

# Provider Manual



**Your guide to providing service to UCare members**

**December 7, 2023**

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[May 5, 2023 Changes](#)

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# Introduction to UCare

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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 650,000 members throughout the state of Minnesota and Western Wisconsin.

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

- Individuals and families who choose health coverage through MNsure, Minnesota's insurance marketplace.
- Medicare-eligible individuals, including those in long-term care skilled nursing facilities, nursing facilities or other similar facility types.
- Individuals and families enrolled in Minnesota Health Care Programs, such as MinnesotaCare and Medical Assistance.
- Adults with disabilities.

## UCare's Mission

Mission statement: "UCare improves the health of our members through innovative services and partnerships across communities."

Powered by the hardest working people in the industry, we de-complicate, advocate and always go the extra mile to help our members. 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 Nondiscrimination Policy

UCare complies with applicable state and 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, ethnicity, religion, creed, language, public assistance status or political beliefs.

# Provider Support

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## 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:

- 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 and third-party agencies\*\*.

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 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 give possible reasons for the denial.

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 am-5 pm.

\*At this time, information for UCare Medicare Supplement plan members is not available on the Provider Portal. Providers should call 1-800-221-6930 and follow the prompts for information on eligibility, benefits, claims and more for Medicare Supplement plans. Providers can identify that the member has a UCare Medicare Supplement plan if their Member ID number starts with a 7 or higher and they have a group number of 10003397 or 10003398.

*\*\*Providers will need to submit the [Third-Party Agreement Notification form](#) for Adds, Updates and terms (located under "Third-Party Agreement") to ensure UCare has proper documentation on authorized third parties.*

## UCare Provider Assistance Center

When providers have questions or issues that cannot be answered by using the self-service features of the 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 am-5 pm.

### *Other UCare Key Contacts*

UCare has assembled a list of [provider key contacts](#) to assist providers. It is available on [Policies and Resources](#) webpage under Administrative Resources.

## **On-site or Virtual Provider Support and Education**

### *UCare Provider Field Representatives*

For on-site or virtual support and education on UCare operations, please contact one of the below representatives:

**Kathy Campeau** - Northern Minnesota providers

[kcampeau@ucare.org](mailto:kcampeau@ucare.org)

612-246-0505

**Kevin Melnick** - Southern Minnesota providers

[kmelnick@ucare.org](mailto:kmelnick@ucare.org)

612-289-0067

**Maryann Mickelson** - Five-county metro providers (Anoka, Dakota, Hennepin, Ramsey and Washington)

[mmickelson@ucare.org](mailto:mmickelson@ucare.org)

612-719-4989

See [Territory Map](#)

### *Elderly Waiver UCare Provider Relations Liaison*

For on-site or virtual support and education on UCare operations, please contact our Elderly Waiver Provider Relations Liaison:

**Brooke Robinson, LADC**

[Brobinson@ucare.org](mailto:Brobinson@ucare.org)

952-256-0849



# Working with UCare's Delegated Business Services

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UCare works with delegated organizations responsible for providing pharmacy benefit management, dental, acupuncture, chiropractic and hearing aid or hearing aid assessment 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 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.

UCare Medicare Plans, UCare Medicare with M Heath Fairview & North Memorial Health, and EssentiaCare members have access to a preferred pharmacy network. Costs for some drugs may be less at pharmacies in this network. Visit the provider search page for an [online pharmacy directory](#). Express Scripts mail order pharmacy is included in the preferred cost sharing pharmacy network.

### *Contact Information for Express Scripts Mail Order Pharmacy*

|   |  |
|---|--|
| <b>ePrescribing</b>   | Express Scripts Home Delivery<br><br>NCPDP: 2623735<br><br>NPI: 1558443911                   |
| <b>Express Scripts Mail Order Pharmacy</b> (by mail)  | Express Scripts Inc.<br>Home Delivery Services<br>P.O. Box 66577<br>St. Louis, MO 63166-6577 |
| <b>Physician Fax</b> (new prescriptions)<br><br>For physicians and physician's office use only<br><br>Some prescriptions cannot be accepted by fax (class II controlled substances) | 1-800-837-0959<br>Available 24 hours   |
| <b>Physician Call-in</b> (new prescriptions)<br><br>Some prescriptions cannot be accepted by phone (class II controlled substances)   | 1-866-544-7950<br>Available 24 hours   |

## 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 [ucare.org](https://ucare.org) and the [Provider Pharmacy webpages](#). Please refer to the website monthly for any changes or updates.

Electronic prior authorization (ePA) is the preferred method to submit prior authorization requests to Express Scripts (ESI). 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 Pharmacy webpage](#). 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:

| Prior Authorization Contacts |                          |                          |
|------------------------------|--------------------------|--------------------------|
| UCare Line of Business       | Phone Line               | Fax Line                 |
| Medicare                     | 1-877-558-7521 toll-free | 1-877-251-5896 toll-free |
| Medicaid                     | 1-877-558-7523 toll-free | 1-877-251-5896 toll-free |
| Health Care Exchange         | 1-877-558-7523 toll-free | 1-877-251-5896 toll-free |

Listed below are decision timeframes for initial prior authorization reviews when a complete request is received.

| UCare Line of Business                      | Standard Request Timeframe              | Expedited Request Timeframe   |
|---|---|---|
| UCare Medicare Plans                        | 72 hours from receipt of request        | 24 hours from receipt of request  |
| Medicaid                                    | 24 hours from receipt of request        | 24 hours from receipt of request  |
| Health Care Exchange                        | 5 business days from receipt of request | 48 hours from receipt of request (must include at least one business day) |
| Health Care Exchange: Non-Formulary Reviews | 72 hours from receipt of request        | 24 hours from receipt of request  |

## Physician Administered Drugs

### *Care Continuum*

Care Continuum performs first-level prior authorization reviews for physician administered drugs. Some medical injection drugs given in the doctor's office may require authorization. Visit the [Pharmacy page](#) and the Medical Injectable Drug Prior Authorization Resources drop-down for general information regarding requirements for all UCare lines of business.

Providers can submit a prior authorization request to Care Continuum in one of several ways:

- Online ePA using Care Continuum's [ExpressPath](http://www.express-path.com) portal at [www.express-path.com](http://www.express-path.com).
  - Providers can submit requests, check on the status of submitted requests and submit an authorization renewal on the ExpressPath Portal.
  - The website also provides 24/7 access, potential for real-time approvals and email notifications once a decision is reached.
- By calling 1-800-818-6747, TTY 1-800-648-6056, Monday - Friday, 7 am-6 pm CT.
- By faxing 1-877-266-1871 toll-free using the prior authorization fax form found in the Medical Injectable Drug Prior Authorization Resources drop-down on the [Pharmacy webpage](#).

Providers will find medical drug criteria in UCare's [Medical Drug Policies library](#).

Listed below are decision timeframes for medical injectable drug requests when a complete request is received.

| UCare Line of Business  | Standard Request Timeframe | Expedited Request Timeframe                         |
|---|----------------------------|---|
| UCare Medicare Plans, including Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare plans | 72 hours                   | 24 hours  |
| Medicaid  | 24 hours                   | 24 hours  |
| Health Care Exchange  | 5 business days            | 48 hours (which includes at least one business day) |

To request an adjustment to an existing prior authorization:

- The authorization must be active.
- End date extensions can be completed due to scheduling issues or health reasons (e.g., chemo delayed due to blood count) that may prevent the administration of the previously approved drug.
- Required information for these requests include:
  - Reason for the extension.
  - Revised end date.
- Adjustments are not approved for the reasons listed below. A new review or renewal is required.
- Additional drug is requested.
- The patient is due for a renewal.

Non-participating providers should send requests

- By fax to UCare, Attn: Clinical Services at 612-884-2300, using the Medical Injectable Drug Prior Authorization Request fax form found on the [Provider Pharmacy webpages](#) in the Medical Injectable Drug Prior Authorization Resources drop-down.
- Or by mail to UCare, Attn: Clinical Services at P.O. Box 52, Minneapolis, MN 55440-0052.

Post-service or retrospective authorization requests should be completed using an Online Provider Claim Reconsideration Request form, located on the [Claims and Billing](#) webpage, under the Forms and Links drop-down.

Appeals and grievances are handled by UCare and should follow the member appeal process outlined in the [Member Appeals and Grievances section](#) of this manual.

## Specialty Medications

UCare works exclusively with Fairview Specialty Pharmacy for our Medicaid, UCare Individual & Family Plans and UCare Individual & Family Plans with M Health 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 toll-free

[www.FairviewSpecialtyRx.org](http://www.FairviewSpecialtyRx.org)

## *Minnesota Department of Human Services (DHS) Cash Payment Policy for Minnesota Health Care Programs (MHCP) Covered Drugs*

Providers should not accept cash payment from a member, or from someone paying on behalf of the member, for any MHCP-covered prescription drug.

UCare has adopted the Minnesota DHS Cash Payment Policy. Providers may seek payment from an enrollee for non-covered services (not otherwise eligible for payment), only under the circumstances described in Minnesota Statutes, §256B.0625, subd. 55.

A pharmacy may accept cash payment for a non-covered prescription drug if **all** the following apply:

- The member is not enrolled in the restricted member program.
- The pharmacist has reviewed all available covered alternatives with the member.
- The pharmacy obtains an [Advance Member Notice of Noncovered Prescription \(DHS-3641\) \(PDF\)](#).
- The prescription is not for a controlled substance (other than weight loss medications that are not part of the medical assistance benefit, such as phentermine).
- The prescription is not for gabapentin.

A pharmacy may accept cash payment for a controlled substance or gabapentin only if the pharmacy has received an [Advance Member Notice of Noncovered Prescription \(DHS-3641\) \(PDF\)](#) signed by the prescriber and all criteria has been met for a member who is not enrolled in the restricted member program. MHCP will not authorize a pharmacy to accept cash if the medication requires prior authorization or is subject to a quantity limit and the prescriber has not attempted to obtain the prior authorization or authorization to exceed the quantity limit. MHCP will authorize cash payment if the pharmacy and member complete their sections of the DHS-3641 and the prescriber also confirms the following:

- Covered alternatives are not viable options for the member.
- The prescriber is aware that he or she is seeking authorization for the pharmacy to charge the member for the medication.
- The prescriber is aware of the last time the medication was filled for the member, if applicable.
- The prescriber attests that allowing the member to purchase the medication is medically necessary.

The prescriber must sign the DHS-3641, send the completed form to the pharmacy and retain a copy of the completed form in the member's medical record. The pharmacy must also retain a copy of the completed form as documentation of approval from MHCP to accept cash payment on the date of service. The completed DHS-3641 is authorization from MHCP to accept cash payment on the date of service; you do not need to submit a copy to MHCP, unless requested.

The prescriber or pharmacy does not need to call MHCP for additional authorization. If a member's MHCP eligibility status is in question and the member offers cash payment for prescriptions, the pharmacy must verify eligibility through MN-ITS or the Eligibility Verification System (EVS). If the person does not have coverage through MHCP, you may charge that person and accept cash as payment. If the member is covered by MHCP, do not accept cash payment from the member for the prescription if he or she is enrolled in the restricted member program.

## 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, visit [www.deltadentalmn.org](http://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.
  - Dental providers who participate in the Minnesota Select Dental Network through Delta Dental of Minnesota are considered in-network for members in UCare's State Public Programs.
- UCare Medicare Plans, EssentiaCare and Institutional/Equivalent Special Needs Plan (I/E-SNP) (Medicare Advantage): 1-855-648-1416 toll-free or 651-768-1416.
  - Dental providers who participate in the Delta Dental National Medicare Advantage Network through Delta Dental of Minnesota are considered in-network for members in UCare Medicare Plans, EssentiaCare and Institutional/Equivalent Special Needs Plan (I/E-SNP) (Medicare Advantage).
- UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview: 1-855-648-1417 toll-free or 651-768-1417.
  - Dental Providers who participate in the Select Dental Network through Delta Dental of Minnesota are considered in-network for members in UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview.

### UCare Dental Connection

Members of the Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect, UCare Connect + Medicare, Minnesota Senior Care Plus (MSC+) and UCare's Minnesota Senior Health Options (MSHO) can take advantage of the UCare Dental Connection program. The goal of UCare Dental Connection is to help our members manage their dental care with one 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.

# Acupuncture Services

## *Fulcrum Health*

UCare contracts with Fulcrum Health, Inc. (Fulcrum) to perform medical necessity reviews on prior authorization requests for acupuncture services. Members with the following benefit plans require authorization after the threshold limit has been met:

- Prepaid Medical Assistance Program (PMAP)
- MinnesotaCare
- UCare Connect
- Minnesota Senior Care Plus (MSC+)
- UCare's Minnesota Senior Health Options (MSHO)
- UCare Connect + Medicare

All providers should submit the Acupuncture Prior Authorization Request Form to Fulcrum by fax at 763-204-8572.

Please contact the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free or visit [www.ucare.org/providers](http://www.ucare.org/providers) for questions related to network status, member eligibility and benefit information.

# 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](http://www.chirocare.com). This online provider directory is also available through UCare's website.

Contact the Provider Services Department at ChiroCare by Fulcrum Health at [www.chirocare.com](http://www.chirocare.com) or call 1-877-886-4941 toll-free.

# Hearing Aid and Hearing Aid Assessment Services

## *TruHearing*

UCare contracts with [TruHearing](http://TruHearing) to administer hearing aid and hearing aid assessment benefits for many Medicare plan members.

Current procedure codes covered under this benefit are:

- V5010 - Assessment for Hearing Aid
- V5050 - Hearing Aid, Monaural, In the Ear
- V5060 - Hearing Aid, Monaural, Behind the Ear

- V5130 - Hearing Aid, Binaural, In the Ear
- V5140 - Hearing Aid, Binaural, Behind the Ear
- V5256 - Hearing Aid, Monaural, In the Ear
- V5257 - Hearing Aid, Monaural, Behind the Ear
- V5260 - Hearing Aid, Binaural, In the Ear
- V5261 - Hearing Aid, Binaural, Behind the Ear
- V5254 - Hearing Aid, Monaural, Completely in Canal
- V5255 - Hearing Aid, Monaural, In the Canal
- V5256 - Hearing Aid, Monaural, In the Ear
- V5257 - Hearing Aid, Monaural, Behind the Ear
- V5210 - Hearing Aid, BICROS, In the Ear
- V5220 - Hearing Aid, BICROS, Behind the Ear

TruHearing contracts with providers for these services and the benefit is only available to members when the TruHearing network is utilized. TruHearing providers follow TruHearing claims submission and reimbursement processes.

Providers with questions about TruHearing can contact them at 1-855-286-0550 toll-free.

## Vision Services

### *Eye-Kraft*

UCare offers supplemental eyewear coverage for UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members exclusively through Eye-Kraft.

Supplemental eyewear benefits include:

- V2750 - Anti-reflective lens coating
- V2744 - Photochromic tinting
- V2745 - Tinted lenses
- V2781 - Progressive lenses

Benefits are only covered when obtained from Eye-Kraft. Coverage for supplemental eyewear through Eye-Kraft is not subject to medical necessity requirements and is not limited to specific diagnoses. The benefit does not require prior authorization. Members can use the benefit one time every year.\*

Providers may order supplemental eyewear through Eye-Kraft's online portal at [orders.eyekraft.com](https://orders.eyekraft.com) or by mailing or faxing approved UCare forms from Eye-Kraft to:

Mail:

**Eye-Kraft**  
8 Mclellad Rd.  
St. Cloud, MN 56303

Fax:

1-800-950-7070

For assistance with ordering or getting set up in the online portal, please call Eye-Kraft at 320-281-2617, or email [jtorgerson@eyekraft.com](mailto:jtorgerson@eyekraft.com).

Claims received from other providers for supplemental coverage of the codes indicated above may be

denied. Providers cannot bill MSHO or UCare Connect + Medicare members for denied claims for these services.

Please contact UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free or Eye-Kraft at 320-281-2617 with any questions.

\*Exceptions to frequency of benefit coverage is possible for loss, theft, breakage or medical necessity. Provider should submit claim and UCare will follow up with the provider for additional documentation, if needed.



# Provider Responsibilities

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## Appointment Availability Standards

To ensure members receive care in a timely manner, UCare has established appointment availability standards for primary care, mental health, substance use disorder 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: provide care immediately or instruct the member to call 911

Urgent care: within 24 hours

Routine/follow up care: within two weeks

Preventive: within 60 days

### *Mental Health or Substance Use Disorder*

Emergency: immediately or call 911

Non-life-threatening emergency (medication refill, immediate crisis care, claims to commit crime, suicidal ideation): within six 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 sixty (60) days prior to the effective date of a change in its ownership status due to:

- The removal, addition or substitution of a partner.
- The transfer of title to property to another party in the case of a sole proprietorship.
- The merger of the corporation into another corporation.
- The consolidation of two or more corporations into a new corporation.

Provider notification should be in the form of a letter (send to UCare, Provider Relations and Contracting, PO Box 70, Minneapolis, MN 55413) or email communication and should be sent to UCare's provider contracts mailbox at: [providercontracts@ucare.org](mailto:providercontracts@ucare.org).

# Communication With Enrollees

Providers have the right and are 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.

Per the Provider Participation Agreement, providers may discuss UCare's reimbursement method with an enrollee. Such discussions are subject to the provider's general contractual and ethical obligations:

- To not make false or misleading statements.
- To maintain the confidentiality of specific reimbursement rates paid by UCare to the provider.
- To not disparage UCare or to encourage enrollees to disenroll from 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, no less than sixty (60) days prior to any site opening, closing, change of location or material reduction in services. Provider 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 [Manage Your Information](#) webpage.

## MHCP Provider Enrollment Requirement

All UCare network providers must be enrolled with the state (Minnesota Department of Human Services, DHS) as Minnesota Health Care Programs (MHCP) providers. Network providers must comply with the provider disclosure, screening and enrollment requirements in 42 CFR §455 [Minnesota Statutes, §256B.69, subd. 37; and 42 CFR §438.602(b)].

## 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, located on the [Provider Portal](#) (click Resource Center and then the Resources tab). Use the list 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

**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 the Centers for Medicare & Medicaid Services (CMS), the Minnesota Department of Human Services (DHS) or other regulatory entities.

Questions regarding the UCare Ineligible Providers List should be directed to [compliance@ucare.org](mailto:compliance@ucare.org).

# Notification of Medicare Deactivation

Providers contracted with UCare are required to provide a ten (10) day written notification of changes in participation status with Medicare, Medicaid or any Minnesota state health care program. This includes, but is not limited to, informing UCare when CMS has deactivated Medicare billing privileges.

