular and continuing basis. This includes both regular route transit and paratransit.

Special Transportation Services (STS): Includes, but is not limited to, service provided by specially equipped buses, vans, sedans or taxis. STS drivers provide passenger assistance including escort to the desk of the medical service and/or through the door of the member’s destination. STS services are provided to eligible UCare members with valid CONs. STS includes NEMT Modes 4-7. UCare uses STS interchangeably with Modes 4-7 to describe these services.

Stretcher Transportation: Transportation services provided to a UCare member who must be transported in a prone or supine position, which require a nonemergency medical transportation provider use a vehicle that can transport a client in a prone or supine position. This is NEMT Mode 7.
Unassisted Transportation: Transportation services completed by a nonemergency medical transportation services provider where the UCare member does not require driver-assisted services. See also Common Carrier Transportation. This is NEMT Mode 3.

Volunteer Transportation: Transportation services completed by a volunteer driver; this is NEMT Mode 2.

See also:
- Elderly Waiver Services
- Minnesota DHS Provider Manual (external link)

### Transportation Benefits by Type of Enrollee Coverage

<table>
<thead>
<tr>
<th></th>
<th>Ambulance Transportation</th>
<th>Unassisted Transportation (Modes 1-3)</th>
<th>Assisted Transportation (Modes 4-7)</th>
<th>Extended Transportation (Elderly Waiver Services)</th>
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*Covered for MinnesotaCare Child enrollees under age 19. MinnesotaCare adults age 19 and older have coverage for modes 1-3 for expecting mothers and transportation to and from mammogram or colonoscopy appointments only.

** Covered through the member’s county of residence for members with a BI, DD, CAC or CADI waiver.

To determine if a client is enrolled with UCare and the program they are enrolled in, please use the Member Eligibility Lookup (log-in required) function in the UCare Provider Portal.

### Section One: Administrative Requirements

Any violation of the service expectations and requirements listed below is subject to disciplinary actions at UCare’s discretion, up to and including termination of the UCare contract.

1. Transportation providers must have established policies and/or procedures, which are documented in a format that could be shown to a UCare representative during a site visit. All
staff, drivers, contractors and management must be aware of and knowledgeable about these policies and/or procedures and must be able to demonstrate they follow and maintain their policies and/or procedures. Policies and procedures must be reviewed and updated at least annually. Policies and/or procedures must include, but are not limited to, the following:

- **Operations**
  - Accident reporting
  - Ride management (e.g., member eligibility, call triage, scheduling, pickups)
  - Customer service standards for drivers and staff
  - Roles and responsibilities for all staff; includes independent contractors
  - Tracking and auditing drivers' performance standards
  - Handling Protected Health Information (PHI)
  - UCare member appeals and grievances
  - Ride reports (includes completed, no-shows, cancellations, mileage)
  - Ride declines for UCare members
  - Verification process for rides; prior to billing UCare

- **Driver Management**
  - Training
  - Qualifications
  - Tracking and auditing performance standards
  - Fraud, Waste and Abuse Training
  - Exclusion Search Results (OIG/SAM Results)

- **Vehicle Management**
  - Service records
  - Safety inspection and maintenance records
  - Retention Policy
  - Standards for operation of vehicles

2. Transportation providers must maintain company documentation records for at least 10 years. The provider must have the following documents in their files:

- W-9
- Automobile Insurance Certificate(s)*
- General Liability Insurance Certificate*
- Driver signature logs of annual fraud, waste and abuse training*
- Current Vehicle Roster*
- Current Driver Roster*
- Trip log documentation (e.g., driver dispatch records, drive manifests, driver assignments)
- Special Transportation Certificate (STS) or MnDOT Certifications*
- If applicable, copies of UCare members' Special Transportation Certificate of Need forms*

*County and volunteer providers are exempt from this specific requirement.

3. Transportation providers must notify UCare of accidents involving UCare members within 24 hours by completing the Accident Reporting Form found on the Providers Manual web page, under Transportation & Interpreters. Then email the form to TransProv@UCare.org or fax it to
Please attach copies of all accident reports and violations that were given at the scene of the accident. Immediate notification is required if a member is seriously injured or hospitalized.