Notifications related to CMS deactivation should be sent to UCare at [demographicupdates@ucare.org](mailto:demographicupdates@ucare.org) and should include provider name, tax ID, NPI and the effective date of deactivation. Providers should also indicate whether deactivation is effective at the entity level or the practitioner level. A copy of the notification from CMS should be included.

**Note:** It is necessary to notify UCare when CMS billing privileges have been reinstated.

## Model of Care Training

UCare and the Centers for Medicare and Medicaid Services (CMS) require that all providers complete Model of Care (MOC) training for Dual Eligible Special Needs (D-SNP) and Institutional Special Needs (I-SNP) Plans when initially contracting with UCare and annually thereafter. The MOC training includes information about UCare's D-SNP and I-SNP plans: Minnesota Senior Health Options (MSHO), UCare Connect + Medicare, Advocate Choice and Advocate Plus.

The training covers a description of the population, details of care coordination requirements, UCare's provider network and quality measurements, and performance improvement practices. Providers are required to submit a completed Attestation Form after finishing the MOC training. More details about the training, attestation and requirements can be found on the [UCare Model of Care Training page](#). Provider agrees to complete the mandatory initial and annual Model of Care training and to submit the Attestation Form to UCare.

## 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, Model of Care (MOC) training 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 quality, utilization and cost of covered services rendered to enrollees by the 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 or quality improvement (QI) activities related to covered services provided under the provider's agreement with UCare. Provider agrees to cooperate with UCare's quality improvement (QI) activities to improve the quality of care, quality of services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. Provider shall make available to UCare any information pertaining to enrollees requested in connection with said 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 QI activities, public reporting to consumers and designation as a preferred or tiered network.

# 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, copayments, coinsurance and other common provider questions. Member product information and ID card examples are available on the [Provider Product/Benefit Tip Sheet page](#).

## Minnesota Health Care Programs (MHCP)

| Product  | Application Submission                    | Eligibility Determination or Renewal |
|--|---|--------------------------------------|
| <a href="#">Prepaid Medical Assistance Program</a> (PMAP)      | MNsure or counties via paper application  | Counties via MNsure                  |
| <a href="#">MinnesotaCare</a>                                  | MNsure                                    | DHS via MNsure                       |
| <a href="#">Minnesota Senior Care Plus</a> (MSC+)              | MNsure or counties via paper applications | DHS via MNsure                       |
| <a href="#">UCare's Minnesota Senior Health Options</a> (MSHO) | Counties, UCare                           | DHS, CMS                             |
| <a href="#">UCare Connect</a> (SNBC)                           | UCare, MNsure (non-duals)                 | DHS, non-duals via via MNsure        |
| <a href="#">UCare Connect + Medicare</a>                       | UCare                                     | DHS, CMS, some via MNsure            |

**Paper applications** are to be sent to the applicant's county of residence. The county then enters it in the MNsure eligibility system. The Minnesota Department of Human Services (DHS) and the local county human services agency educate 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.

**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.

**For more information** on how to apply for each program and links to applications, visit: [Applying for Medical Assistance \(MA\) or MinnesotaCare/Minnesota Department of Human Services \(mn.gov\)](#) or

[MNSure Home](#). For information on how to renew, visit [Renewing eligibility and reporting changes for Minnesota Health Care Programs/Minnesota Department of Human Services \(mn.gov\)](#).

MNSure Navigators can help members apply and renew their eligibility. Visit [Help from a Navigator/MNSure](#) to find a local navigator.

## Medicare Programs

*UCare Medicare Plans, UCare Your Choice, EssentiaCare, UCare Medicare with M Health Fairview & North Memorial Health, UCare Medicare Supplement and Institutional Special Needs Plans (I-SNP)*

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, UCare Medicare with M Health Fairview & North Memorial Health, UCare Advocate Choice (HMO-I-SNP) or UCare Advocate Plus (HMO-I-SNP) plans.

### **UCare Medicare Plans, UCare Your Choice, EssentiaCare and UCare Medicare with M Health Fairview & North Memorial Health Plans**

Individuals who are eligible for Medicare and wish to join UCare Medicare Plans, UCare Your Choice, EssentiaCare and UCare Medicare with M Health Fairview & North Memorial Health plans must submit a completed enrollment application form to UCare. Applications are available on the [UCare website](#). Prospective members can also enroll in a plan using UCare's online enrollment tool, through an agent or broker, or by contacting the UCare Sales department at:

- **UCare Medicare Plans:** 612-676-3500 or 1-877-523-1518 toll-free
- **UCare Medicare with M Health Fairview & North Memorial Health Plans:** 612-676-6545 or 1-855-432-7029 toll-free
- **UCare Your Choice Plans:** 612-676-6627 or 1-833-951-3188 toll-free
- **EssentiaCare:** 612-676-6630 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 a signature, to be processed. Applications are processed on the date the order is received.

### **Medicare Supplemental Plans**

UCare offers Medicare Supplement plans. Prospective members should call the UCare Sales Department to enroll at 612-676-6532 or 1-833-276-1188 toll-free. At this time all enrollment for Medicare Supplement must be done through paper applications. Online options are planned but not yet available.

### **I-SNP Plans**

To be eligible for UCare Advocate I-SNP plans, an individual must live in a participating nursing home, assisted living or memory care facility and must be receiving or assessed as eligible for nursing home level of care. Prospective enrollees or their representatives should contact the UCare Sales Department at 612-676-6821 or 1-877-671-1054 toll-free.

## Individual & Family Plans

### *UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview*

Individuals and/or their dependents who wish to purchase UCare Individual & Family Plans or UCare Individual & Family Plans with M Health Fairview must enroll for coverage through MNsure. Consumers can access MNsure through [MNsured.org](https://MNsured.org) or with help from 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.

## How to Change a Member's Primary Care Clinic (PCC)

UCare supports and values primary care and encourages all 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 assign members to a PCC within the same ZIP code as their home address.

To determine which clinic a Medicare or State Public Programs 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 M Health 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 may contact the UCare Provider Assistance Center (PAC) team in Customer Service 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:

- 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 Service 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.
- Send a copy of the certified letter to:
  - UCare  
Attn: 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 Change Healthcare 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 [CHC\\_PCSSupport@changehealthcare.com](mailto:CHC_PCSSupport@changehealthcare.com) or call 1-877-411-7271 toll-free to begin the enrollment and provisioning process.

For Medicare Supplement plan members, providers should call 1-800-221-6930 toll-free and follow the prompts for information on eligibility.

For Minnesota Health Care Program members, providers can use [MN-ITS](#), the Minnesota DHS system for MHCP claims and other transactions. Providers must be MHCP-enrolled and registered with MN-ITS to use the system. Providers who have questions or need access to MN-ITS should contact the MHCP Provider Call Center at 651-431-2700 or 1-800-366-5411 toll-free.

MN-ITS has the most current eligibility information and can reflect 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 the member's UCare 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 or 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](#) webpage for UCare's Eligibility Benefit Inquiry and Response 270/271 Companion Guide and additional information.



# Restricted Recipient/ Restricted Member Program

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## **For Minnesota Health Care Program Products (Prepaid Medical Assistance Program, MinnesotaCare, UCare Connect and Minnesota Senior Care Plus)**

The Minnesota Restricted Recipient Program (MRRP) is a program for Minnesota Health Care Program (MHCP) recipients, developed and operated under the direction of the Minnesota Department of Human Services (DHS) for recipients who have used health care services at a frequency or amount that is not medically necessary and/or who have used health care 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 recipients 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 such as specialty 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 service utilization and claims.

Reasons for restriction include, but are not limited to:

- Obtaining equipment, supplies, medications 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 medications.
- 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 recipients can be restricted by DHS or another health plan. MHCP recipients 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 recipients must be written by their designated primary care provider or by a provider whom the recipient has been referred to by the primary care provider and filled at the recipient's designated participating pharmacy.

## **Program Management**

- The RRC obtains available claims data to identify potential recipients for the program. The data is reviewed to determine if the recipient meets criteria for program enrollment.
- Once the recipient has met criteria for program enrollment, the recipient is contacted by the RRC to assist with provider selection, coordination of care and services.
- Each member enrolled in the MRRP will be offered case management services by their assigned RRC. The RRC will assess the member for needs including medical, mental health, substance use and social determinants of health, and will develop a member-centric care plan.

## **Provider Involvement**

- The designated primary care provider is responsible to oversee the recipient's health care in a holistic manner.
- The designated primary care provider authorizes referrals to other providers, as medically necessary.
- UCare's Restricted Recipient Program only accepts specialty provider referrals that were submitted within 90 days of the service being rendered. Referrals are required from the recipient's assigned primary care provider (PCP) for any specialty provider visits for a UCare member enrolled in the Restricted Recipient Program.
- The designated primary care provider may authorize some or all the other providers in the primary care clinic to see and prescribe for the recipient if the primary care provider is not available.
- Referrals to non-assigned hospital emergency room visits will not be accepted.

**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 recipients to the UCare Restricted Recipient Program. They are located on the [Authorization](#) webpage, under Restricted Recipient Program:

- Restricted Recipient Program Intake Form
  - This referral form is used when referring UCare recipients to the Restricted Recipient program.
- Specialty Referral Form
  - This referral form is used when referring an already restricted recipient to a specialist.
    - Continuity of Care cannot be a reason for a specialty referral
  - Specialty referrals are not required for the following:
    - Physical therapy (PT), Occupational therapy (OT) and Speech therapy (ST)
    - Chiropractor
    - Behavioral Health Counseling
    - Routine lab work at assigned Primary Care Clinic or assigned hospital
    - Routine dental care/vision care (unless provider is prescribing medication)

- Routine vaccination administered at pharmacies
- Durable medical equipment
- Medical Therapy Management
- Diagnostic procedures at independent diagnostic testing facility (unless provider is prescribing medication)
- Prescribing Privileges for PCP Partners
  - This referral form is used when allowing an already restricted recipient to receive care and medications from other providers in the primary care clinic.

For more information about the UCare Restricted Recipient Program, call Mental Health and Substance Use Disorder 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/lfserver/Public/DHS-6752-ENG>.

## **For Exchange Products (UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview)**

Members may be required to select a single in-network primary care provider, primary care clinic, hospital and pharmacy for coordination of services if UCare determines a member has received 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 below forms are located on the [Authorization](#) webpage, under Restricted Recipient Program, and may be used when referring members to the UCare Individual & Family Plans or UCare Individual & Family Plans with M Health Fairview Restricted Member Programs.

- 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 or UCare Individual & Family Plans with M Health Fairview Restricted Member Program, call Mental Health and Substance Use Disorder Services at 612-676-3397 or 1-877-447-4384 toll-free.

# Provider Credentialing

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## Practitioner License Types That Require Credentialing

- LAc Acupuncturist
- CICSW Certified Independent Clinical Social Worker (WI only)
- CNM Certified Nurse Midwife
- CNP Certified Nurse Practitioner
- APNP Advanced Practice Nurse Prescriber (WI only)
- 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
- 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 and only when practice does not hold a facility license)
- LPC Licensed Professional Counselor (MN only and only when able to practice without supervision)
- LCSW Licensed Clinical Social Worker (WI and ND only)
- LICSW Licensed Independent Clinical Social Worker (MN 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)
- OD Optometrist
- MD Physician
- PA Physician Assistant

**Note:** Residents: Moonlighting only requires credentialing.

# Practitioners Who Do Not Require Credentialing

- AuD Audiologist
- AAEE Association for Anesthesiologist Assistant Education
- ADT Advanced Dental Therapist (MN only)
- CMHRP Certified Mental Health Rehabilitation Professional
- CRNA Certified Registered Nurse Anesthetist
- DT Dental Therapist (MN only)
- EIDBI Non-Licensed Behavioral Technicians/Analysts (Level I, II or III - MN only)
- 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
- LAMFT Licensed Associate Marriage and Family Therapist
- LGSW Licensed Graduate Social Worker
- OPA-C Orthopedic Physician Assistant
- 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 - provides skilled nursing services (not a PCA-only agency)
- Hospital - all types including psychiatric
- Skilled Nursing Facility/Nursing Home

## *Mental Health and Substance Use Disorder*

- Ambulatory Setting
- Inpatient
- Residential Facilities

## **Provider Credentialing | Purpose and 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 section of the provider manual 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 [credentialsmart.net](https://credentialsmart.net).

### **Initial**

Applications should be submitted at least three months prior to an individual practitioner's start date at a clinic. UCare follows a standard 45-day turnaround time for a decision of clean applications. UCare 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, UCare will notify the submitter of the missing details required to move forward with the application within three (3) business days of determination of the missing information. If upon review of the application, UCare determines that the file is not clean and will need further review by our Credentialing Committee, UCare will notify the provider that it may take an additional thirty (30) days for review.

### **Recredentialing**

- When recredentialing is requested from UCare, the Minnesota Uniform Recredentialing Application should be submitted through the Credential Smart link above.
- 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 in the Organization/Facility Forms section of the [Credentialing & Recredentialing page](#) on UCare's Provider website. The application and supporting documents can be submitted to [credentialinginfo@ucare.org](mailto:credentialinginfo@ucare.org).

## Credentialing and Recredentialing Process

- 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.
- Applications that are determined "clean" credentialing/recredentialing files are approved by UCare's Medical Director on a weekly basis.
- If a practitioner has variations from established credentialing criteria, UCare's Credentialing Committee may review and make a determination for network participation. The Credentialing Committee meets monthly to consider these items.
- Recredentialing is performed every thirty-six months, or earlier for any recredentialing files, with variations from credentialing.
- 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

## 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.

## More Information

See link for: [Credentialing forms](#)

**Credentialing questions:** Contact UCare's Credentialing Department via email at [credentialinginfo@ucare.org](mailto:credentialinginfo@ucare.org)

**Claims and contracting questions:** Contact UCare's Provider Assistance Center at [pac@ucare.org](mailto:pac@ucare.org) or 612-676-3300 or 1-888-531-1493 toll-free

# Delegated Provider Contacts

## *Chiropractic*

**Fulcrum Health, Inc.**

[www.chirocare.com](http://www.chirocare.com)

1-877-886-4941 toll-free

## *Dental*

**Delta Dental of Minnesota**

[www.deltadentalmn.org](http://www.deltadentalmn.org)

1-800-448-3815 toll-free, option 2

## *Hearing*

**TruHearing, Inc.**

[www.truhearing.com](http://www.truhearing.com)

1-855-286-0550 toll-free

# Claims and Payment

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## Claim Payment

All Minnesota providers are required 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. See the [Electronic Data Interchange section](#) of this manual for details on the submission process and guidelines.

Below are the addresses and fax numbers for submitting claims for UCare members, except UCare Medicare Supplement Plans members.

For UCare Medicare Supplement Plans, submit claims directly to Medicare as shown on the Member Medicare ID card.

- Medicare provider will submit a claim directly to Medicare.
- Medicare will crossover claim to UCare to process accordingly.
- If the service is not eligible for Medicare coverage, the UCare plan will not pay. All claims processing and decisions are identical to Medicare coverage.

## *Clearinghouse Information*

A clearinghouse allows you to submit secure claims electronically. They scrub the claim for errors, then securely transmit the electronic claim to the insurance payer.

HealthEC is a free clearinghouse established to meet Administrative Uniform Committee (AUC) guidelines for Minnesota electronic billing requirements.

- To register, visit [MN E-Connect/Health EC Log In](#)
- UCare payer ID: 55413
- Contact information:
  - Phone: 1-877-444-7194 toll-free
  - Email: [support@healthec.com](mailto:support@healthec.com)

For more information visit, [Resources for Electronic Transactions](#). If you have questions about EDI transactions, email [EDISupport@ucare.org](mailto:EDISupport@ucare.org).

## *UCare Medical Claims (Paper – Available For Non-Minnesota Providers Only)*

Mail paper claims and completed W-9 to:

UCare  
Attention: Claims  
P.O. Box 70  
Minneapolis, MN 55440-0070

Fax:

612-884-2261



## *Claim Reconsideration Requests (Adjustments, Recoupments and Appeals)*

The Provider Claim Reconsideration Form is located on the [Claims and Billing webpage](#), under Forms & Links. Providers who choose not to submit the form electronically may submit it via:

Mail:

UCare  
Attention: Claims  
P.O. Box 405  
Minneapolis, MN 55440-0070

Fax:

612-884-2186

## Chiropractic Claims

If you have questions about chiropractic claim submissions, call the Provider Services Department at ChiroCare by Fulcrum Health 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 claim submissions, call Delta Dental of Minnesota (Delta Dental) at the numbers listed below or visit [www.deltadentalmn.org/providers](http://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

## Eyewear Claims for UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare

UCare offers supplemental eyewear coverage for MSHO and UCare Connect + Medicare members **exclusively** through Eye-Kraft. See the [Working with UCare Delegates section](#) for details on benefits. Contact UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free, or contact Eye-Kraft at 320-281-2617 with questions.

# Pharmacy Claims

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

## *Vaccines Covered by Medicare Part D*

### **UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare**

Jan. 1, 2022, UCare began denying claims for providers administering Part D vaccines for Medicare + Medicaid members. UCare members covered under UCare's MSHO and UCare Connect + Medicare receiving Medicare Part D vaccinations must have both the vaccine and its administration billed through the member's Part D benefit. Claims for vaccines classified as Part D cannot be reimbursed through UCare's medical administration.

**If claims are submitted to UCare, they will be denied as Contractual Obligation (CO)** with the CARC and RARC described below:

- **CARC** - 280 - claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
- **RARC** - N751 - adjusted because the patient is covered under a Medicare Part D plan.

### **UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health and EssentiaCare**

Jan. 1, 2021, UCare began denying claims for providers administering Part D vaccines in their clinics. UCare providers need to bill both the vaccine and its administration through the member's Part D benefit.

**If claims are submitted to UCare, they will be denied as Patient Responsibility (PR)** with the CARC and RARC described below:

- **CARC** - 280 - claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
- **RARC** - N751 - adjusted because the patient is covered under a Medicare Part D plan.

### **Providers Are to Follow One of These Steps for Part D Vaccines and Administration**

#### **Part D Vaccination Provided at the Pharmacy**

Member buys a Part D vaccine at a pharmacy and has it administered at the pharmacy. The member is only responsible for the coinsurance or copayment.

#### **Part D Vaccination Provided at a Clinic**

Provider submits the claim electronically using an electronic claims adjudication portal called TransactRx. By submitting the claims electronically, the member is charged the same copay that they would be charged 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 Medicare members. 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.

## Notifying UCare of Contracts with Third-Party Billers

Providers who contract with a third-party biller must have a signed authorization form on file that gives 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 [Claims & Billing page](#) in the Third-Party Billing section.

Additional instructions for when third-party billers call 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 authorization 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.
- Following HIPAA and state requirements, as well as internal processes, we are not authorized to release information to a third party until the provider has submitted the Provider Notification/Change/Update/Termination Third Party Agreement form.

## Timely Filing

Effective for dates of service Aug. 1, 2023, for Medicaid products, including dual plans where UCare is the primary payer, initial claims must be received no later than six months after the date of service. For all other product lines, including Medicare and Individual and Family Plans, initial claims must be received no later than 12 months after the date of service. All claims must be submitted in a format approved by UCare and in compliance with state and federal law.

For claims needing adjustments, see the section on [Adjustment Time Limits](#).

## 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 Centers for Medicare & Medicaid Services (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).

## Explanation of Payment (EOP)

UCare accompanies all payments with an 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 toll-free.

UCare recommends that you retain EOPs according to your business record retention policies.

Select the Administrative Resources drop down on the [Policies & Resources page](#) to view the Explanation of Payment (EOP).

## Claims Payable Calendar

The Claims Payable Calendar is available on the [Claims & Billing webpage](#) under the Payment & Remittance section.

## Claims Forms

### *UB-04 CMS 1450*

The UB-04 CMS 1450 form is for the submission of facility claims. The National Uniform Billing Committee (NUBC) publishes an instruction manual that explains how to complete the UB-04 CMS 1450 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 alphabetical 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 National Provider Identifier (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). Providers should visit the [Provider Portal](#) to complete the Provider Payment Remittance Request Form. Once logged in, click “Resource Center,” then “Resources” and “Provider Payment Remittance Advice Form.” This form is used for new enrollments, to change enrollments or to end enrollments for EFTs or ERAs.

## **Paper Claims**

All Minnesota providers are required to submit claims electronically. **Mailed paper claims received from Minnesota providers will be rejected for all products.** 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 six 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 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.
- The original UCare claim number is required for replacement (frequency code 7) and void (frequency code 8) submissions. Follow the guidelines below:
  - CMS 1500-Form field 22 Medicaid Resubmission Code and Original Ref. No..
  - UB04-Form field 64 Document Control Number.

## **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 toll-free.

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 Minnesota Health Care Plan (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, 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 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 a member and UCare is determined the primary insurer, UCare will update our 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 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 electronically and forward supporting documentation including Administrative Uniform Committee (AUC) cover sheet by fax to:

Subject: Unsuccessful TPL Billing  
612-884-2261

Please refer to the State of Minnesota Uniform Companion Guide requirements and the AUC Best Practices for claim attachments at <https://www.health.state.mn.us/facilities/ehealth/auc/index.html>. For more information on electronic claim attachments, refer to the [Electronic Data Interchange chapter](#) of this manual.

**Note:** 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

Providers are not allowed to balance-bill the patient for plan-covered services. 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 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](#).
- See the [DHS policy](#) on billing Minnesota Health Care Programs enrollees for services.

## Copayments and Cost Sharing Reminders for MHCP 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 Program (PMAP):** children younger than age 21, members who are pregnant and American Indians enrolled in a federally recognized tribe do not have copays.
- **PMAP and Minnesota Senior Care Plus (MSC+):** 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 toward 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 toll-free, and a representative can verify the cost sharing level for the member.
- **UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare:** enrollees 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 (SNBC):** 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.

## *Medicare Advantage Plans*

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

For a provider to hold a member financially responsible for services that are not clearly excluded within the member's Evidence of Coverage (EOC), a pre-determination must be obtained from UCare prior to rendering. A pre-determination can be requested from UCare by completing the Pre-Determination Request Form on UCare's [Authorization](#) webpage. UCare Medicare Plans, UCare Medicare with Fairview & North Memorial Health 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-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 several 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 that 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 M Health Fairview)*

Providers without qualified health plan products (UCare Individual & Family Plans or UCare Individual & Family Plans with M Health Fairview) contained in their agreements 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 M Health 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 M Health 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 has the right to make, and participants 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 Form (under Forms & Links on the [Claims & Billing webpage](#)) 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 Form (under Forms & Links on the [Claims & Billing webpage](#)) 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 Form (under Forms & Links on the [Claims & Billing webpage](#)) and check “Second Request” on the form. UCare will review if the claim’s adjudication is upheld, and 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 uses claims editing software that aligns with 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.

Mail or fax your request to:

Mail:

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

Fax:

612-884-2186

Include the following: UCare Provider Claim Reconsideration Form (under Forms & Links on the [Claims & Billing webpage](#)) 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 M Health Fairview & North Memorial Health 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 Form can be faxed to 612-884-2186. A Claims Attachment Cover Sheet should not be sent.

## *Void and Replacement Claims*

Minnesota Statutes, section 62J.536 requires providers to submit all claims electronically, including void and replacement claims. UCare only accepts paper void/replacement claims from providers outside 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 <https://www.health.state.mn.us/facilities/ehealth/auc/index.html>.

## *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 Form (under Forms & Links on the [Claims & Billing webpage](#)); note the overpaid claim or service(s), including the amount of overpayment 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 60 calendar days after the date on which the overpayment was identified, and that UCare be notified 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](#)
- Minnesota Administrative Uniform Committee (AUC) Companion Guides and Coding Practice Recommendation Table
  - [Minnesota AUC Companion Guides](#)
  - [Minnesota AUC Coding Practice Recommendation Table](#)
- [Centers for Medicare & Medicaid Services \(CMS\) 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 \(MAC\)](#)
- [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, 10<sup>th</sup> 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 alphabetical 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](#) has a comprehensive list of modifiers.

In addition, as part of [UCare's Payment Policy](#), the Professional Modifier Grid provides information that may help with the appropriate use of modifiers and billing and payment questions related to a particular modifier, including frequently submitted modifiers like the following:

- -22 Increased Procedural Service
- -59 Distinct Procedural Service and X-EPSU modifiers
- -57 Decision for Surgery
- -62 Two Surgeons, and other surgical modifiers

## UCare Claims Edits

### *Services Edits*

The following edits apply to all UCare plans.

### **Strategic National Implementation Process (SNIP) Edits**

UCare Minnesota uses a higher SNIP level to claim submission for our 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:

- SNIP 1-5
- Invalid character or data element
- Date of service expected to be in numeric format CCYYMMDD
- Attending provider name is required for any services other than non-scheduled transportation claims
- Ambulance pick-up/drop-off location is required
- Diagnosis code has already been used
- Admission dates are required on inpatient claims
- All industry standard codes (CPT, HCPCS, revenue, diagnosis, taxonomy, ZIP code, etc.) are valid and active on the date of service



- Zero units/minutes will not be accepted
- EPSDT condition indicator “NU” to be used when there is no referral given
- Other subscriber name ID qualifier must be equal to “MI”
- The claim level adjustments CAS cannot be equal to zero

## Claims Editing System (CES)

UCare uses version 5.4 of the Claims Edit System (CES) in the claims adjudication system.

### *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 Form (under Forms & Links on the [Claims & Billing webpage](#)).

## UCare Claims Editing and Prospective Payment System (PPS)

UCare uses automated claims pricing and editing software. This tool provides 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 including, but not limited to:

- Centers for Medicare & Medicaid Services (CMS) guide
- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 10th Edition (ICD-10)

Pricing software and edits are also used to apply the following methodologies, when appropriate:

- Ambulatory Payment Classifications (APC)
- Ambulatory Surgical Center (ASC)
- Federally Qualified Health Center (FQHC)
- Skilled Nursing Facility (SNF)
- Diagnostic Related Groups (DRGs)
- All Patients Refined Diagnosis Related Groups (APR DRG)
- Inpatient Psychiatric Facility (IPF)
- Inpatient Rehab Facility (IRF)
- End-Stage Renal Disease (ESRD)
- Professional Services

These edits align with CMS and DHS guidelines and UCare’s published payment policies (see [Payment Policies](#) on the UCare provider website).



## *Prospective Payment System (PPS)*

UCare will use an automated pricing tool for claims for Skilled Nursing Facilities (SNF), Inpatient Psychiatric Facilities (IPF), Inpatient Rehabilitation Facilities (IRF), Acute Inpatient Facilities, Hospital Outpatient Departments (HOPD), Ambulatory Surgical Centers (ASC), Federally Qualified Health Centers (FQHC), End-Stage Renal Disease (ESRD) and Professional Services. 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 policies 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 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 & 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](mailto: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.

| UCARE FEE SCHEDULE UPDATES                            |   |   |                       |  |                          |  |  |
|---|---|---|-----------------------|--|--------------------------|--|--|
| Product   | Physicians, Ancillary<br>or Ambulatory<br>Surgical Centers<br>(ASC)   | Mental Health   | Hospital              |  | Skilled Nursing Facility |  | Specialized<br>Providers<br>or Services<br>Paid<br>Outside<br>Published<br>MHCP and<br>CMS Fee<br>Schedules* |
|   |   |   | In-patient            | Out-patient                            | In-patient               | Out-patient                            |  |
| Prepaid<br>Medical<br>Assistance<br>Program<br>(PMAP) | <ul style="list-style-type: none"> <li>• Semi-Annual January and July MHCP file</li> <li>• Vaccines: as notified</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other services: Semi-Annual January and July MHCP file</li> </ul> | Per provider contract | Semi-Annual January and July MHCP file | Annual                   | Semi-Annual January and July MHCP file | As notified  |
| Minnesota Care  | <ul style="list-style-type: none"> <li>• Semi-Annual January and July MHCP file</li> <li>• Vaccines: as notified</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other services: Semi-Annual January and July MHCP file</li> </ul> | Per provider contract | Semi-Annual January and July MHCP file | Annual                   | Semi-Annual January and July MHCP file | As notified  |
| Minnesota Senior Care Plus (MSC+)                     | <ul style="list-style-type: none"> <li>• Semi-Annual January and July MHCP file</li> <li>• Vaccines: as notified</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other services: Semi-Annual January and July MHCP file</li> </ul> | Per provider contract | Semi-Annual January and July MHCP file | Annual                   | Semi-Annual January and July MHCP file | As notified  |
| UCare Connect (SNBC) Non-Duals                        | <ul style="list-style-type: none"> <li>• Semi-Annual January and July MHCP file</li> <li>• Vaccines: as notified</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other services: Semi-Annual January and July MHCP file</li> </ul> | Per provider contract | Semi-Annual January and July MHCP file | Annual                   | Semi-Annual January and July MHCP file | As notified  |

| UCARE FEE SCHEDULE UPDATES   |  |   |            |             |                          |             |  |
|--|--|---|------------|-------------|--------------------------|-------------|--|
| Product  | Physicians, Ancillary<br>or Ambulatory<br>Surgical Centers<br>(ASC)  | Mental Health   | Hospital   |             | Skilled Nursing Facility |             | Specialized<br>Providers<br>or Services<br>Paid<br>Outside<br>Published<br>MHCP and<br>CMS Fee<br>Schedules* |
|  |  |   | In-patient | Out-patient | In-patient               | Out-patient |  |
| UCare's<br>Minnesota<br>Senior Health<br>Options<br>(MSHO)                         | <ul style="list-style-type: none"> <li>• CMS Services Quarterly or DHS Services</li> <li>• Semi-Annual January and July MHCP file</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other: CMS Services Quarterly or DHS Services Semi-Annual January and July MHCP file</li> </ul> | Annual     | Quarterly   | Annual                   | Quarterly   | As notified  |
| UCare<br>Connect +<br>Medicare<br>(SNBC)<br>Integrated                             | <ul style="list-style-type: none"> <li>• CMS Services Quarterly or DHS Services</li> <li>• Semi-Annual January and July MHCP file</li> </ul> | <ul style="list-style-type: none"> <li>• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified</li> <li>• EIDBI and CCDTF Services: as notified</li> <li>• Other: CMS Services Quarterly or DHS Services Semi-Annual January and July MHCP file</li> </ul> | Annual     | Quarterly   | Annual                   | Quarterly   | As notified  |
| UCare<br>Medicare<br>Plans   | Quarterly  | Quarterly   | Annual     | Quarterly   | Annual                   | Quarterly   | As notified  |
| UCare<br>Medicare<br>with M<br>Health<br>Fairview &<br>North<br>Memorial<br>Health | Quarterly  | Quarterly   | Annual     | Quarterly   | Annual                   | Quarterly   | As notified  |
| EssentiaCare   | Quarterly  | Quarterly   | Annual     | Quarterly   | Annual                   | Quarterly   | As notified  |

| UCARE FEE SCHEDULE UPDATES   |  |  |          |           |                          |           |  |
|--|--|--|----------|-----------|--------------------------|-----------|--|
| Product  | Physicians, Ancillary or Ambulatory Surgical Centers (ASC) | Mental Health  | Hospital |           | Skilled Nursing Facility |           | Specialized Providers or Services Paid Outside Published MHCP and CMS Fee Schedules* |
| UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview | Quarterly  | <ul style="list-style-type: none"> <li>State Only Services: Annual</li> <li>Other Services: Quarterly</li> </ul> | Annual   | Quarterly | Annual                   | Quarterly | As notified  |

\*Includes, but not limited to, Hospice, Elderly Waiver, HealthCare Home, Enteral Nutrition subject to product specific pricing per DHS, Mental Health and Substance Use Disorder Facilities.

- All updates are subject to a 40-business day implementation delay.
- The UCare Standard Fee Schedule will be updated on an annual basis, implemented May 1 of each year.

## MinnesotaCare Tax

Unless otherwise stated in your provider participation agreement, UCare reimburses providers for the tax imposed on them under Minn. Stat. § 292.53 (known as the “MinnesotaCare Tax”) as follows:

- For eligible health services reimbursed on fee schedules of any type or any bundled payment methodology (e.g., DRG, APC, etc.), UCare adds an amount representing the MinnesotaCare Tax to such payments. The amount added is based on the then-current tax percentage rate, as set forth in state law.
- For eligible health services reimbursed on a percentage of billed charge or discount from billed charge, the amount billed to UCare by the provider is deemed to include the then-current tax amount. As a result, UCare will not increase its payment amount to account for the MinnesotaCare Tax for these services.
- For eligible health services reimbursed based on per diems, case rates or carve out rates (i.e., the provider participation agreement lists a specific code or service with a corresponding specific rate), the rates documented in the provider agreement are deemed to include the tax amount and such amount may be adjusted as necessary to conform with changes in the tax rate as set forth in state law.

## Unauthorized Provider Services

UCare complies with [Minnesota Statute §62Q.556](#) 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 the [Authorization](#) 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 response (i.e., adjudicate at the standard non-par rate) or if parties cannot reach agreement.

If a non-participating provider fails to respond within 30 calendar days, providers without existing Qualified Health Plan (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 Form (under Forms & Links on the [Claims & Billing webpage](#)) 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 is 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 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](#)
- [Mental Health & Substance Use Disorder Services Department](#)
- [UCare's Federally Qualified Health Center - Rural Health Clinic Carve-Out Process](#)
- [Home & Community Based Services - Waiver Services](#)
- [Interpreter Services](#)
- [Maternity, Obstetrics & Gynecology](#)
- [Transportation Services](#)

# Electronic Data Interchange (EDI)

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Using 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), pharmacy (NCPDP 5.1) and secondary claims, using a standard format.

UCare can only accept paper claims from providers outside of Minnesota.

Find details on this requirement at:

[Minnesota Department of Health](#)

[Minnesota Office of the Revisor of Statutes](#)

## Electronic Claims Submission (837) Payer ID List

**All UCare claims with dates of service (DOS) on or after Jan. 1, 2022, should be submitted to Payer ID 55413.**

Additionally, providers should ensure both the interchange Receiver Control Header (ISA08) and Functional Receiver Group Header ID (GS03) are updated to reflect UCAREMN.

| Element | Value   |
|---------|---------|
| ISA07   | ZZ      |
| ISA08   | UCAREMN |
| GS03    | UCAREMN |

Please see the Payer ID grid below for DOS prior to Jan. 1, 2022, by product.

Change Healthcare's Provider Payer list can be found at <https://support.changehealthcare.com/customer-resources/payer-lists>. Contact your clearinghouse for assistance as each clearinghouse can have unique internal payer IDs.

| Payer ID | ISA Element            | ISA Value            | Product                                       | Additional Information   |
|----------|------------------------|----------------------|---|--|
| 52629    | ISA07<br>ISA08<br>GS03 | ZZ<br>UCare<br>UCare | UCare<br>Minnesota<br>Health Care<br>Programs | <b>DOS before 1/1/2022</b><br>Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect, UCare Connect + Medicare, Minnesota Senior Care Plus (MSC+) and UCare's Minnesota Senior Health Options (MSHO). |
| 52629    | ISA07<br>ISA08<br>GS03 | ZZ<br>UCare<br>UCare | UCare<br>Medicare<br>Plans                    | <b>DOS before 1/1/2020</b><br>All UCare Medicare Plans.  |
| 52629    | ISA07<br>ISA08<br>GS03 | ZZ<br>UCare<br>UCare | UCare<br>Individual &<br>Family Plans         | <b>DOS before 1/1/2019</b><br>All UCare Individual & Family Plans.   |

## 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/Payer Enrollment

Phone: 1-800-527-8133 toll-free (option 1)

E-Fax: 1-916-267-2963

Email: [EDIEnrollmentSupport@ChangeHealthcare.com](mailto:EDIEnrollmentSupport@ChangeHealthcare.com)

Eligibility

Phone: 1-800-527-8133 toll-free (option 4)

E-Fax: 1-916-267-2966

Email: [ClearanceEDISupport@ChangeHealthcare.com](mailto:ClearanceEDISupport@ChangeHealthcare.com)

Claims, Remits and Claim Status

Phone: 1-800-527-8133 toll-free (option 2)

E-Fax: 1-916-267-2968

Email: [AssuranceEDISupport@ChangeHealthcare.com](mailto:AssuranceEDISupport@ChangeHealthcare.com)

General Change Healthcare Questions

Phone: 1-800-527-8133 toll-free

E-Fax: 1-916-267-2963

### MN E-Connect/Health EC (free, AUC-compliant web-based claims data entry tool)

Website: <https://www.healthec.com/>

Email: [support@healthec.com](mailto:support@healthec.com)

Phone: 1-877-444-7194 toll-free



# Taxonomy Code Requirements

UCare relies on provider-submitted taxonomy for accurate and timely claims processing. 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 claims (submitted via 837I or UB04) billing and attending taxonomy

For services that require rendering NPI and taxonomy, do not submit billing NPIs and taxonomy in the rendering fields. There are many services that require an individual practitioner to render the service. In these instances, the NPI and taxonomy should reflect this practitioner delivering the services and not the billing entity (often a facility). These claims will either deny or pend and ultimately be denied for invalid taxonomy

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

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

Generally, provider types that are not required to submit claims with NPI are not required to submit taxonomy on claims to UCare. For services beginning Jan. 1, 2022, all non-emergency medical transportation providers are **required** to submit the billing taxonomy aligned with the service provided (e.g., Common Carrier or Specialized Transportation Services). See the transportation services section of manual for more detail.