4. Transportation providers may not subcontract with another company to provide transportation services to UCare members without UCare’s prior written consent. Subcontracts include, but are not limited to, independent contractor and lease arrangements with other companies.

5. The use of the UCare name or logo in any marketing efforts by the provider is strictly prohibited without prior approval from UCare.

6. Rides may originate from any locale within the service area of the transportation provider and must end at a UCare covered service. Rides may also originate at any UCare provider in the service area and end at the member’s original pickup point or their home.

7. All rides will be reviewed and audited by UCare to verify the following:
   - The ride is to an approved UCare covered service.
   - The member is eligible to receive transportation services.
   - If applicable, the nearest and most appropriate emergency room.

8. Transportation providers must take members to the health care provider using the most direct route and only to the location(s) listed on the Health Ride assignment. Transportation Provider must direct members back to UCare if they need to be taken to a location different than what has been assigned.

9. Providers are responsible to verify the member’s eligibility and coverage benefits before providing a ride. You can do this through MN-ITS, UCare’s secure Provider Portal or a phone call to UCare’s Health Ride department.

10. Transportation providers need to carefully manage pickup times to ensure that passengers arrive at least 10 minutes before the appointment time.

11. Drivers must wait 10 minutes past their scheduled arrival time and make an attempt to contact the member prior to leaving.

12. Transportation providers who are unable to provide a ride to a UCare member must contact UCare’s Health Ride department to coordinate alternative transportation for the member. Please provide the reason for declining the ride, following the ride decline policy as established by your own company.

13. The office staff of the transportation company must coordinate, schedule and dispatch the transportation rides for all UCare members. This includes providing the UCare member with a company business card or paper slip that lists a phone number to ensure that the member is able to call for their return ride. Companies smaller than four drivers and volunteer driver agencies are exempt from this guideline.

14. Drivers are prohibited from working directly with interpreters and/or UCare members to arrange transportation.

15. Transportation providers are required to designate a person with appropriate authority to be responsible for working with UCare in the handling and resolution of all appeals and grievances within the contractually required five day response time.

16. Return ride pickups from a UCare covered service must be dispatched within 30 minutes of receiving the return ride request. Providers who cannot meet this requirement must contact UCare’s Health Ride Department to coordinate alternative transportation for the member.
17. Transportation providers are required to complete and return a Health Ride Profile Form, found on the Providers Manual web page, under Transportation & Interpreters. Any changes to the information included on the Health Ride Profile Form must be sent to UCare at least 30 days prior to the change. These may be submitted by email to Trans-Prov@UCare.org or by fax to 612-676-6541.

Service area updates and/or changes made on the Health Ride Provider Profile Form are subject to review by UCare Provider Relations and Contracting. All requests to add new or discontinue existing transportation services within your UCare-approved service area will be reviewed by UCare Provider Relations and Contracting.

Requests will be reviewed within 30 days, and a written response will be provided upon determination. Please allow up to 60 days to receive the determination letter from UCare.

18. All providers are subject to post-payment claim audits and must fully cooperate with UCare requests.

19. **Unaccompanied Minors:** Transportation providers may accommodate ride requests for unaccompanied minors aged 17 and under (those without the presence of a parent/guardian) but, MUST escort all unaccompanied minors to a staff member of the destination appointment and make sure they are checked in. As with rides for all UCare members, provider agencies are responsible for taking all reasonable steps, including following applicable UCare requirements, to ensure that their drivers transport such minor members safely.

20. **Multiple Riders:** Transportation provider may, but is not required to, transport two or more recipients in one vehicle from the same or different points of pickup, to the same or different destinations.
   
   A. For multiple rider trips, where multiple members are riding to the same destination and/or are being picked up at the same location, mileage charges can only be billed for one of the members and must reflect the most direct mileage between that member’s pickup and destination addresses. The provider can only bill for pick-up and/or drop-off charges for each member that rides in the vehicle.
   
   B. For members that may be picked up at any time during the trip, the provider may only bill for the pick-up and/or drop-off charges.

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**Section Two: Personnel Requirements**

1. Each year by January 31, the transportation provider must submit the required Vehicle Roster and Driver Roster Listings to UCare’s Provider Relations and Contracting department. These documents may be submitted by email to Trans-Prov@UCare.org. Please complete and maintain the Excel file provided below, per the instructions provided in the file. It must be in Excel format.