If you are billing durable medical equipment (DME) services without a registered taxonomy for DME, the claims editing system will deny the service line.

The rendering provider NPI and taxonomy should be reported when required and 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](http://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:

- Individuals and groups of individuals (e.g., provider groups, physicians defined by specialty, behavioral health and social service providers, pharmacy providers, physician assistants and advance practice providers).

- 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.

| <b>Taxonomy Type</b> | <b>Paper Claim Box</b>  | <b>837P Loop Professional</b>  | <b>837I Loop Institutional</b>   |
|----------------------|---|--|--|
| Billing provider     | CMS-1500<br>Box: 33B with ZZ indicator<br><br>UB04<br>Box: 81CC, box a<br>First box - Qualifier B3<br>Second box over - taxonomy number | <b>2000A</b> - Billing provider specialty information<br><br>PRV01 - BI for billing provider<br><br>PRV02 - PXC (Health Care Provider Taxonomy)<br><br>PRV03 - Taxonomy number | <b>2000A</b> - Billing provider specialty information<br><br>PRV01 - BI for billing provider<br><br>PRV02 - PXC (Health Care Provider Taxonomy)<br><br>PRV03 - Taxonomy number     |
| Rendering provider   | CMS-1500<br>Box: 24J with ZZ indicator  | <b>2310B</b> - Rendering Provider Specialty Information<br><br>PRV01 - PE for performing provider<br><br>PRV02 - PXC<br><br>PRV03 - Taxonomy number                            | N/A  |
| Attending provider   | N/A - taxonomy not required on paper claims   | N/A  | <b>2310A</b> - Attending provider specialty information<br><br>PRV01 - AT for attending provider<br><br>PRV02 - PXC (Health Care Provider Taxonomy)<br><br>PRV03 - Taxonomy number |

## 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 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](#). **Review your taxonomy submissions and make sure they reflect your actual locations and/or services.** Failure to submit appropriate taxonomy could lead to denials, inaccurate payment, and potential recoupment as we work through reports and encounter errors.

Additional information is available in the [Taxonomy FAQ](#), found in the Taxonomy Code Requirements drawer on the [Resources for Electronic Transactions webpage](#).

## **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](#).

See the [Claims and Billing page](#) for specifics on adjustment 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](mailto:CHC_pcssupport@changehealthcare.com) or call 1-877-411-7271 toll-free 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](#) webpage.

## **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](mailto:CHC_pcssupport@changehealthcare.com) or call 1-877-411-7271 toll-free 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](#) webpage.

## 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.

| Step | Report                            | Definition  |
|------|-----------------------------------|---|
| 1    | 999 ACKNOWLEDGMENTS               | A 999 acknowledges that the EDI batch submitted to UCare is "packaged" appropriately. <ul style="list-style-type: none"><li>• Batch is readable and will move on, or</li><li>• Batch is unreadable and is being returned.</li></ul>   |
| 2    | 277CA ACKNOWLEDGMENT              | A 277CA report validates the claims at the pre-processing stage. Report will show the following for each claim line: <ul style="list-style-type: none"><li>• Claim is accepted, will receive a claim number and be processed, or</li><li>• Claim was rejected along with the reason why.</li></ul>          |
| 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: <ul style="list-style-type: none"><li>• Denied, or</li><li>• Paid (payment information will be listed).</li></ul> |

\*Additional information about 835 Remittance Advice, including a companion guide, is available on the [Resources for Electronic Transactions](#) webpage 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 used terms. It is found in the Other Resources accordion on the [EDI webpage](#).

### [X12](#)

X12, chartered by the American National Standards Institute for more than 40 years, develops and maintains EDI standards and XML schemas which drive business processes globally.

X12 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 and RARC).

# Authorization and Notification Standards

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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:** UCare or an organization delegated by UCare to approve or deny prior authorization requests.

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

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

**Prior authorization:** An approval by an approval authority prior to delivering 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, and an appropriate, eligible expense and that other alternatives have been considered.

## General Guidelines

Some services require an authorization or notification, and these services are listed on the [Authorization page of the UCare provider website](#).

If a member needs a service or procedure listed in the authorization and notification requirement grids, the provider must obtain an authorization or submit a notification to UCare within the timeframe indicated on the authorization grids. 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. Routine referrals are to be made to participating providers to the greatest extent possible.

## 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.

- Ensuring UCare is aware of the services utilized by members for assistance with shaping care and referrals to care management programs.

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

Authorization and notification requirement documents are available on the [Authorization page of the UCare provider website](#).

## How to Submit Authorization or Notification Documentation

Authorization requests should be submitted via fax, mail or secure email to the appropriate approval authority. UCare's authorization request forms are available on the [Authorization page of the UCare provider website](#). The forms will assist 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.

**Note:** Photographs are not required to be submitted when requesting authorization for cosmetic or reconstructive surgeries. If UCare determines photographs are needed, the Utilization Review Specialist will call to request them.

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

- Member name and UCare ID number
- Member date of birth and address
- Rendering and billing provider information, including name, address, National Provider Identifier (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
- X-rays where appropriate
- Pertinent primary care and/or specialist notes
- Proposed date of service, provider and location
- Requestor name, title and contact information (phone, fax and email)
- Procedure code (CPT or HCPCS) and description of service
- ICD-10 diagnosis code and description

### *Reminders When Submitting Authorization Requests*

All fields on the Medical and Mental Health & Substance Use Disorder 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 mental health, substance use disorder and medical services can be found on the [Authorization page of UCare's provider website](#). To view Medical or Mental Health & SUD forms, choose the appropriate service category and scroll down to find the forms section.

**Note:** To comply with Health Insurance Portability and Accountability (HIPAA) and internal compliance requirements, providers should fax each member's prior authorization request separately. When authorization requests are faxed in bulk, it increases the risk of information being lost or inappropriately filed.

## Services That Require Pre-Determination (PD)

A pre-determination (PD) is needed to hold a UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health 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 PD **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 with M Health Fairview & North Memorial Health and EssentiaCare providers should not use the Advanced Beneficiary Notice (ABN).

## Timelines for Decision and Notification for Authorization Requests

### *Medicare and Medicaid Lines of Business*

#### **Standard review**

- The timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received. UCare considers the 14-calendar-day timespan to begin on the day of receipt and it is counted as day one.
- Notification to requesting, 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**

- The timeframe for urgent or emergent requests is 72 hours. **Only request an expedited review if waiting for the standard review timeframe would potentially jeopardize the member's health, life or ability to regain function.**
- Notification to requesting, 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 and 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 post-service or retrospective authorizations.



## *UCare's Individual and Family Plan Lines of Business*

### **Standard review**

- The timeframe for an authorization decision is within five business days from the date the request was received. UCare considers the five-business-day timespan to begin on the day of receipt, and it is counted as day one.
- Notification to requesting, 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 five 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 five business days from the date the request was received.

### **Expedited review**

- The timeframe for urgent or emergent requests is 48 hours and must include one business day after the initial request. Only request an **expedited review** if waiting for the standard review timeframe would **potentially jeopardize the member's health, life or ability to regain function**.
- Notification to requesting, 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 48 hours and must include one business day from the date and 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 post-service or retrospective authorizations.

## **How to Submit Authorization Requests**

### *Mental Health and Substance Use Disorder Requests*

#### **Fax requests to:**

612-884-2033 or 1-855-260-9710

UCare

Attn: Mental Health and Substance Use Disorder Services

#### **Mail requests to:**

UCare

Attn: Mental Health and Substance Use Disorder Services

P.O. Box 52

Minneapolis, MN 55440-0052

Questions may be directed to 612-676-6533 or 1-833-276-1185 toll-free.

## *Medical Requests*

### **Fax requests to:**

612-884-2499 or 1-866-610-7215

UCare

Attn: Clinical Services

### **Mail requests to:**

UCare

Attn: Clinical Services

P.O. Box 52

Minneapolis, MN 55440-0052

## *More Information*

- Medical injectable drugs: see the Care Continuum portion of the [Working with UCare's Delegated Business Services chapter](#).
- Hospital notifications: see the [Hospital Services chapter](#).
- Nursing home admissions: see the [Nursing Facility Services chapter](#).
- Transplant notification: call UCare upon inpatient admission at 612-676-6705 or 1-877-447-4384 toll-free.
- [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 referenced in the [Medical Necessity Criteria section](#) of this manual and are available upon request. Additionally, you may speak to a medical director at UCare or to the delegated approval authority who considered your request.

Authorization decisions are based on an 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.

# Medical Necessity Criteria for Services Requiring Authorization

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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 resources and Provider Manual chapters for additional details:

[Mental Health and Substance Use Disorder Services](#)  
[Home Care Services](#)  
[Hospital Services \(Inpatient Notification\)](#)  
[Physician Administered Drugs](#)  
[Request form for Medical Necessity Coverage Criteria](#)  
[Nursing Facility Services](#)

## Medical, Mental Health and Substance Use Disorder Services Requiring Authorization

Medical Necessity Criteria for each plan is outlined in the applicable UCare Authorization and Notification Requirements Grid. Please see the [Authorization](#) provider webpage for the grids and the [Medical Necessity Criteria](#) page for the Medical Necessity Criteria Request Form.

Each Authorization and Notification Requirements Grid includes a column for Medical Necessity Criteria that shows criteria and reference sources for the following medical procedures or services for state and federal programs:

- Acute inpatient rehabilitation
- Adult Rehabilitative Mental Health Services (ARMHS)
- Back (spine) surgery
- Bariatric surgery (gastric bypass)
- Children's residential treatment
- Cosmetic or reconstructive procedures
- Cranial Nerve Stimulation including Vagus Nerve and Hypoglossal Nerve
- Durable medical equipment
- Early Intensive Developmental and Behavioral Intervention (EIDBI)
- Genetic testing
- Home health care (SNV, HHA) (for UCare Connect and UCare Connect + Medicare products only)
- Intensive Residential Treatment Services (IRTS)
- Long-term acute care (LTAC)
- Proton beam therapy
- Psychiatric Residential Treatment Facilities (PRTF)
- Residential Treatment for Eating Disorders
- Skilled nursing facility (SNF) and swing bed admission
- Spinal cord stimulation
- Substance use disorder residential treatment

- Transcranial magnetic stimulation
- Vein procedures
- Wheelchairs and accessories

## Overview of Medical Necessity for Medical, Mental Health and Substance Use Disorder Services

To determine if a level of care is medically necessary or meets the community standard of care, UCare uses a hierarchy of medical necessity clinical decision support tools and published criteria when evaluating medical necessity. This hierarchy is product specific.

UCare uses the following:

### *UCare Medicare Plans and Institutional Special Needs Plans*

1. Change Healthcare InterQual, a nationally recognized evidence-based medical necessity criteria guideline.
2. Written criteria developed and published by the Centers for Medicare & Medicaid Services (CMS) including NCDs and LCDs.
3. American Society of Addiction Medicine (ASAM) Criteria powered by Change HealthCare InterQual as appropriate for Substance Use Disorder (SUD).
4. Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance.
5. UCare medical policy is applied when none of the above is appropriate.
6. When medical necessity criteria are not available from InterQual, CMS or UCare medical policy, medical necessity determinations are based on credible scientific evidence, including published peer reviewed literature, consensus statements or guidelines from national medical alliances or specialty societies or HAYES Technology Assessment.

### *UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare*

1. MSHO and UCare Connect + Medicare follow 1-2 above in ranked order, which are:
  - a. Change Healthcare InterQual.
  - b. Written criteria developed and published by the Centers for Medicare & Medicaid Services (CMS) including NCDs and LCDs.
  - c. UCare medical policy is applied when none of the above is appropriate.
2. When Medicare criteria is not met and a benefit is available under the State of Minnesota Department of Human Services (DHS) benefit set, DHS criteria is applied as found in the Minnesota Health Care Plans (MHCP) provider manual.
3. ASAM criteria powered by Change HealthCare InterQual as appropriate for Substance Use Disorder (SUD).
4. MN Matrix Criteria as appropriate for Substance Use Disorder (SUD).
5. Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance.
6. When medical necessity criteria are not available from InterQual, CMS or UCare medical policy, medical necessity determinations are based on credible scientific

evidence, including published peer reviewed literature, consensus statements or guidelines from national mental health or substance use disorder alliances or specialty societies or HAYES Technology Assessment.

### *Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC)*

1. Change Healthcare InterQual, a nationally recognized evidence-based medical necessity criteria guideline.
2. DHS criteria is applied as found in the Minnesota Health Care Plans (MHCP) provider manual.
3. ASAM criteria powered by Change HealthCare InterQual as appropriate for Substance Use Disorder (SUD).
4. MN Matrix Criteria as appropriate for Substance Use Disorder (SUD).
5. UCare medical policy is applied when none of the above is appropriate.
6. When medical necessity criteria are not available from InterQual, CMS or UCare medical policy, medical necessity determinations are based on credible scientific evidence, including published peer reviewed literature, consensus statements or guidelines from national mental health or substance use disorder alliances or specialty societies or HAYES Technology Assessment.

### *UCare Individual & Family Plans*

- Change Healthcare InterQual, a nationally recognized evidence-based medical necessity criteria guideline.
- ASAM criteria powered by Change HealthCare InterQual as appropriate for Substance Use Disorder (SUD).
- UCare medical policy is applied when none of the above is appropriate.
- When medical necessity criteria are not available from InterQual or UCare medical policy, medical necessity determinations are based on credible scientific evidence, including published peer reviewed literature, consensus statements or guidelines from national mental health or substance use disorder alliances or specialty societies or HAYES Technology Assessment.
- Member Contract.

## **General References**

- Clinical criteria resources:
  - Medicaid: [Minnesota Health Care Programs \(MHCP\) Provider Manual](#)
  - Medicare: [CMS Medicare Coverage Database at National Coverage Determinations \(NCD\), Local Coverage Determinations \(LCD\)](#)
- NSGMedicare and NSGConnex: [National Government Services](#)
- Medicare Benefits Policy Manual & Medicare National Coverage Determinations Manual: [CMS Gov Regulations and Guidance IOM](#)

# Member Appeals and Grievances

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## Member Rights and Responsibilities

UCare takes member rights and responsibilities seriously. Practitioners are expected to be familiar with the Member Rights and Responsibilities. Our Member Rights and Responsibilities can be found in the Evidence of Coverage, Member Handbook or Member Contract for each plan. These documents are available by plan on the [Plan Documents and Information page](#).

Following is a summary of the Member Rights and Responsibilities.

### *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 (EOC) and [Medicare Managed Care Manual, Chapter 13](#): Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance.

## *Grievance | Definitions and 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 Service.
- Problems with wait time on the phone, in the waiting room, in a clinic or 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**

Call UCare Customer Service 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 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 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 timeframe. 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 the [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 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 toll-free  
Fax: 833-868-4059

## Member Appeals | Definitions and Overview

**Plans:** UCare Medicare Plans (UCare Aware, UCare Classic, UCare Complete, UCare Essentials Rx, UCare Standard, UCare Prime, UCare Value, UCare Value Plus, UCare Medicare Group Plans, UCare Your Choice (PPO) and UCare Your Choice Plus (PPO)), EssentiaCare (EssentiaCare Access, EssentiaCare Grand and



EssentiaCare Secure), UCare Medicare with M Health Fairview & North Memorial Health (Care Core with M Health Fairview and North Memorial Health and Care Wise with M Health Fairview and North Memorial Health) and Institutional Special Needs Plan (I-SNP) (UCare Advocate Choice and UCare Advocate Plus).

**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?

- 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 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-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 review 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. For Part B drug service requests, as expeditiously as the member's health requires but within seven calendar days from receipt of the request. The timeframe for resolving any 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. Part B service requests cannot be extended.
  - 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.

## 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 two days in advance of the termination of coverage for these services. See the [Skilled Nursing Facility](#), [Home Care Services](#) or [Rehabilitation Services](#) sections for more information.
- 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](#) for more information. 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.

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

**Plans:** UCare Medicare Plans (UCare Aware, UCare Classic, UCare Complete, UCare Essentials Rx, UCare Standard, UCare Prime, UCare Medicare Group Plan, UCare Your Choice and UCare Your Choice Plus), EssentiaCare (EssentiaCare Access, EssentiaCare Grand and EssentiaCare Secure), UCare Medicare with M Health Fairview & North Memorial Health (Care Core with M Health Fairview and North Memorial Health and Care Wise with M Health Fairview and North Memorial Health), UCare's Minnesota Senior

Health Options (MSHO), UCare Connect + Medicare and Institutional Special Needs Plan (I-SNP) (UCare Advocate Choice and UCare Advocate Plus).

See also: [Evidence of Coverage \(EOC\) or Member Handbook and Prescription Drug Benefit Manual](#), Chapter 18: Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance.

## *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**

Call UCare Customer Service 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 30 calendar days from receipt of the grievance for UCare Medicare Plans in 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 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 the [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 plan provider 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 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 toll-free  
Fax: 833-868-4059

## Appeal | Definitions and 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 that the member believes may be covered by the plan. This includes 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.
- 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), 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). 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 seven calendar day timeframe could seriously jeopardize 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, 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. 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:

- **Standard redeterminations:** as expeditiously as the member's health requires but within seven calendar days from receipt of the request.
- **Standard Payment Redeterminations:** as expeditiously as the member's health requires but within 14 calendar days from receipt of the request.
- **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, C2C Innovative Solutions.

## 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 \(EOC\) 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 and 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 with Member Services.
- Problems with wait time on the phone, in the waiting room, in a clinic or 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 Service 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 complaint may be filed through UCare's grievance process. See the [Quality of Care Review Process section](#) in this chapter for more information and/or file 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's Minnesota Senior Health Options (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 toll-free  
Fax: 833-868-4059

## *Appeal | Definitions and 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 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 (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 jeopardize 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 timeline 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 review 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. For Part B drug service requests, as expeditiously as the member's health requires but within seven calendar days from receipt of the request. The timeframe for resolving any 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. Part B service requests cannot be extended.
  - 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.

## 2nd Level Appeals

If UCare does not make a fully favorable decision, 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 (ALJ) hearing, review by the Medicare Appeals Council (MAC) and judicial review. See [Evidence of Coverage or Member Handbook](#) for further information on these appeal levels.

## 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 and 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.

## 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 two days in advance of the termination of coverage for these services. See the [Skilled Nursing Facility](#), [Home Care Services](#) or [Rehabilitation Services](#) sections for more information.
- 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](#) for additional details.
- 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.

# Member Appeal and Grievance Process | UCare Minnesota Health Care Programs (Prepaid Medical Assistance Program, MinnesotaCare, Minnesota Senior Care Plus, UCare Connect)

See also: [Member's Evidence of Coverage](#).

## *Grievance | Definitions and 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 Service 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 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 toll-free

### **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 toll-free

## *Appeal | Definitions and 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 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.
- UCare Appeals and Grievances staff obtain or review all information used to make the initial decision, contact the provider for any new or additional information, review 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 and 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 timeline 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 the Department of Human Services (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 or 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 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 three days prior to the State Appeal (State Fair Hearing) date.
- At the hearing, which is usually conducted by 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).
- 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 three 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.

# Member Appeal and Grievance Process | UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview

## *Grievance | Definitions and 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

To file orally, call UCare Customer Service 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.
- 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 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 toll-free

### *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 and 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 24 hours for expedited non-formulary requests, or 72 hours for expedited service appeals, after receiving the request because the member's life, health or ability to regain maximum function could be jeopardized if they wait 15 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 decisions, 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 obtain or review all information used to make the initial decision, contact the provider for any new or additional information, review 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

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

Timelines for resolution include:

- **Standard Service appeals:**
  - For service appeals, as expeditiously as the member's health requires but within 15 calendar days from receipt of the request. Non-formulary standard appeals are processed within 72 hours. The timeframe for resolving a service appeal can be extended by up to an additional four 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.
- **Standard Payment appeals:**
  - For payment appeals, within 30 calendar days from receipt of the request.
- **Expedited appeals:**
  - As expeditiously as the member's health requires but within 24-72 hours of receipt of the request depending on the type of request. Non-formulary expedited appeals are processed within 24 hours. Formulary expedited appeals are processed within 72 hours.

## 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 or 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 or 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 medical director to discuss the approach and information needed for the review.
- The 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 medical director decides to request medical records or send a letter to the facility's leadership regarding the issues.
  - Medical records

- The nurse reviewer will review medical records and report the findings to the medical director. The medical director may request additional information from the facility's leadership if needed.
- 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 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 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 or nursing facility director of nursing) regarding the QOC review outcome.
- If a QOC issue is substantiated and notification is appropriate, the 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.

## Appeals and Grievances: Clinic Responsibilities

### *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).

You can find the [Quality Complaint Reporting Form](#) here.

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 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 or grievances for the quarter that you are reporting for. If you have questions, call UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free. 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 the following:

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

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 Service.
- 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 timelines, 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 or 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 Service 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).



# Clinical Practice Guidelines – Medical and Mental Health and Substance Use Disorders

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UCare, through the Quality Improvement Advisory and Credentialing Committee (QIACC), adopts medical, mental health and substance use disorder clinical practice guidelines from nationally or locally recognized sources. 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.

The UCare QIACC reviews and approves the content of the medical, mental health and substance use disorder guidelines at least every two years. 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.

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 adopted eight medical practice guidelines to support good decision-making by patients and clinicians and improve member health outcomes. 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.

Sources for clinical practice guidelines 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.

Currently, UCare has eight medical clinical practice guidelines:

- [Asthma, Diagnosis and Management](#)
  - Primary Source: Global Initiative for Asthma
- [Care of the Older Adult](#)
  - Primary Source: American Geriatrics Society
    - (This is a free resource, but login is required. Once logged in, visit Geriatrics Care Online Products and refer to the Guidelines section on Patient-Centered COA: A Stepwise Approach; Framework for Decision Making for COA; Guiding Principles for the COA with Multimorbidities: An Approach for Clinicians; and Executive Summary: Decision Making for the Care of Older Adults with Multiple Chronic Conditions.)
- [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)

## Mental Health and Substance Use Disorders

UCare adopted five mental health and substance use disorder clinical practice guidelines to support good decision-making by patients and clinicians and improve member health outcomes. Guidelines are adopted from various nationally or locally recognized sources.

- [Assessment and Treatment of Children and Adolescents With Attention Deficit or 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
    - \*Due to the recommendation to implement ASAM for Opioid Use Disorder, we will not use this CPG for opioid related guidance
- [The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder](#)
  - Primary Source: American Society of Addiction Medicine
- [Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder](#)
  - Primary Source: Veterans Association/Department of Defense

# Quality Program

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UCare exists to improve the health care of our members through innovative services and partnerships across communities. UCare is committed to supporting the quadruple aim of improving member experience, improving member health, reducing cost of care and improving the joy of practice for providers.

UCare's Quality Program is a commitment to innovation, affordability, professional competence, continuous learning, teamwork and collaboration. The clinical aspects of the Quality Program are structured from evidence-based medicine. The Quality Program also ensures that health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, are met. The Quality Program supports efforts to understand populations served in terms of age groups, disease categories, social factors and special risk status through analysis, monitoring and evaluation of processes. In addition, the Quality Program designs interventions to target health care disparities and social risk factors to better support members in achieving optimum health. The quality of care and services are optimized and continuously improved while maintaining cost effective utilization of health care resources. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement.

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), 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, substance use disorder, 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, ability to meet member linguistic and cultural preferences, and other administrative functions 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 may become performance improvement projects, focus studies or outcome studies. These activities may be related to social risk factors, health care disparities, referrals, case management, discharge planning, appointment scheduling, wait times, 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, and an analysis is conducted 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 medical records are current, accurate, legible, detailed, accessible and permit effective documentation. We assess that member care is confidential and perform a 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:

| No. | Medical Record Standard   |
|-----|---|
| 1   | Medical record is legible to someone other than the author.   |
| 2   | For every entry, the visit note includes the practitioner's signature and credentials with the date and time documented.  |
| 3   | Record contains a current problem list or problems are documented in the progress notes with dates.   |
| 4   | The medication list, including over-the-counter (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. |
| 5   | 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.                                  |
| 6   | 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.  |
| 7   | If the member received care at a hospital or an outpatient care facility, the report for that care is in the medical record.  |
| 8   | Immunizations are updated and documented on an immunization record.   |
| 9   | Documentation exists related to the inquiry/counseling of smoking habits and/or exposure.   |
| 10  | Documentation exists related to the inquiry/counseling of alcohol/other substances habits and/or exposure.  |
| 11  | Abnormal lab/diagnostics are noted and there is documented follow-up*.  |
| 12  | Documentation addresses the availability of preventive screening services.  |
| 13  | Documentation exists on the social risk factors and any follow-up or treatment provided to address any identified needs.  |

\*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 and/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 within two days after; or evidence of a pre-admission exam completed in relation to a planned admission.
- Receipt of discharge information on day of discharge or within two days after. Discharge 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 primary care provider (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 confirm members receive 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 following CPT codes or CPT Category 2 codes:

- 99483: assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all the following required elements:
  - Cognition-focused evaluation including a pertinent history and examination
  - Use of standardized instruments for staging of dementia
  - Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity
  - Medication reconciliation and review for high-risk medications, if applicable
  - Evaluation for neuropsychiatric and behavioral symptoms, including depression, including the use of standardized screening instrument(s)
  - Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
  - Evaluation of safety (e.g., home safety), including motor vehicle operation, if applicable
  - Address palliative care needs, if applicable and consistent with beneficiary preference
- 99495: communication (direct contact, telephone, electronic) with the patient and/or caregiver within two 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 two business days of discharge; medical decision-making of high complexity during the service period and a face-to-face visit within seven calendar days of discharge
- 1111F: discharge medications reconciled with the current medication list in outpatient medical record

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 two business days of discharge
- A face-to-face encounter within seven 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:

- [Light the Legacy, Health Care Directive Resources and Downloads](#)
- Minnesota Board on Aging's Senior LinkAge Line: 1-800-333-2433 toll-free

Questions and answers about health care directives:

- [Minnesota Health Care Program Members](#)
- [Minnesota Senior Health Options Members](#)
- [UCare Medicare Plans and UCare Medicare with M Health Fairview Members](#)
- [EssentiaCare Members](#)

# Compliance and Fraud, Waste and Abuse

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## 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 \$114 billion and \$ 380 billion a year. Health care fraud can also put members' safety at risk.

### *What is UCare doing about it?*

UCare takes 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, waste 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, to address fraud, waste 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 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 rendered.
- 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.

**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.

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

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

## *Documentation*

Providers must develop and maintain health service records 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 applicable contract provisions in the Provider Participation Agreement, and 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).

# 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:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

## 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 B, Our Obligations Under the Code of Conduct starting on Page 8 for provider-specific expectations related to UCare's Code of Conduct.

## *Contacting UCare*

If you suspect any of the above situations, or if you have any questions, please contact our Compliance hotline at 1-877-826-6847 toll-free. You may remain anonymous. This line is available 24 hours a day, every day.

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](mailto:Compliance@ucare.org)
- Mail your concern to:
  - UCare Special Investigations Unit  
P.O. Box 52  
Minneapolis, MN 55440-0052

## **Risk Adjustment Data**

Risk adjustment is a process that predicts the insurer's enrollees health care expenditures based on demographics (age/gender) and 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 adjustment is based on risk scores that are determined by the 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 claims 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 the following actions:

- Code identified conditions in accordance with the current ICD-10-CM Official Guidelines for Coding and Reporting to the highest level of specificity.
- Ensure documentation is complete, clear, concise, consistent and legible.
- Ensure reported diagnosis codes are 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 capture the complete health profile.
- Document "history of" to indicate only those conditions that are no longer present. Do not use "history of" 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.

- Ensure records are signed with credentials from the rendering provider.
- Use standard abbreviations.
- Ensure each progress note is able to “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. Requirements 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 the supporting medical documentation and imposes financial penalties for a provider’s non-compliance.

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 risk adjustment chart and quality review in accordance with CMS guidelines by providing UCare with access to specific member medical records.

CMS has stated it will validate encounter data by performing annual risk adjustment data validation (RADV) audits on a selection of Medicare Advantage plans. U.S. Department of Health and Human Services (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.

# Culturally Congruent Care

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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 Culturally Congruent Care? Why is it Important?

Culturally congruent 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 congruency is important in every aspect of our public lives, including health care providers, who deal daily with diverse people in life-and-death situations. Find more resources on the Policies & Resources webpage, under [Cultural Support Resources](#).

Culturally congruent health care can contribute to better health outcomes, improve diagnostic accuracy, increase 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 congruent 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.
- Should acknowledge culture's profound effect on health outcomes and be willing to learn more about this powerful interaction.

## Diversity and Cultural Congruence

UCare has a high concentration of members from non-white backgrounds across its UCare's Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) products. Out of its 359,798 State Public Program members, 244,404 identify as non-white and 111,150 register as unknown. Within Prepaid Medical Assistance Program (PMAP) and MinnesotaCare products, we have a large number of members who 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 221,417 members from diverse cultural backgrounds.

The following chart illustrates the diverse membership enrolled in the Minnesota Health Care Programs UCare offers as of October 2020, as a percentage of enrollment:

| Self-Identified Race                                | PMAP   | MSC+   | MinnesotaCare | MSHO   | Connect + Medicare | Connect |
|---|--------|--------|---------------|--------|--------------------|---------|
| Asian or Pacific Islander                           | 5.74%  | 19.67% | 8.80%         | 17.94% | 7.25%              | 7.29%   |
| Black or African/American                           | 20.87% | 31.26% | 14.36%        | 19.46% | 14.91%             | 23.89%  |
| Hispanic  | 8.32%  | 2.88%  | 7.13%         | 2.91%  | 2.79%              | 2.87%   |
| Native American<br>(American Indian/Alaskan Native) | 1.90%  | 1.66%  | 1.24%         | 1.12%  | 2.19%              | 3.70%   |
| Pacific Islander                                    | 0.21%  | 0.03%  | 0.41%         | 0.11%  | 0.06%              | 0.10%   |
| Unknown   | 36.15% | 3.38%  | 32.21%        | 1.60%  | 1.49%              | 3.74%   |
| White/Caucasian<br>(Not of Hispanic Origin)         | 26.81% | 41.13% | 35.84%        | 56.86% | 71.31%             | 58.41%  |

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 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 to improve members' health.

## Culture Care Connection

[Culture Care Connection](#) is an 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 congruent care in Minnesota.

This resource includes Diversity in Minnesota Information Sheets to learn more about the languages, communication preferences, backgrounds, religious and cultural beliefs of populations in Minnesota. It also offers language assistance resources, such as a roster of health care interpreters that is maintained by the Minnesota Department of Health. In addition, there are a variety of training resources for health care professionals on the provision of language services and providing culturally congruent care.

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

The [National Standards for CLAS in Health Care](#) were 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

Find information about [LEARN: Process for Improved Communication here](#).

### *UCare Innovations in Culturally and Linguistically Appropriate Services*

- UCare’s Health Equity Plan addresses all [15 CLAS standards](#).
- UCare involves members to ensure that health care services are patient focused. For example, members comprise 40 percent of our Board of Directors, we convene regular member advisory committees and we conduct periodic focus groups to receive input from a diverse range of community representatives.
- UCare is recognized nationally by health professionals. For example, the America’s Health Insurance Plans awarded 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.
- UCare developed a CMS-recognized culturally congruent section for our Provider Manual.
- 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.
- UCare integrates the cultural needs of our members into our daily activity. For example, 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.
- UCare works with providers to improve cultural congruence, including using a clinic-specific culturally congruent assessment tool and supporting activities that assist providers through the Culture Care Connection initiative led by Stratis Health throughout Minnesota (see [www.culturecareconnection.org](http://www.culturecareconnection.org)).
- Grants from the UCare Foundation and community benefit program 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.
- 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 Twin Cities Public Television (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/UCKPjzRExklqYtnbTPomxqlw/videos>).

- UCare provides health information through innovative 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 multilingual health materials, use the following log-in information:
  - Log-in: UCare
  - Password: UCare

## Interpreter Services and Language Assistance Resources

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

There are additional language assistance resources for providers and members:

- Notice of language access services by posting in public areas the “Language Poster,” available through the DHS public website (<https://mn.gov/dhs/general-public/about-dhs/lep/lep-resources.jsp>).
- The “I need an interpreter” card is available in 15 languages through the DHS public website (<https://mn.gov/dhs/general-public/about-dhs/lep/lep-resources.jsp>).

### *Minnesota Initiatives to Improve Interpreter Training and Services*

[Online resources from UMTIA](#)  
[Interpreting Stakeholder Group](#)



# Disease Management Programs

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UCare offers disease management programs to our members living with asthma, diabetes and hypertension, diabetes, heart failure, migraines. 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 (PCP) is notified of member enrollment into the disease management program. Please review our [disease management programs](#) and complete the referral form(s) for members who would benefit from 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 coaching on their condition.
- Are looking to improve their health through learning how to manage their chronic condition.

## Asthma

*Interactive Voice Response (IVR) or Texting Program* Pediatric and adult members in our IVR or texting program receive regularly scheduled education phone calls providing chronic condition education and condition-related questions to respond to. Answers are triaged for follow-up support provided by an asthma educator where the call is triaged for further education, referral to PCP or enrollment in the asthma education program.

### *Asthma Education Program*

Pediatric and adult members (under 65) in our asthma program receive regular asthma education and asthma 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

### *Brook – Diabetes and Hypertension*

UCare partners with Brook to bring members their Health Companion program. Brook helps members manage their general wellness, diabetes, hypertension and other chronic conditions from their smartphone. Members can chat with dietitians to help turn health goals into sustainable habits. Features include in app chats, meal planning and scheduled reminders. More information can be found at [ucare.org/brook](https://ucare.org/brook).

### *Interactive Voice Response (IVR) or Texting Program*

Adult members in our IVR or texting program receive regularly scheduled education phone calls providing chronic condition education and condition-related questions to respond to. A health coach follows up on the responses by triaging the member for further education and a referral to a PCP or enrollment in the health coaching program.

## *Health Coaching*

Adult members in our diabetes program receive regularly scheduled health coaching calls with a UCare health coach. Our team of coaches partner with members to discover their barriers and vision for the future, establish short and long-term behavior change goals and empower members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Diabetes management tools, such as our Health Journey education book, pedometer, diabetic bracelet 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 partner with members to discover their barriers and vision for the future, establish short and long-term behavior change goals and empower members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Heart failure management tools, such as our Health Journey education book, bathroom scale and wrist blood pressure cuff are provided to participating members.

### *Telemonitoring Program*

Adult members in our high-risk heart failure program receive a Medtronic telemonitoring tablet 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 tablet is available in English and Spanish.




## **Migraine Management Program**




Adult members in our migraine management program receive regularly scheduled health coaching calls with a UCare health coach. Our team of coaches partner with members to discover their barriers and vision for the future, establish short and long-term behavior change goals and empower members to achieve their goals. Health coaches use active listening, motivational interviewing and behavior change techniques. Migraine management tools are provided to participating members and include a headache management book, migraine diary and migraine action plan.

# Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) program is a free service for eligible UCare members to optimize their medication therapy and experience.