Any changes to the Vehicle Roster and Driver Roster Listings must be sent to UCare within 30 days of the change. These changes include information on newly hired drivers and drivers that have been terminated. Updates can be submitted by updating the information listed in the Annual Driver and Vehicle Rosters. UCare may request this information at any time for any reason.

The provider must have the following information in the column order listed below for each driver in the Driver Roster:
• First name  
• Middle initial  
• Last name  
• Date of birth  
• Driver’s license number  
• Social security number  
• Date of hire  
• Date of termination, if applicable  
• Active or inactive driver status  

*If you terminate a driver for fraudulent or inappropriate activity or behavior, please contact UCare immediately.*

The Driver and Vehicle Roster File is found on the Providers Manual web page, under Transportation & Interpreters. (Click the link above and download the report and then open the Excel document. You can save a copy to your own computer for your use.)

2. Transportation providers must furnish all drivers with picture ID badges. Drivers must display their ID badge either in their vehicle or on their persons at all times. *County and volunteer providers are exempt from this specific requirement.*

3. Drivers must provide the member with a company business card or paper slip that lists a phone number to ensure that the member is able to call for a return ride.

4. A driver cannot also be the member’s PCA and/or interpreter and bill for all services. If the transportation agency identifies that the driver is also the member’s PCA and/or interpreter, the agency cannot bill for transportation services. The links below should be used to assist the transportation provider in identifying interpreters and PCAs registered with the Minnesota Department of Health. This is public information.

PCA: https://mn-its.dhs.state.mn.us/GatewayWebUnprotected/index.faces
(Click on Provider lists – Individual PCAs)
Interpreters: https://pqc.health.state.mn.us/hci/searchInterpreter.jsp

5. A driver cannot be a family member of the UCare member being transported. Family member is defined as the driver’s parents, spouse, domestic partner, children, grandparents, sibling, mother-in-law, father-in-law, brother-in-law or sister-in-law.

6. Transportation providers must maintain individual driver records according to Minnesota Administrative Rules 8840.6100 subpart 3, 8840.5900, and 8840.5910*.

7. The driver’s file must also include, but is not limited to the following:
   • Copy of their driver’s license
   • Completed application form or resume
   • If applicable, signed independent contract or lease agreements between the company and driver
   • Copy of their Social Security card*
   • Copy of a picture ID indicating the name of the company*
   • W-9, W-2 and/or I-9 forms*
• Annual Fraud, Waste and Abuse Training attestation/acknowledgment*
  *County and volunteer providers are exempt from this specific requirement.

8. Transportation providers must monitor and assess the quality of drivers’ performance. If there are performance issues or if fraudulent activities are suspected or confirmed with specific drivers, this must be reported to UCare immediately. You are also required to implement a corrective action plan and/or disciplinary action with the driver. UCare reserves the right to deny future rides to that driver or ban that driver from providing services to UCare members.

9. Transportation providers must check each driver’s status using the Office of Inspector General Exclusion (OIG) - [https://exclusions.oig.hhs.gov/](https://exclusions.oig.hhs.gov/) at the following schedule:
   A. At the time of hire – prior to starting assigned rides. This documentation must be kept in the individual driver’s file in a hard copy format.
   B. On a monthly basis for the entirety of the driver’s affiliation with the company. These monthly checks may be maintained either as above or in an electronic exclusion report file. If using an electronic exclusion report file, the transportation provider must track for each driver the date on which the check was performed, whether the result showed exclusions, and the name of the individual that performed the review.

On an annual basis for the entirety of the driver’s affiliation with the company. This search documentation must be in hard copy format and saved in the individual provider’s file.

10. Transportation providers must check each driver’s status using the System of Award Management (SAM) available at [https://www.sam.gov/](https://www.sam.gov/) at the following schedule:
    A. At the time of hire – prior to starting assigned rides. This documentation must be kept in the individual driver’s file in a hard copy format.
    B. On a monthly basis for the entirety of the driver’s affiliation with the company. These monthly checks may be maintained either as above or in an electronic exclusion report file. If using an electronic exclusion report file, the transportation provider must track for each driver the date on which the check was performed, whether the result showed exclusions, and the name of the individual that performed the review.