## Eligibility

| Member Plan Type  | MTM Eligible  | Notes Regarding Eligibility  |
|---|---|--|
| <b>Medicaid</b><br>Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+) and UCare Connect (SNBC)             |    | <ul style="list-style-type: none"><li>UCare follows guidance from the Minnesota Department of Human Services (DHS). Please see details here: <a href="#">DHS MTM website</a>.</li></ul>  |
| <b>Dual-eligible Medicaid</b><br>MSC+ Duals, PMAP Duals, and UCare Connect Duals  |    | <ul style="list-style-type: none"><li>Members receive Medicaid benefits through UCare and Medicare benefits, including MTM services, through an outside payer. Patients should be directed to their primary Medicare payer to determine if they are eligible for MTM.</li></ul>  |
| <b>Medicare</b><br>UCare Medicare Plans, UCare Medicare Group Plans, EssentiaCare and UCare Medicare with M Health Fairview & North Memorial Health |  | <ul style="list-style-type: none"><li>All members with Part D benefits are eligible for MTM.</li><li>MTM services must be completed by an in-network pharmacist. Pharmacists must meet requirements to submit standardized continuity of care document (CCD) data to UCare.</li><li>Not all members will receive active outreach or enrollment letters, but they can opt in or request services at any point.</li><li>Some members will receive active outreach for MTM if they meet specific Centers for Medicare and Medicaid Services (CMS) criteria.</li><li>MTM services may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist.</li></ul> |

| Member Plan Type  | MTM Eligible   | Notes Regarding Eligibility   |
|---|--|---|
| <b>Dual-eligible Medicare</b><br>UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare  |   | <ul style="list-style-type: none"> <li>All members with Part D benefits are eligible for MTM.</li> <li>MTM services must be completed by an in-network pharmacist. Pharmacists must meet requirements to submit standardized continuity of care document (CCD) data to UCare.</li> <li>Not all members will receive active outreach or enrollment letters, but they can opt in or request services at any point.</li> <li>Some members will receive active outreach for MTM if they meet specific CMS criteria.</li> <li>MTM services may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist.</li> </ul> |
| <b>Medicare Value</b><br>UCare Value and UCare Value Plus   |   | <ul style="list-style-type: none"> <li>Not eligible without Part D benefits.</li> </ul>   |
| <b>Health Exchange and Individual &amp; Family Plans</b><br>UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview |  | <ul style="list-style-type: none"> <li>MTM services must be completed by an in-network pharmacist.</li> <li>MTM services may be completed in person, telephonically, or virtually through interactive video (ITV) with a pharmacist.</li> </ul>   |

## Provider Expectations

UCare expects providers to follow [American Pharmacist Association \(APhA\)](#) and the [Patient-Centered Primary Care Collaborative's \(PCPCC\)](#) professional guidance when delivering all MTM services. Members should receive a one-on-one consultation with a pharmacist to review a member's entire medication regimen (including prescription, over-the-counter medications and/or herbal supplements) to help resolve any potential medication-related issues regarding indication, effectiveness, safety and convenience. Providers should communicate with the member's health care team to resolve medication-related problems, acquire clinical information and obtain relevant lab information. UCare may send quarterly Medicare member eligibility reports based on CMS criteria for comprehensive medication review (CMR) completion to select providers or health systems. Providers are expected to utilize these lists to target eligible members.

# Documentation Expectations

Providers are expected to document all encounters electronically. Providers are legally required to follow all Minnesota DHS requirements for Medicaid members and CMS requirements for Medicare members. Each encounter will require the following information:

- Patient demographics\*
- Date of encounter
- Chief complaint/reason for visit
- Allergies
- Current and previously treated medical conditions (problem list)
- Social history (including alcohol and tobacco use, relevant environmental factors, etc.)
- List of all current medications\*\*
- Number and assessment of medication-related problems both identified and resolved
- Plan to resolve medication-related problems
- Follow-up plan and/or patient instructions
- Lab results (if applicable)
- Time spent with patient
- Recipient of service and method of delivery (i.e., face-to-face, phone or virtual)\*\*\*
- Cognitive status
- CMS standardized summary and date of delivery (Medicare only)\*\*\*\*
- Primary physician and contact information
- List of all relevant medical devices (if applicable)

\*Including full name, date of birth, gender, address, phone number and member ID.

\*\*Including all prescription drugs, over-the-counter drugs, dietary supplements and herbal products with their indications, doses and directions.

\*\*\*Medicaid members must have location of the patient documented if using telehealth.

\*\*\*\*Medicare members must be provided with CMS standardized format materials (including medication action plan and personalized medication list) within 14 days of the encounter. This applies to the annual CMR and must be completed at least once per calendar year.

## Audits

UCare reserves the right to audit MTM providers for supporting documentation, which may include, but is not limited to, medical and/or administrative records. The MTM provider is responsible for submitting the requested information within seven calendar days of the request. MTM providers are required to comply with any documentation requests that result from a regulatory agency audit. Failure to meet requirements may result in recoupment of the affected claim(s) and/or termination of a pharmacist's network status to provide services.

## Billing Processes

All MTM codes must be submitted through UCare's claims processing utilizing the HCFA-1500/837P electronic submission form. Providers are expected to bill UCare by specific, HIPPA-compliant, MTM CPT codes applicable to the MTM service provided. CPT codes include: 99605, 99606 and 99607. Rates are based on individual provider service agreements. MTM services are provided at no cost to members. Members who reside in an inpatient setting are not eligible for MTM services.

Contracted pharmacists are eligible to submit one CPT 99605 per provider per member in a calendar year. There is not a limit on CPT 99606 per calendar year. Providers can bill up to four CPT 99607 per member per date of service. The expectation is that providers will bill based on complexity, not time, for the visit. Please adhere to the following CPT code definitions and bill for the lowest level where all listed criteria are met:

- 99605: A first encounter service with a patient; one per calendar year.
- 99606: Follow-up encounter use with the same patient for a subsequent encounter.
- 99607: Additional increments based on complexity in addition to 99605 or 99606.

| Level | Number of Current Medical Conditions | Number of Medications    | Number of Drug Therapy Problems  | Bill CPT Code      | Units   |
|-------|--------------------------------------|--------------------------|----------------------------------|--------------------|---------|
| 1     | 1 medical condition                  | At least 1 medication    | No drug therapy problems         | 99605 or 99606     | 1 unit  |
| 2     | 1 medical condition                  | At least 2 medications   | At least 1 drug therapy problem  | 99605 or 99606     | 1 unit  |
|       |                                      |                          |                                  | 99607              | 1 unit  |
| 3     | At least 2 medical conditions        | At least 3-5 medications | At least 2 drug therapy problems | 99605 or 99606 and | 1 unit  |
|       |                                      |                          |                                  | 99607              | 2 units |
| 4     | At least 3 medical conditions        | At least 6-8 medications | At least 3 drug therapy problems | 99605 or 99606 and | 1 unit  |
|       |                                      |                          |                                  | 99607              | 3 units |
| 5     | At least 4 medical conditions        | ≥9 medications           | At least 4 drug therapy problems | 99605 or 99606 and | 1 unit  |
|       |                                      |                          |                                  | 99607              | 4 units |

**Example 1:** A pharmacist performs a CMR for a new patient with two medical conditions, five medications and two drug-therapy problems. Pharmacist should bill a level 3 service:

Claim line 1: 99605 - 1 unit

Claim line 2: 99607 - 2 units

**Example 2:** A pharmacist has a follow-up encounter with an existing patient with four medical conditions, ten medications and three drug-therapy problems. Pharmacist should bill a level 4 service:

Claim line 1: 99606 - 1 unit

Claim line 2: 99607 - 3 units

## Continuity of Care Document (CCD) Expectations

MTM providers are required to maintain and submit UCare's standard continuity of care document (CCD) for all Medicare visits ([Exhibit B](#)). Information about the CCD document can be found on the [Pharmacy webpage](#) in the Medication Therapy Management Program drop-down. The CCD must be submitted to UCare within 45 days of the original visit. It is acceptable to send information for non-

Medicare members as well. All end of year CCD records must be submitted to UCare by January 15 of the next calendar year. Failure to submit CCD records may result in denial of claims.

## Opt-Out Processes

Medicare members may elect to opt-out of MTM services. Opt-out decisions can only be made by the member or a legal representative. Refusing an individual service for any reason or lack of responsiveness does not automatically disenroll the patient from future MTM services. Providers are required to send UCare information regarding those who elect to opt-out within 30 days of the member's decision to opt-out. Expectations for opt out processes are available in [Exhibit A](#) of the CCD document (located on the [Pharmacy webpage](#) in the Medication Therapy Management Program drop-down).

## Contact Information

If you have questions regarding the MTM program at UCare, please contact us via email at [pharmacyliaison@ucare.org](mailto:pharmacyliaison@ucare.org) or via telephone at 612-676-6536 (option 2) or 1-855-931-5272 toll-free.

# Health Promotion Programs

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UCare is committed to keeping our members healthy and safe. The following Health Promotion programs and resources are available to eligible UCare members. Visit [UCare's Health and Wellness](#) webpage to learn more.

## **Fitness Programs | UCare Medicare Plans (Excluding UCare Advocate Plans), UCare Medicare Group Plans, UCare Medicare with M Health Fairview & North Memorial Health and EssentiaCare**

UCare Medicare Plans (excluding UCare Advocate Choice [HMO-I-SNP] and UCare Advocate Plus [HMO-I-SNP]), UCare Medicare Group Plans, UCare Medicare with M Health Fairview & North Memorial Health and EssentiaCare members may choose one of two fitness benefit options.

### *Option 1: One Pass*

One Pass is a complete fitness solution for body and mind, available to eligible members at no additional cost. Members have access to more than 23,000 participating fitness locations nationwide, plus:

- More than 32,000 on-demand and live-streaming fitness classes
- Workout builders to create workouts and walk through each exercise
- Home Fitness Kits available to members who are physically unable to visit, or who reside at least 15 miles outside of, a participating fitness location
- Personalized, online brain training program to help improve memory, attention and focus
- More than 30,000 social activities, community classes and events available for online or in-person participation

Members can find participating locations at [ucare.org/onepass](https://ucare.org/onepass) or they can call toll-free 1-877-504-6830 (TTY 711), from 8 am-9 pm, Monday - Friday.

### *Option 2: Health Club Savings*

- If the member belongs to a participating health club that is not in the One Pass network, they may be eligible to receive a reimbursement of up to \$30 in monthly health club membership fees. For a list of participating locations, visit the [Health Club Savings](#) page.
- Members will need to show their UCare member ID card to sign up at a participating location.



# **Fitness Programs | UCare's Minnesota Senior Health Options (MSHO), UCare Connect and UCare Connect + Medicare and UCare Medicare Supplement**

## *One Pass*

One Pass is a complete fitness solution for body and mind, available to eligible members at no additional cost. Members have access to more than 23,000 participating fitness locations nationwide, plus:

- More than 32,000 on-demand and live-streaming fitness classes
- Workout builders to create workouts and walk through each exercise
- Home Fitness Kits available to members who are physically unable to visit, or who reside at least 15 miles outside of, a participating fitness location
- Personalized, online brain training program to help improve memory, attention and focus
- More than 30,000 social activities, community classes and events available for online or in-person participation

Members can find participating locations near you at [ucare.org/onepass](https://ucare.org/onepass) or they can call toll-free 1-877-504-6830 (TTY 711), from 8 am-9 pm, Monday - Friday.

# **Fitness Programs | UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview**

## *Health Club Savings*

- Members must be 18 years or older to qualify.
- For a list of participating locations, visit the [Health Club Savings](#) page.
- Members visit an eligible health club at least 12 times per calendar month and receive a reimbursement of up to \$20 in monthly health club membership fees. 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.
- Members will need to show their UCare member ID card to sign-up at a participating location.

# **Fitness Programs | Prepaid Medical Assistance Program (PMAP) and MinnesotaCare**

## *Health Club Savings*

- Members must be 18 years or older to qualify.
- For a list of participating locations, visit the [Health Club Savings](#) page.

- Members visit an eligible health club at least 12 times per calendar month and receive a reimbursement of up to \$20 in monthly health club membership fees. Members will need to show their UCare member ID card to sign-up at a participating location.

## Community Education Classes

Available to UCare Medicare Plans (excluding UCare Advocate Plans [HMO-I-SNP] and UCare Your Choice Plans), UCare Medicare Group Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview, UCare Connect, UCare Connect + Medicare, Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare's Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) members.

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. Members may get their discount by showing their UCare member ID card when enrolling in a class.

UCare Medicare Plans (excluding UCare Advocate Plans [HMO-I-SNP] and UCare Your Choice Plans), UCare Medicare Group Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview include a limit of three discounts in a calendar year (one discount per class enrollment).

PMAP, MinnesotaCare, UCare's MSHO, MSC+, UCare Connect and UCare Connect + Medicare plans include unlimited discounts in a calendar year (one discount per class enrollment).

## Connect to Wellness Kit

UCare Connect and UCare Connect + Medicare members can order a Connect to Wellness Kit at no cost. Each kit includes engaging tools to help improve health and wellness.

Members may choose one of the following kit options:

- Kit A: Fitness Kit
- Kit B: Sleep Aid Kit
- Kit C: Stress Relief Kit
- Kit D: Dental Kit
- Kit E: Amazon Echo Kit
- Kit F: Five-pound weighted blanket (only available to UCare Connect + Medicare Members)

To order a kit, members can log in or create an account at [member.ucare.org](https://member.ucare.org). Members can also order a kit over the phone, they can call UCare Customer Service at the number on the back of their member ID card. Kit information can also be found on the [Connect to Wellness Kit](#) page.

**Note:** Members must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

# Dental Programs

## *Adult Dental Kit*

Available to UCare's Minnesota Senior Health Options (MSHO), UCare Connect + Medicare and UCare Advocate Choice (HMO-I-SNP) and UCare Advocate Plus (HMO-I-SNP) members. Eligible members can receive this kit once every three years. On the years the member does not receive the Adult Dental Kit, they can request the Adult Dental Refill Kit. Members are not eligible to receive the Adult Dental Refill Kit in the same year they receive the complete adult dental kit.

The Adult Dental Kit has:

- Electric toothbrush and charger
- Replacement brush heads
- Toothpaste
- Dental floss

The Adult Dental Refill Kit has:

- Replacement brush heads
- Toothpaste
- Dental floss

For more information or to order a kit, members can log in or create an account at [member.ucare.org](https://member.ucare.org). Members can also order their kit over the phone, or they can call UCare Customer Service at the number on the back of their member ID card.

Kit information can also be found on the [Adult Dental Kit](#) page.

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## *UCare Mobile Dental Clinic*

The UCare Mobile Dental Clinic (MDC) 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 MDC partner.

The clinic is a special-designed, wheelchair-accessible, 43-foot dentist 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 MDC. For appointments, call 1-866-451-1555 toll-free Monday through Friday 8 am-4:30 pm.

For a complete schedule of the MDC, visit our [Mobile Dental Clinic](#) page.

## **LivingWell Kids Kit**

Available to Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members age 17 or younger. UCare offers fitness and wellness Kids Kits to help kids feel well and be well. Each kit includes engaging tools to help improve health and wellness, at no cost.

Members may choose one of the following kit options:

- Kit 1: Fitness Fun Kit
- Kit 2: Youth De-stress Kit
- Kit 3: Child Dental Kit
- Kit 4: Teen/Tween Dental Kit

For more information or to order a kit, members can log in or create an account at [member.ucare.org](https://member.ucare.org). Members can also order their kit over the phone, or they can call UCare Customer Service at the number on the back of their member ID card

Kit information can also be found on the [LivingWell Kid Kit page](#).

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## Management of Maternity Services (MOMS) Program

UCare wants members to have a great pregnancy and a healthy baby. Our MOMS Program gives members important information to help them stay healthy during and after pregnancy. Eligible members can earn a \$75 reward when they have early prenatal and timely postpartum visits. Members may call 612-676-3326 or 1-855-260-9708 toll-free to receive pregnancy education through the Pregnancy Advisor Nurse Line or our telephonic case management program. Once the baby is born, breastfeeding members are eligible for lactation services. Members 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. Members can call Customer Service at the number listed on the back of their member ID card for additional information.

UCare offers a special tobacco and nicotine quit line program with special-trained coaches and additional outbound calls from a quit coach throughout the pregnancy into postpartum. This service is available for members who are planning a pregnancy, who are currently pregnant or are postpartum. Pregnant smokers who complete an assessment with UCare's Tobacco and Nicotine Quit Line during their pregnancy, or within one year after delivery, are also eligible for a \$25 reward.

## 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 for members to get ready for parenthood. UCare members in Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect and UCare Connect + Medicare can take these classes, and breast-feeding classes, at no charge. No referral from a provider is needed. Classes are offered through clinics, hospitals and other health agencies. To find out more about classes, members should ask their OB provider or call UCare Customer Service.

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

## Rewards and Incentives

UCare offers member incentives for a variety of preventive health services. Members should call UCare Customer Service to see if they are eligible. Additional information about 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 eligible UCare members who are pregnant or have children under age 8 through [UCare's SEATS Program](#). To be eligible, the person must be a UCare member in Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect, UCare Connect + Medicare, UCare Individual & Family Plans or UCare Individual & Family Plans with M Health Fairview. Members can call UCare Customer Service at the number on the back of their member ID card to get the name and phone number of a partnering agency in their area. Members are required to attend an education session to learn proper installation and use before receiving car seats. There is typically a two to three week waiting period, and limits apply.

## Quit Smoking and Vaping Program

UCare members can get help at no charge to quit through the tobacco and nicotine quit line. UCare members may access the UCare Tobacco and Nicotine Quit Line by calling 1-855-260-9713 toll-free or TTY users dialing 711 toll-free, visiting <https://myquitforlife.com/ucare>, or downloading the Rally Coach Quit for Life mobile app on their smartphone. Coaches at the quit line help members learn to live without tobacco or nicotine. The coaches 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
- Medication options to help fight cravings

UCare offers a special tobacco and nicotine quit line program with special-trained coaches and additional outbound calls from a quit coach throughout the pregnancy into postpartum. This service is available for members who are planning a pregnancy, who are currently pregnant or are postpartum.

## Strong & Stable Kit

Available to UCare's Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), UCare Medicare (excluding UCare Your Choice Plans), UCare Advocate Choice (HMO-I-SNP), UCare Advocate Plus (HMO-I-SNP) and UCare Medicare with M Health Fairview & North Memorial Health members. The Strong & Stable Kit provides tools to help members stay strong and prevent falls.

The member's care coordinator or case manager will order the kit for the member when requested. Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card.

The Strong & Stable - Falls Prevention Kit has:

- Resistance band strength kit
- Tip sheets with helpful falls prevention advice
- 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

Kit information can also be found on the [Strong & Stable Kit page](#).

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## Medication Toolkit

Available to Minnesota Senior Health Options (MSHO), UCare Connect + Medicare, UCare Medicare (excluding UCare Advocate Plans and UCare Your Choice Plans members).

For more information, or to order a kit, members can contact their care coordinator or log in or create an account at [member.ucare.org](https://member.ucare.org). Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card.

The Medication Toolkit has:

- Pillbox alarm
- Pill splitter
- Pillbox (two)
- Medicine tracker with marker
- Medication record pad
- Medication bag carrier
- Deterra Drug Deactivation System pouch order form

Kit information can be found on the [Medication Toolkit page](#).

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## Memory Support Kit

Available to UCare's Minnesota Senior Health Options (MSHO) members. Tools and activities to help members living with memory loss.

Members should contact their care coordinator or case manager to see if this tool would be useful for them. Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card.

Members may choose between two kit options that include tools to help members deal with memory loss, Dementia or Alzheimer's.

Kit information can also be found on the [Memory Support Kit page](#).

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## Mask & Sanitizer Kit

Available to UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members. Members can call Customer Service at the number on the back of their member ID card, to request a kit.

The Mask and Sanitizer Kit has:

- Sanitizing wipes
- Two reusable face masks
- A bottle of hand sanitizer
- A box of disposable gloves

For more information, or to order a kit, members can log on or create an account at [member.ucare.org](https://member.ucare.org). Members can also order their kit over the phone, they can call UCare Customer Service at the number on the back of their member ID card.

Kit information can also be found on the [Mask & Sanitizer Kit page](#).

**Note:** Must be an eligible UCare member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4-6 weeks for delivery.

## WW (Formerly WeightWatchers Program) Local Workshop Vouchers

Available to UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members.

This benefit includes:

- Access to 13 consecutive weeks of WW workshops
- 14 consecutive weeks of access to WW digital tools
- No meeting registration fee required

For more information, or to order a kit, members can contact their care coordinator or log on or create an account at [member.ucare.org](https://member.ucare.org). Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card.

**Note:** Must be an eligible UCare member at the time of the order. Limit one per year per member. Please allow 4-6 weeks for delivery.

## Activity Tracker Plus Personal Emergency Response System (PERS) Device

Available to UCare's Minnesota Senior Health Options (MSHO) members. Members should contact their care coordinator to learn more and see if they are eligible. Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card.

This is an easy-to-use smartwatch activity tracker plus PERS device. This device features:

- 24/7 emergency call-for-help to a support agent directly through the watch
- Step and heart rate tracking to help members reach their health goals
- Works inside and outside of the home with built-in GPS

The smartwatch is ready-to-use out of the box. Set up is not required. Pairing to a cell phone or Wi-Fi is not needed.

Members with hypertension who use the activity tracker plus personal emergency response system (PERS) device smartwatch are eligible for one blood pressure monitor per two years.

## **Evidence-based Health Management and Wellness Classes**

UCare's Minnesota Senior Health Options (MSHO) members can access Juniper®, an evidence-based health management and wellness classes program, at no cost. Juniper provides a statewide network of community-based providers who help members manage chronic health conditions, prevent falls and foster well-being. Group classes are available at a broad network of participating facilities including customized living facilities, community centers, senior centers, churches and fitness centers. Juniper® classes are designed for older adults and are led by certified instructors/coaches. These classes provide education, skills and strategies to prevent falls and promote self-management of chronic conditions including diabetes and chronic pain.

Members should contact their care coordinator to learn more. Members who are unsure of how to contact their care coordinator or care manager should call Customer Service at the number listed on the back of their member ID card. To refer a UCare's MSHO member or to learn more, visit <https://yourjuniper.org/>.

## **UCare Transportation Card Program**

Eligible UCare Advocate Choice (HMO-I-SNP) and UCare Advocate Plus (HMO-I-SNP) members will receive the UCare Rewards Benefit Mastercard for use on allowed transportation services. Members can use this card for up to 16, one-way trips from eligible providers to covered services. Round-trip rides should be paid as two, one-way trips.

Members should call Customer Service at the number listed on the back of their member ID card to learn about what transportation services the card can be used for and the number of one-way rides still available on the card.

## **Garmin Discount**

UCare partners with Garmin to offer members a 20% discount on select Garmin wearable products, like fitness trackers and running watches.

Members should access the member portal to browse or purchase Garmin wearable products. The discount is only available online.

The discount is available on up to two Garmin wearable and two Garmin accessories (like a watch or strap) per calendar year.



## Healthy Savings Program

Available to UCare Medicare Plans, UCare Medicare Group Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview, UCare Connect, UCare Connect + Medicare, Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare's Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) members.

Members who join Healthy Savings® sponsored by UCare, can save up to \$50 a week on pre-qualified healthy food including milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more. Savings and weekly specials are pre-loaded into the Healthy Savings account. Additional savings can be added from the save more section on the Healthy Savings mobile app or website. To receive the savings, members simply scan the Healthy Savings card or mobile app when paying at participating location.

More information is available at [www.HealthySavings.com/UCare](http://www.HealthySavings.com/UCare).

Healthy Savings is a registered trademark of Solutran, Inc.

## Healthy Savings Food Allowance

Available to UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members with a qualifying chronic condition. Eligible MSHO members with congestive heart failure (CHF), ischemic heart failure, diabetes or hypertension receive a \$60 monthly allowance on their Healthy Savings card. Connect + Medicare members with diabetes, hypertension or lipid disorders receive a \$30 monthly allowance on their Healthy Savings card. The allowance can be used toward the purchase of approved healthy and nutritious food and produce. Approved items such as fruits, vegetables, healthy grains, dairy, beans and more can be purchased at participating retailers such as Cub, Hy-Vee and Walmart simply by scanning the card at checkout.

This benefit becomes effective the first day of each month and cannot roll over into the next month. Money that is unused by the end of the month will expire.

Eligible members will receive a welcome letter including the card used to access the benefit. Additional benefit details are available on [HealthySavings.com/UCare](http://HealthySavings.com/UCare) or by calling 1-855-570-4740 toll-free, TTY 711 toll-free.

Healthy Savings is a registered trademark of Solutran, Inc.

## Over-the-Counter (OTC) Benefit Through Healthy Savings

Available to UCare Medicare Plans, UCare Advocate Choice Plans (HMO-I-SNP), UCare Your Choice Plans, UCare Medicare Group Plans, EssentiaCare and UCare Medicare with M Health Fairview & North Memorial Health members.

Eligible members receive the over-the-counter (OTC) benefit through Healthy Savings. The OTC benefit is an allowance to purchase eligible health items at participating retailers. Members receive a semi-annual allowance to purchase items like cough drops, first aid supplies, pain relief, sinus medications, toothpaste and much more. More information is available at [www.HealthySavings.com/UCare](http://www.HealthySavings.com/UCare).

Members can use their Healthy Savings food discount and OTC benefit at participating stores, including:

- Walmart (OTC only)
- Cub
- Coborn's
- Hornbachers
- Hy-Vee
- Lunds & Byerlys

Healthy Savings is a registered trademark of Solutran, Inc.

## UCare Member Perks

UCare offers additional perks to its members like discounts on food and groceries, as well as hearing and navigation services. Please refer to the [UCare Member Perks](#) page on [ucare.org/healthwellness](https://ucare.org/healthwellness) for a current listing.

# Mental Health and Substance Use Disorder Services

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This chapter provides information regarding mental health and substance use disorder services provided to UCare members.

## Manage Your Provider File

Mental health and substance use disorder providers must be set up in the UCare system for electronic claim submission. Learn more about updating your information on the [Manage Your Information](#) webpage.

Mental health and substance use disorder providers not currently in the UCare network can submit a Facility Location Add form (found within the How to Submit Claims for Payment drop-down on the [Non-Contracted Provider Resources webpage](#)) to enroll in UCare's payment system. These providers can also submit a request to join the UCare network.

Please visit the [Our Network](#) page of the provider website for information on credentialing, how to manage your organization's information and how to request to join the UCare network.

## *Mental Health and Substance Use Disorder Services*

The following are some of the mental health and substance use disorder services available to UCare members. This list is intended to serve as a resource for providers; coverage and benefits vary 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.

See the [Authorization and Notification Standards section](#) of the provider manual to review authorization requirements for mental health and substance use disorder services.

UCare has several mental health and substance use disorder payment policies that may help answer your payment and billing questions. The most current UCare payment policies can be found [here](#).

## *Mental Health*

The list below is a partial summary of mental health services frequently provided to UCare members.

### **Adult Rehabilitative Mental Health Services (ARMHS)**

- ARMHS are a set of services that were developed to bring restorative, recovery-oriented interventions directly to individuals who have the capacity to benefit from them, whether in their homes or elsewhere in the community.
- See the [Mental Health & Substance Use Disorder Services Authorizations page](#) of the provider website for additional information relating to notification and concurrent review requirements for ARMHS.

### **Behavioral Health Homes (BHH)**

- To be eligible for behavioral health home services, a member must be eligible for Medical Assistance (MA) and have a condition that meets the definition of serious mental illness as defined in Minnesota Statute.
- BHH providers are required to inform UCare within 30 days of a member starting BHH services. The Determination of Eligibility for BHH services (DHS-4797-ENG) form can be faxed to UCare's Mental Health and Substance Use Disorder Services Intake Team at 612-884-2033 or 1-855-260-9710 toll-free.

## **Day Treatment (Adult and Children)**

- Day treatment programs provide more intensive mental health services to patients whose needs are unmet in routine outpatient treatment/therapies.

## **Diagnostic Assessment, Psychotherapy, Psychological and Neurological Testing**

- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

## **Early Intensive Developmental and Behavioral Intervention (EIDBI)**

- Under age 21 and has autism spectrum disorder or a related condition.
- A Comprehensive Multi-Disciplinary Evaluation (CMDE) is required to determine eligibility and medical need for EIDBI services.
- The member's CMDE is used to develop and monitor an Individual Treatment Plan (ITP). The ITP specifies the type and amount of medically necessary services the member will receive.

## **Transition and/or Discharge from an EIDBI Agency**

- The Qualified Supervising Professional (QSP) may download and complete the [EIDBI transition and/or discharge summary \(DHS-7109A\)](#) when a transition or discharge occurs. This form is optional but recommended to complete when a discharge or transition occurs. Please email ([MHSUDservices@ucare.org](mailto:MHSUDservices@ucare.org)) or fax (612-884-2033 or 855-260-9710) the form to UCare.

## **Intensive Outpatient Dialectical Behavioral Therapy (IOP DBT)**

- Includes group and individual IOP DBT.

## **Partial Hospitalization Program**

- A minimum of 20 hours per week required.
- A minimum of four to five hours of services per day for a child under 18 years of age.
- A minimum of five to six hours of services per week for an adult age 18 and older.
- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

## ***Substance Use Disorder***

The list below is a partial summary of substance use disorder services frequently provided to UCare members.

## **Substance Use Disorder Treatment with Medication for Opioid Use Disorder (SUD-MOUD)**

- A comprehensive assessment or summary is required to evaluate substance use, individual risk, create an appropriate treatment plan and/or access to SUD-MOUD services.
- Medicare practitioner and place of service rules must be followed for use of Medicare benefits.

## **Outpatient Substance Use Disorder Treatment**

- Medicare practitioner and place of service rules must be followed for use of Medicare benefits. A Medicare accepted assessment must be used.
- For State Public Programs and Individual and Family Plans products, a comprehensive assessment and summary is required.

## **Peer Recovery Support and Treatment Coordination Services**

- A comprehensive assessment or summary is required.

## **Substance Use Disorder Assessments (Comprehensive Assessment)**

- Must be a qualified assessor as defined in Minnesota Statute ([Minnesota Statutes 245G.11 subd. 1 & 4](#)) or, licensed and identified as an eligible vendor for providing comprehensive assessment and assessment summary as defined in Minnesota Statute ([Minnesota Statutes 245B.05. subd.1](#)).
- UCare must receive a copy of the comprehensive assessment or placement summary.

## **Withdrawal Management**

- Withdrawal management programs may provide one or both levels of withdrawal management care. There are two levels of care:
  - Clinical management
  - Medically monitored

## **1115 Waiver Substance Use Disorder (SUD) Demonstration**

- Enrolled 1115 demonstration providers of residential and outpatient SUD services are eligible for a rate enhancement. Effective Jan. 1, 2022, the rate enhancement for treatment services provided to Medicaid members is 25% over the Fee-for-Service (FFS) per diem base rate for residential SUD providers and a 20% rate enhancement over the FFS base rate for outpatient SUD services. A 5% increase over current payment rates is also available for programs that (as defined by Minnesota legislature):
  - Serve parents with their children as defined in section 254B.05, subdivision 5, paragraph c, clause (1).
  - Are culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a.
  - Are disability responsive programs as defined in section 254B.01, subdivision 4b.
- Additional documentation is required for a 1115 enrolled provider to receive the enhanced reimbursement rate for outpatient and residential SUD services. The required documentation is listed

on the 1115 Waiver Concurrent Review Substance Use Disorder Residential forms found in the UCare Authorization & Notification Forms accordion on the [Mental Health & Substance Use Disorder Services Authorizations page](#). Please note, there is a form that should be used by 1115 enrolled providers for residential concurrent reviews.

## Institutions for Mental Disease (IMD)

An Institute for Mental Disease (IMD) is a hospital, nursing facility or other institution of 17 beds or more that primarily provides diagnosis and treatment for people with mental illness or substance use disorder.

For members who are enrolled in Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect (SNBC), UCare Connect + Medicare, UCare's Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+), providers must notify UCare when a member is admitted to an IMD facility, as previously defined, and again when the member is discharged. Providers must bill UCare for treatment using the DHS-designed provider identification number (NPI/UMPI) associated with their IMD status.

## Residential Treatment for Mental Health and Substance Use Disorders

Residential treatment services may be covered by UCare; DHS-approved rates may be used to determine payment. Coverage of room and board may vary between UCare plans and require approval by the county of residence or DHS.

Residential services include:

- Children's Mental Health Residential Treatment
- Crisis Residential Treatment
- Intensive Treatment in Foster Care (ITFC)
- Intensive Residential Treatment Services (IRTS)
- Psychiatric Residential Treatment Facilities (PRTF)
- Residential Treatment for Eating Disorders
- Substance Use Disorder Residential Treatment (*Placement summary or comprehensive assessment required to determine appropriate level of care*).

Annual DHS approved per diem rate letters should be submitted to email: [rateletters@ucare.org](mailto:rateletters@ucare.org). Include NPI or TIN when submitting letters. Allow 30 days for rates to be loaded in our system.

## Inpatient Hospital Mental Health and Substance Use Disorder (Admissions)

See the [Hospital Services section](#) of the provider manual and the [Authorizations](#) page of the provider website for additional information related to mental health and substance use disorder inpatient hospital (acute settings).

# UCare Mental Health and Substance Use Disorder Case Management

The goal of mental health and substance use disorder case management is to provide member-centric advocacy and access to appropriate care for mental health, substance use and/or social risk factors across the life span.

For a member to qualify for mental health and substance use disorder case management, the member must have a mental health condition or substance use disorder and a need for more support is identified.

## Child and Adolescent Case Management (CACM)

The goal of CACM is to provide children diagnosed with Autism Spectrum Disorder (ASD) or related conditions additional support from UCare's team of Case Managers who specialize in working with children. The case managers assist the children and their families with education and connection to appropriate resources, which include connection with resources or providers who can care for the child, support for social needs such as housing and food insecurity, and family/care giver support.

UCare's CACM Case Managers will assess for:

- Social determinants of health
- Care team
- Services in place
- Safety
- Preventative care

Through this assessment we will identify gaps in care and make the appropriate referrals to supports. The CACM program is a long-term program providing support for the child and family as long as our support is needed.

To refer a member to mental health and substance use disorder (MHSUD) case management or Child and Adolescent Case Management (CACM), please complete the MHSUD case management referral form within the Care/Case Management Referral Forms accordion on the [MHSUD Authorizations page](#). If the member does not meet criteria for these services, there is an option to consult with a MHSUD Case Manager to discuss the member's care needs via UCare's MHSUD Triage phone line at 612-676-6533 or 1-833-276-1185 toll-free.

## Mental Health Targeted Case Management (MH-TCM)

UCare does not require a referral, notification, or prior authorization for 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 Mental Health and Substance Use Disorder Triage phone line for assistance at 612-676-6533 or 1-833-276-1185 toll-free.

### *Providers Rendering MH-TCM Services*

- Non-county MH-TCM providers are required to be contracted with the Minnesota county where services are provided to render services to UCare members.
- 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. Provider's 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 have county delegation contracts and 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, Minnesota Administrative Rules, American Society of Addiction Medicine (ASAM) Criteria and Change Healthcare InterQual Behavioral Health Level of Care. 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 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](#)
  - InterQual Behavioral Health Level of Care - request a copy via the [UCare Medical Necessity Criteria Request Form](#)

## **Authorization/Notification Requirements**



Annually, or more frequently, if necessary, 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 utilization of the service, and legal and regulatory changes.

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 on the [Authorization](#) page of the UCare provider website. You will also be able to access authorization and notification forms in this section. Mental health and substance use disorder 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 UCare's 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.

## *Mental Health and Substance Use Disorder Authorization Documentation Requirements*

A list of clinical records UCare Mental Health and Substance Use Disorder Services requires for prior authorization and/or concurrent review is listed on the [MHSUD Authorization](#) page of the UCare website. Within the Authorization & Notification Forms accordion on the authorization page, you'll find the needed forms with instructions. The documents listed assist the MHSUD Utilization Management Specialist in determining medical necessity for the level of care or service requested. Providing the requested documentation in a timely manner may reduce the possibility of an adverse determination. When sending documentation, please send the most recent assessments dated within the last 12 months, unless a different timeline is specified.

**Note:** progress notes are required for concurrent review of services or continued stay in the current level of care.

## *Mental Health and Substance Use Disorder Services Claims Denial*

If your claim has been denied for medical records, use the Provider Claim Reconsideration Form found on the [Claims & Billing](#) webpage under Forms & Links.

Directions for submitting an electronic claim attachment can be found in the [Electronic Data Interchange section](#) of the UCare Provider Manual.

## **Peer-to-Peer Review**

If coverage guidelines or medical necessity has not been established for the level of care or service requested, UCare's Mental Health and Substance Use Disorder Utilization Management Specialists will consult with our Mental Health and Substance Use Disorder Medical Director. UCare's Mental Health and Substance Use Disorder Medical Director will review the case and render a determination. If the Mental Health and Substance Use Disorder Medical Director's decision results in an adverse determination, the ordering or treating provider can discuss the plan of care and clinical basis for the

level of care or service requested in a peer-to-peer review with the Mental Health and Substance Use Disorder Medical Director. If an adverse determination has already been given, the member or member's representative maintains their right to file an appeal. Please contact UCare's Mental Health and Substance Use Disorder Services Department at 612-676-6533 or 1-833-276-1185 toll-free to request a peer-to-peer review.

# Child and Teen Checkups

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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 age 21 are eligible to receive this service from their primary care clinic. If you have questions regarding C&TC, please call the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free.

You can also contact the MHCP Provider Resource Center at 651-431-2700, 1-800-366-5411 toll-free or via email at [dhs.childteencheckups@state.mn.us](mailto:dhs.childteencheckups@state.mn.us).

## Determining In-Person vs. Telemedicine for C&TC

### *In-person*

Providers can deliver comprehensive preventive care by pairing virtual care with an in-person appointment when necessary. This allows clinics and providers to optimally bill for the care they provide.