On an annual basis for the entirety of the driver’s affiliation with the company. This search documentation must be in hard copy format and saved in the individual provider’s file.

11. Transportation providers must offer orientation and training to drivers to ensure safe, prompt, culturally appropriate and courteous service to UCare members. Drivers may be subject to monitoring by UCare. You may only utilize drivers who meet the requirements set forth in Minnesota Statutes section 174.30.

12. Providers should cooperate with members who bring their own car seats and recommend that the member install the car seat themselves. Provider agencies that have their own car seats should follow all manufacturer recommendations regarding appropriate installation and use. UCare assumes no responsibility for any problem arising out of a provider’s use or installation of a car seat.
Section Three: Vehicle Requirements

1. Each year by January 31, the transportation provider must submit the required Vehicle Roster* and Driver Roster* Listings to UCare's Provider Relations and Contracting department by email to Trans-Prov@UCare.org. Complete and maintain the excel file provided below, per the instructions provided in the file. It must be in Microsoft Excel format and include the following information in the column order listed below.

   Any changes to the Vehicle Roster and Driver Roster Listings must be sent to UCare within 30 days of the change. These changes include information added vehicles and vehicles no longer in service. Updates can be submitted by updating the information listed in the Annual Driver and Vehicle Rosters. UCare may request this information at any time for any reason.

   The provider must have the following information for each vehicle listed in the Vehicle Roster:
   • Year of the vehicle
   • Make of the vehicle
   • Model of the vehicle
   • Serial or VIN number
   • License plate number
   • Vehicle Number assigned to the vehicle
   • Type of Vehicle [i.e., non-van vehicle (sedan/taxi), ambulatory van, wheelchair ramp vehicle, wheelchair lift vehicle, stretcher vehicle, bus (more than eight passengers)]
   • Last MnDOT inspection date

2. Every vehicle must display on both sides the provider's business name and the applicable certification numbers for the services being provided by the vehicle. The name and numbers must be marked in colors that sharply contrast with the background, be readily legible during daylight hours from a distance of 50 feet while the vehicle is stationary, and be maintained in a manner that retains the legibility of the markings. The markings may be shown by use of a removable device if that device meets the identification and legibility requirements of this requirement. It is the duty of the transportation provider to ensure that all vehicles have proper signage, prior to providing transportation to any UCare member.*

   *County and Volunteer providers are exempt from this specific requirement.

Section Four: Fraud, Waste and Abuse Requirements

UCare requires that you educate, and hold accountable, your contracted or employed drivers and managers about the below requirements annually. Failure to follow these requirements and to provide driver education will result in action against your UCare contract, including potential termination from
the network. Contracted provider companies are responsible for ensuring that its drivers follow these fraud, waste and abuse requirements and all applicable laws and regulations.

1. Transportation providers and drivers cannot steer UCare members to particular medical, mental health or interpreter providers. If you or your drivers are receiving payments or any items of value from other providers in exchange for encouraging UCare members to use the other providers, you are violating federal law and could be prosecuted for committing a crime.

2. Transportation providers and drivers should not directly market to or pressure UCare members to use transportation services. If you or your drivers are providing UCare members payments or items of value (including trips for personal shopping or other errands), you could be violating federal law and prosecuted for committing a crime.

3. Transportation providers and drivers are prohibited from providing payments or any items of value to other providers, such as interpreters, mental health providers and adult day care centers, in exchange for those providers steering or encouraging UCare members to use your transportation services. This is a violation of federal law and could result in criminal prosecution.

4. Transportation providers and drivers cannot provide UCare members payments or items of value to change health plans to or from UCare, or to provide individuals payments or items of value to enroll in UCare. This also is a violation of federal law and could be considered a crime.

5. Transportation providers and drivers should not submit claims for the following transportation services:
   A. Rides you did not provide.
   B. Rides to services not covered by UCare (such as a social worker visits or grocery shopping).
   C. Mileage submission that is more than the actual miles of the trip.
   D. Mileage for each rider when there are multiple riders on the trip.
   E. Any service if you do not have a required Health Ride assignment, certificate of need and supporting documentation such as trip logs and special transportation forms.
   F. Any service if your Health Ride assignment, certificate of need and supporting documentation such as trip logs and special transportation forms are obtained or documented by misrepresenting a person’s identity, medical condition or services received or by forging signatures.

If you bill UCare for services in these circumstances, this is a violation of your UCare contract, and could be considered fraud or abuse and result in termination of your contract.

6. Transportation providers must notify UCare of any information you discover regarding fraudulent, wasteful or abusive use of the transportation system by a UCare member or driver.

7. If requested by UCare, providers shall conduct a thorough internal investigation and take appropriate remedial action. Such an investigation must be conducted as soon as practicable but no longer than five (5) business days after UCare notifies the provider of an issue. In the event of serious allegations such as sexual harassment, unsafe behavior or significant member safety concerns, the involved driver or staff may not provide transportation services during the period in which the allegation is being investigated.

8. Providers must fully cooperate with any UCare investigation.
If you are aware of any individuals engaged in any of the above conduct, their services should be terminated, and you should contact UCare immediately at 1-877-826-6847.

Section Five: Assignment Requirements and Process

Any violation related to the service authorization or billing requirements listed below are subject to disciplinary actions at UCare’s discretion, up to and including termination of the UCare contract.

1. Common Carrier Ride Assignment Information
   A. All common carrier transportation services, NEMT Modes 2-3, must be coordinated and arranged by UCare's Health Ride department before the service is rendered. UCare’s Health Ride department will not provide retroactive assignment for services.
   B. UCare’s Health Ride department will schedule each ride and then notify the provider via phone, fax or email. The ride assignment notifications will include the following information:
      • Member name
      • Phone number
      • Home address
      • Destination
      • Date of service
      • Time of pickup
      • Appointment time
      • Phone number of the requestor, if different from the member
      • One way or round trip
      • Number of passengers
      • Health Ride assignment number (HR#)
      • If a car seat is needed
      • Any other information the transportation provider will need

2. Special Transportation Services (STS) Ride Assignment Information
   A. To obtain a UCare Ride Assignment and CON Authorization Number for STS, the authorized STS provider representative may contact UCare’s Health Ride department by emailing stscon@UCare.org or calling 612-676-6830 or 1-800-864-2157. Ride assignments are sent to providers confirming the ride and contain the required assignment numbers only if the member has a valid CON on file with UCare.
   The ride criteria must include the following information:
      • Member name, UCare ID #, DOB (date of birth) and Phone Number
      • Pickup Location - Facility/Clinic Name and Address or Home Address
      • Destination Location - Facility/Clinic Name and Address or Home Address
      • Date of service
- Time of pickup
- Appointment time
- One way or round trip
- Ride Type (SNF Transport, Unaccompanied Minor, Dialysis, Hospital Discharge, Standard Medical Appointment, Other)
- CON authorization status (whether you need a CON authorization for the member)

The STS Ride Notification File (Sample) is found on the Provider Manual web page, under Transportation & Interpreters.

4. Transportation companies providing NEMT Modes 4-7 may work directly from UCare members, UCare Customer Services, nursing homes, UCare’s Health Ride department, primary care clinics, hospitals or UCare Clinical Services staff. Providers are still required to obtain ride assignments and CON authorization numbers in order to receive payment from UCare for NEMT Modes 4-7.

5. A 60-day grace period is allotted for new UCare members to complete their Level of Service assessment process. A member or medical provider can contact UCare’s Health Ride department to initiate the authorization process. UCare will provide a CON authorization number for each member that qualifies for NEMT Modes 4-7.

6. Providers should report emergency room, hospital discharge, SNF appointments, same day or urgent appointments to UCare’s Health Ride department within 72 hours of the provided ride. All other rides should be reported to UCare’s Health Ride department at least 48 hours before the member’s appointment.

A. If the dispatcher and/or personnel are unable to report rides prior to the ride 48 hours before the ride or within 72 hours of the provided ride, UCare will only allow five (5) business days to obtain a ride assignment after the ride was provided. This window only applies to STS (NEMT Mode 4-7); Common Carrier Transportation (NEMT Modes 2-3) will not be given retroactive ride assignments.

B. All STS ride assignment requests are subject to trip log reviews. UCare will monitor trends and has sole discretion to allow or not allow payment.

Section Six: Trip Log/Documentation Requirements

All Transportation providers must maintain trip documentation for each ride provided on a UCare member. This documentation must be kept for a minimum of 10 years.

1. Transportation providers must maintain trip documentation by using paper and/or electronic trip logs, these logs must be in English and must be legible according to the standard of a reasonable person. You do not have to use UCare-specific forms. Electronic documentation or paper documentation is acceptable as long as the required information is available when requested for review and/or audit purposes. Transportation providers are required to review trip documentation prior to billing UCare. Additionally, if trip logs are not maintained, UCare will recover any associated claims payment. See below to review the specifics required for the applicable provider type.
2. **Driver Attestation**: All trip logs must require the driver to sign the following attestation, "I certify and swear that I have accurately reported in this mileage log the miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings." This can be documented by paper and/or electronic means, but is required in order to be considered a valid trip log.

3. For NEMT Modes 4-7 (STS) transportation providers must maintain trip documentation for all UCare members containing all of the following:
   - Date of service
   - The date on which the entry is made
   - Company Name, STS Provider Certificate Number, License Plate Number and STS Vehicle Number
   - Name (last name, first name, middle initial), driver’s license number and signature of driver
   - The name of the extra attendant when an extra attendant is used to provide special transportation service
   - Member name and UCare member ID number
   - Pickup and/or Destination Address (or description if the address is not available) with the Clinic/Facility Name
   - Pickup and/or Destination Address of the member
   - Time of pickup and/or drop off with “a.m.” and “p.m.” designations
   - Total per leg mileage
   - The mode of transportation in which the service is provided
   - Whether the service was ambulatory or nonambulatory
   - Clinic/Facility Staff printed Name and Title
   - Signature and Date of the Clinic/Facility Staff to verify the scheduled medical appointment (this indicates the recipient was taken to the appropriate medical appointment desk on the appropriate date)
   - Driver attestation referenced above

   The Sample Special Transportation Trip Log is found on the Provider Manual web page, under Transportation & Interpreters.

4. For NEMT Modes 2-3 (CC) transportation providers must maintain trip documentation for all UCare members that includes the all of the following:
   - Date of service
   - The date on which the entry is made
   - Company Name, STS Provider Certificate Number, License Plate Number, and STS Vehicle Number
   - Name (last name, first name, middle initial), driver’s license number and signature of driver
   - Member name (if multiple pages member’s name must be on each page of the record), UCare Member ID number and Signature of Member or authorized party attesting to the following. The name and signature of an authorized medical representative (parent, legal guardian, power of attorney), or facility/clinic representative may be substituted for the member signature.
• Pickup and/or Destination Address (or description if the address is not available) with the Clinic/Facility Name
• Pickup and/or Destination Address of the member
• Time of pickup and/or drop off with “a.m.” and “p.m.” designations
• The mode of transportation in which the service is provided
• Whether the service was ambulatory or nonambulatory
• Total per leg mileage
• Address of the member's pickup location
• Name and address of the member's destination
• Driver Attestation referenced above
  Sample Common Carrier Trip Log, found on the Provider Manual web page, under Transportation & Interpreters.

*County and Volunteer providers are exempt from obtaining the signature of the member, authorized medical representative (parent, legal guardian, power of attorney and facility/clinic representative). Trip documentation is still required to confirm the ride took place.

Section Seven: Billing and Claim Requirements

See the Claims section for general claim submission guidelines.

The following is NOT billable to UCare:

• No load or “dead” miles
• "No show" fees to transportation providers for rides missed by UCare members
• Failure of the provider to pick up the member that results in the member missing their scheduled appointment
• Passenger assistance including escort to the desk of the medical service and/or to the door of the destination
• Extra attendant charges for PCAs or interpreters accompanying members for whom they are providing services
• Other provisions specifically mentioned as exclusions in the Transportation Provider Agreement

Do not use an NPI or an UMPI when billing for transportation services.

The below information is needed to properly bill UCare for transportation services.

1. **Provider Identification:** All providers must bill with their UCare-assigned 6-digit legacy provider number and 4-digit Group Practice Number (GPN). If claims are billed using and NPI or UMPI, they will be rejected. If your agency is contracted for both special transportation (NEMT Modes 4-7) and common carrier transportation services (NEMT Modes 2-3), you will have two separate legacy provider numbers and two separate GPNs.

   **Note:** If you do not know your legacy provider number or GPN, please contact our Provider Assistance Center at 612-676-3300 or 1-888-531-1493.
2. **Place of Service Code**: Always use code 99 for the place of service code for Transportation Services.

3. **Diagnosis Code**: Always use either Z00.8 or Z02.89 as the diagnosis code for Transportation Services.

4. **Ride Assignment Numbers**: Claims that do not contain this information are subject to deny.
   
   A. UCare Health Ride (HR or ST #) ride assignment number(s) are required for ALL claims.
   
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<thead>
<tr>
<th>Loop/Segment</th>
<th>What to Enter</th>
<th>Place on Claim Image</th>
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</thead>
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</tr>
<tr>
<td>2400 – NTE02</td>
<td>HR or ST #</td>
<td>N/A – in raw data</td>
</tr>
</tbody>
</table>

   B. A Certificate of Need (CON #) authorization number is required for STS, NEMT Modes 4-7 claims only.
   
<table>
<thead>
<tr>
<th>Loop/Segment</th>
<th>What to Enter</th>
<th>Place on Claim Image</th>
</tr>
</thead>
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5. **Standard Transportation Procedure Codes**: Your contract determines which codes are approved and applicable.

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6. **Transportation Billing Modifiers**

   Please use the approved Transportation procedure codes with the appropriate corresponding alpha modifiers listed below when providing transportation services. If you are unsure what modifier to use, you may use “P” for the medical appointment, “R” for the residential location, and “D” or “P” for Pharmacy runs.

   Each leg (line of claim) gets two modifiers.
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<tr>
<th>Origin/ Destination Modifier</th>
<th>Description (for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination)</th>
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<tr>
<td>D-</td>
<td>Diagnostic or therapeutic site other than ‘P’ or ‘H’. This also includes dental appointments, chiropractic services, and childbirth or pregnancy education classes.</td>
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<tr>
<td>E -</td>
<td>Residential, domiciliary, custodial facility (other than a SNF)</td>
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<tr>
<td>G -</td>
<td>Hospital based ESRD facility (Dialysis)</td>
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<tr>
<td>H -</td>
<td>Hospital emergencies or hospital discharges</td>
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<td>J -</td>
<td>Freestanding ESRD facility (Dialysis)</td>
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<td>Skilled nursing facility (SNF)</td>
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<td>P -</td>
<td>Physician’s office or medical appointment</td>
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<tr>
<td>R -</td>
<td>Residential address</td>
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<td>X -</td>
<td>Intermediate stop at physician’s office en route to the hospital (destination code only)</td>
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<td>76 -</td>
<td>Repeat procedure by same provider</td>
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<td>77 -</td>
<td>Repeat procedure by another provider</td>
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**EXAMPLES SHOWING THE BOTTOM OF A TRANSPORTATION CLAIM**

### Ambulatory Round Trip

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### Ambulatory 3 Leg Trip (Pharmacy Run)

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## Ambulatory 2 Round Trips on Same Day

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## Wheelchair 2 Round Trips on Same Day

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### April 30, 2019 Provider Manual Update

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<tr>
<td>5-1</td>
<td>Provider Responsibilities</td>
<td>Added Change of Ownership and Ineligible Providers, updated Demographic Data Updates</td>
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<td>9-4</td>
<td>Provider Credentialing</td>
<td>Updated Credentialing Decisions, Appeals, Other Reviews</td>
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<td>Claims &amp; Payment</td>
<td>Updated Provider Exclusion</td>
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<td>Health Promotion</td>
<td>Updated chapter order, Community Education Classes, Smoking and Tobacco Cessation Program, and name for LivingWell Kid Kit</td>
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<td>Behavioral Health</td>
<td>Updated Substance Use Disorder Services – Chemical Use or Dependency Assessment</td>
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# July 31, 2019 Provider Manual Update

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<td>Added Appointment Availability Standards information.</td>
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<td>Data Elements removed from Ineligible Provider List.</td>
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<td>Changed Discharge Notification Guidelines QIO reviewer for Minnesota and Wisconsin members.</td>
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