Care that is difficult to perform virtually and typically requires an in-person visit includes:

- Physical exam
- Labs: lead, hemoglobin, HIV
- Oral health and fluoride varnish application (FVA)
- Immunizations
- Pure tone audiometry and vision charts

### *Telemedicine*

Providers may find the following components are easily provided in a virtual visit:

- History
- Risk assessments
- Screening questionnaires
- Developmental
- Social-emotional
- Mental health
- Substance use

## Every Visit Is an Opportunity

Every visit a child makes to a clinic offers the opportunity to complete a C&TC screening. Here are a few examples:

- Camp physicals
- Sports physicals
- Head start physicals

- Acute-only or sick visits
- Chronic conditions (e.g., repeat asthma visits)

Medical record documentation must show that the visit took place with a primary care physician or OB/GYN, which must include documentation of the date when the visit occurred and evidence of all the following:

- Patient health history
- A physical exam
- A physical developmental history
- A mental developmental history
- Health education or anticipatory guidance

## Well Child Care Coding for Quality Measurement and Payment

- Billing for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) should always include one of the following codes to ensure visits are able to count toward national and state quality benchmarks.

|               |   |
|---------------|---|
| <b>CPT</b>    | 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461           |
| <b>HCPCS</b>  | G0438, G0439  |
| <b>ICD 10</b> | Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2 |

## Two-Character Referral Code

When billing for a C&TC screening, providers 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 or clinic to conduct additional follow up with the patient regarding these referrals to ensure they receive the services they need. If this code is not included, the claim will deny. You must use one of the following two-character referral codes to append to the C&TC procedure code:

| <b>HIPAA Compliant Referral Condition Code</b>              | <b>Use this referral condition code for billing when a C&amp;TC screening results in one of the following:</b>  |
|---|---|
| <b>NU</b><br>(no referral - not used)                       | <ul style="list-style-type: none"> <li>• No referral(s) given (“NU”).</li> <li>• If only a verbal dental referral was made for preventive dental health care.</li> </ul>  |
| <b>ST</b><br>(new diagnosis or treatment service requested) | <ul style="list-style-type: none"> <li>• One or more referrals were made (“ST”).</li> <li>• 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).</li> <li>• Patient is scheduled for another appointment with the screening provider for diagnostic or corrective</li> </ul> |

| HIPAA Compliant Referral Condition Code                                   | Use this referral condition code for billing when a C&TC screening results in one of the following:   |
|---|---|
|   | treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).        |
| <b>AV - declined referral</b><br>(referral recommended, but was declined) | <ul style="list-style-type: none"> <li>One or more referrals were made and the patient declined one or more of the referrals (AV).</li> </ul> |
| <b>S2</b><br>(continue current services or treatment)                     | <ul style="list-style-type: none"> <li>The patient is currently under treatment for a diagnostic or corrective health problem(s).</li> </ul>  |

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 medical record when the attempt was made. Please review the section of the [MHCP Provider Manual](#) for correct billing for C&TC. Refer also to the [HIPAA Compliant C&TC Referral Code Fact Sheet](#) for more information.

### *HCPCS Code S0302*

- Code S0302 should **only** be submitted when a **complete** C&TC is performed for a MHCP subscriber (Prepaid Medical Assistance Program, MinnesotaCare, UCare Connect or UCare Connect + Medicare). The components that make up a complete C&TC visit are determined by Minnesota Department of Human Services and are published in their [C&TC Schedule of Age-Related Screening Standards](#).
- If HCPCS code S0302 is submitted on a claim for any subscriber other than a MHCP subscriber, it will deny as provider liability.

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.

## **Billing for C&TC When Using Telemedicine**

- Billing procedures for a complete C&TC remain the same for telemedicine and in-person office visits.
- Refer to the [Minnesota Health Care Programs \(MHCP\) Provider Manual](#) C&TC Section and COVID-19 Section for further information, including questions regarding telemedicine services related to C&TC visits.
- C&TC components completed via telemedicine should be billed accordingly:
  - The time between scheduled telemedicine and in-person visits should be minimal. Providers could get the bundled payment this way (if all required components are complete) along with the other billing requirements.
  - To bill for telemedicine visits, providers should follow the MHCP Provider Manual exceptions.
  - Combining telemedicine and in-person visits to make a complete C&TC is possible.

- For specific questions, contact the MHCP Provider Resource Center at 651-431-2700, 1-800-366-5411 toll-free or via email at [dhs.childteencheckups@state.mn.us](mailto:dhs.childteencheckups@state.mn.us).

## Lead

Children should have two tests for lead poisoning - the first at age one and the second at age two. Children are eligible between their nine and 24-month birth dates for the lead test, and up to age six 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 Child & Teen Checkups Fact Sheets](#): includes fact sheets on many required C&TC components, including Anticipatory Guidance, HIV screening, Maternal Depression Screening, Oral Health and Fluoride Varnish.

Minnesota Department of Health information on [C&TC](#).

Minnesota Department of Health information on [immunizations](#), including data on pediatric immunization gaps due to the COVID-19 pandemic.

## UCare C&TC Clinic Tools

[C&TC information for providers](#)

[UCare Member C&TC Schedule](#)

[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.

# Comprehensive Outpatient Rehabilitation Facility Services

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## Notifying UCare Members of Medicare Coverage Termination

The Centers for Medicare and Medicaid Services (CMS) requires that comprehensive outpatient rehabilitation facilities (CORFs) provide 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 and Discharge Notices | UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plan and EssentiaCare

### *Notice of Medicare Non-coverage (NOMNC)*

- Issued by CORF staff when ongoing services will be terminated.
- Must be given two days prior to discharge or service termination.

### *Notice of Denial of Medical Coverage or Payment (NDMCP)*

- Issued by UCare or delegates when CORF services **are denied at, or prior to, the start of services.**

### *Detailed Explanation of Non-coverage (DENC)*

- Issued by CORF staff when the member disagrees with service termination and wants a fast appeal using the Quality Improvement Organization (QIO).

## Denial and Discharge Notices | UCare's Minnesota Senior Health Options and UCare Connect + Medicare

### *Notice of Medicare Non-coverage (NOMNC)*

- Issued by CORF staff when ongoing services will be terminated.
- Must be given two days prior to discharge or service termination.

## *Integrated Plan Coverage Decision Letter - CMS 10176*

- Issued by UCare or delegates when CORF services **are denied at, or prior to, the start of services.**

### *Detailed Explanation of Non-coverage (DENC)*

- Issued by CORF staff when the member disagrees 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 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.

- The provider of the service is responsible for delivering the NOMNC to the member no later than two days before the end of the coverage. Even if a provider disagrees 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.
- 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.
- The representative must receive all required notifications if a member has an appointed authorized representative.
- 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 on UCare's NOMNC Valid Delivery Documentation Form, available in the member's medical record or on UCare's Provider Forms page within the Denials accordion.
- If the member decides to appeal the end of coverage, they must contact the QIO no later than noon 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. This form can be found on [UCare's Denial Notice Forms page](#).
  - By the end of the business day, the QIO must decide when the coverage is to end. The provider and UCare must cooperate with the QIO to provide 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 - Helpline 888-524-9900 and TTY 888-985-8775.

- Protected Health Information provided to the QIO must be handled in accordance with Health Insurance Portability and Accountability (HIPAA).
- Providers must issue 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.
- The provider must use the most current version of the denial notice from [UCare's website](#) each time rather than saving and reusing the previous version. Notices cannot be altered, and a CORF cannot create its notice.
- The provider must send UCare a copy of the NOMNC, DENC and documentation supporting valid delivery of the denial notices to a member or a member's authorized representative.

## **Denial Forms | UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plans, EssentiaCare, UCare's Minnesota Senior Health Options and UCare Connect + Medicare Plans**

Denial forms for UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health and EssentiaCare are located on the [Denial Notice Forms page](#) on the UCare website.

# 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 will have partial, full or no “carve out” services for payment by managed care plans. The FQHC-RHC Payment Carve-Out process impacts medical (837P), dental (837D) and pharmacy claims.

The below charts show the type of service, program and provider type.

## Professional Services Billed by FQHCs:

| Carve-out Type   | Claim Path        | Notes   |
|--|-------------------|---|
| Full Carve-out <ul style="list-style-type: none"><li>Prepaid Medical Assistance Program (PMAP)</li><li>Minnesota Senior Care Plus (MSC+) Non-duals</li><li>UCare Connect Non-duals</li></ul>                     | Provider to DHS   | <ul style="list-style-type: none"><li>Provider bills DHS directly.</li><li>DHS determines and pays provider encounter rate.</li><li><b>Note:</b> if provider sends claim to UCare, then the claim will be denied with instructions to “bill other payer.”</li></ul> |
| No Carve-out <ul style="list-style-type: none"><li>MinnesotaCare</li><li>MSC+ Duals</li><li>UCare Connect (SNBC) Duals</li><li>Minnesota Senior Health Options (MSHO)</li><li>UCare Connect + Medicare</li></ul> | Provider to UCare | <ul style="list-style-type: none"><li>Provider bills UCare directly.</li><li>UCare determines and pays the provider reimbursement according to the UCare provider contract.</li></ul>   |

## Dental Services Billed by FQHCs:

**Note:** Delta Dental of Minnesota is UCare’s dental administrator for all dental claims.

| Carve-out Type  | Claim Path                            | Notes   |
|---|---------------------------------------|---|
| Full Carve-out <ul style="list-style-type: none"> <li>• PMAP</li> <li>• MSC+ Non-duals</li> <li>• MSC+ Duals</li> <li>• UCare Connect Non-duals</li> <li>• UCare Connect Duals</li> <li>• UCare Connect + Medicare</li> <li>• MSHO</li> </ul> | Provider to DHS                       | <ul style="list-style-type: none"> <li>• Provider bills DHS directly.</li> <li>• DHS determines and pays the provider encounter rate.</li> <li>• <b>Note:</b> if provider sends claim to UCare or Delta Dental of Minnesota, the claim will be denied with instructions to “bill other payer.”</li> </ul>   |
| No Carve-out <ul style="list-style-type: none"> <li>• MinnesotaCare</li> </ul>  | Provider to Delta Dental of Minnesota | <ul style="list-style-type: none"> <li>• Provider bills Delta Dental of Minnesota directly.</li> <li>• Delta Dental of Minnesota determines and pays the provider reimbursement according to the Delta Dental of Minnesota contract.</li> <li>• <b>Note:</b> if provider sends claim to UCare, the claim will be denied with instructions to “bill other payer.”</li> </ul> |

## Medicaid-covered Pharmacy Services Billed by FQHCs:

**Note:** there are three FQHCs that have pharmacies

| Carve-out Type  | Claim Path      | Notes   |
|---|-----------------|---|
| Full Carve-out <ul style="list-style-type: none"> <li>• PMAP</li> <li>• MSC+ Non-duals</li> <li>• UCare Connect Non-duals</li> </ul> For Medicaid-covered drugs <ul style="list-style-type: none"> <li>• MSC+ Duals</li> <li>• UCare Connect Duals</li> <li>• MSHO</li> <li>• UCare Connect + Medicare</li> </ul> | Provider to DHS | <ul style="list-style-type: none"> <li>• Provider bills DHS directly.</li> <li>• DHS determines and pays provider encounter rate.</li> <li>• <b>Note:</b> if provider sends claim to UCare, then the claim will be denied with instructions to “bill other payer.”</li> </ul> |

| Carve-out Type   | Claim Path        | Notes  |
|--|-------------------|--|
| No Carve-out <ul style="list-style-type: none"> <li>MinnesotaCare</li> </ul> | Provider to UCare | <ul style="list-style-type: none"> <li>Provider bills UCare directly.</li> <li>UCare determines and pays the provider reimbursement according to the UCare provider contract.</li> </ul> |

## Medicaid-covered Chiropractic Services Billed by FQHCs:

**Note:** Fulcrum Health is UCare’s chiropractic administrator for all chiropractic claims.

| Carve-out Type  | Claim Path  | Notes  |
|---|---|--|
| Full Carve-out <ul style="list-style-type: none"> <li>PMAP</li> <li>MSC+ Non-duals</li> <li>UCare Connect Non-duals</li> </ul> For Medicaid-covered Service <ul style="list-style-type: none"> <li>MSC+ Duals</li> <li>UCare Connect Duals</li> <li>MSHO</li> <li>UCare Connect + Medicare</li> </ul> | Provider to Fulcrum Health<br><br>Fulcrum Health to DHS | <ul style="list-style-type: none"> <li>Provider bills Fulcrum Health directly.</li> <li>Fulcrum Health will send the claim to DHS for processing.</li> <li>DHS determines and pays the provider encounter rate.</li> <li><b>Note:</b> if provider sends claim to UCare, the claim will be denied with instructions to “bill other payer.”</li> </ul> |
| No Carve-out <ul style="list-style-type: none"> <li>MinnesotaCare</li> </ul>  | Provider to Fulcrum Health                              | <ul style="list-style-type: none"> <li>Provider bills Fulcrum Health directly.</li> <li>Fulcrum Health determines and pays the provider reimbursement according to the Fulcrum provider contract.</li> <li><b>Note:</b> if provider sends claim to UCare, the claim will be denied with instructions to “bill other payer.”</li> </ul>               |

## Professional Services Billed by RHCs:

| Carve-out Type   | Claim Path                        | Notes  |
|--|-----------------------------------|--|
| Partial Carve-out <ul style="list-style-type: none"> <li>• PMAP Non-duals</li> <li>• MSC+ Non-duals</li> <li>• UCare Connect (SNBC) Non-duals</li> </ul>   | Provider to UCare<br>UCare to DHS | <ul style="list-style-type: none"> <li>• Provider bills UCare directly.</li> <li>• In most cases, UCare “pays” \$0 and sends the claim to DHS for processing.</li> <li>• DHS determines and pays the provider encounter rate.</li> </ul> |
| No Carve-out <ul style="list-style-type: none"> <li>• PMAP Duals</li> <li>• MinnesotaCare</li> <li>• MSC+ Duals</li> <li>• UCare Connect (SNBC) Duals</li> <li>• MSHO</li> <li>• UCare Connect + Medicare</li> </ul> | Provider to UCare                 | <ul style="list-style-type: none"> <li>• Provider bills UCare directly.</li> <li>• UCare determines and pays the provider reimbursement according to the UCare provider contract.</li> </ul>   |

## Dental Services Billed by RHCs:

**Note:** Delta Dental of Minnesota is UCare’s dental administrator for all dental claims.

| Carve-out Type   | Claim Path  | Notes   |
|--|---|---|
| Partial Carve-out <ul style="list-style-type: none"> <li>• PMAP</li> <li>• MSC+ Non-duals</li> <li>• MSC+ Duals</li> <li>• UCare Connect Non-duals</li> <li>• UCare Connect Duals</li> <li>• UCare Connect + Medicare</li> <li>• MSHO</li> </ul> | Provider to Delta Dental of Minnesota<br><br>Delta Dental of Minnesota to DHS | <ul style="list-style-type: none"> <li>• Provider bills Delta Dental of Minnesota directly.</li> <li>• Delta Dental of Minnesota “pays” \$0 and sends the claim to DHS for processing.</li> <li>• DHS determines and pays the provider encounter rate.</li> <li>• <b>Note:</b> if provider sends claim to UCare, the claim will be denied with instructions to “bill other payer.”</li> </ul> |
| No Carve-out <ul style="list-style-type: none"> <li>• MinnesotaCare</li> </ul>   | Provider to Delta Dental of Minnesota   | <ul style="list-style-type: none"> <li>• Provider bills Delta Dental of Minnesota directly.</li> <li>• Delta Dental of Minnesota determines and pays the provider reimbursement according to the Delta Dental of Minnesota contract.</li> <li>• <b>Note:</b> if provider sends claim to UCare, the claim will be denied</li> </ul>  |

|  |  |  |
|--|--|--|
|  |  | with instructions to “bill other payer.” |
|--|--|--|

## Medicaid-covered Chiropractic Services Billed by RHCs:

**Note:** Fulcrum Health is UCare’s chiropractic administrator for chiropractic claims.

| Carve-out Type   | Claim Path  | Notes  |
|--|---|--|
| Partial Carve-out <ul style="list-style-type: none"> <li>• PMAP</li> <li>• MSC+ Non-duals</li> <li>• UCare Connect Non-duals</li> </ul> For Medicaid-covered Service <ul style="list-style-type: none"> <li>• MSC+ Duals</li> <li>• UCare Connect Duals</li> <li>• MSHO</li> <li>• UCare Connect + Medicare</li> </ul> | Provider to Fulcrum Health<br><br>Fulcrum Health to DHS | <ul style="list-style-type: none"> <li>• Provider bills Fulcrum Health directly.</li> <li>• Fulcrum Health will send the claim to DHS for processing.</li> <li>• DHS determines and pays the provider encounter rate.</li> <li>• <b>Note:</b> if provider sends claim to UCare, UCare will be denied with instructions to “bill other payer.”</li> </ul> |
| No Carve-out <ul style="list-style-type: none"> <li>• MinnesotaCare</li> </ul>   | Provider to Fulcrum Health                              | <ul style="list-style-type: none"> <li>• Provider bills Fulcrum Health directly.</li> <li>• Fulcrum Health determines and pays the provider reimbursement according to the Fulcrum provider contract.</li> <li>• <b>Note:</b> if provider sends claim to UCare, the claim will be denied with instructions to “bill other payer.”</li> </ul>             |

## 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.

| UCare ANSI Code Grid - RHC Payment Carve-out Process                   |  |   |
|--|--|---|
| Scenario   | CARC   | RARC  |
| UCare “paid” claims at \$0 and forwarded to DHS for encounter payment. | 256 - Service not payable per managed care contract.<br><br>24 - Charges are covered under a capitation agreement/managed care plan. | N193 - Specific federal/state/local program may cover this service through another payer. |

|  |   |   |
|--|---|---|
| UCare “paid” replacement claim at \$0 and forwarded to DHS for encounter payment.    | 256 - Service not payable per managed care contract.  | N193 - Specific federal/state/local program may cover this service through another payer. |
| UCare denied claim - DHS TCN missing so cannot forward replacement to DHS.           | 16 - Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.                                    | M47 - Missing/incomplete/invalid/internal or document control number.                     |
| Provider initiated void claim processed by UCare and forwarded to DHS to void claim. | B11 - The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. | N193 - Specific federal/state/local program may cover this service through another payer. |
| UCare initiated void - voided claim not forwarded to DHS.                            | 16 - Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.                                    | N463 - Missing support data for claim.  |
| Provider sends claim to UCare that should have been submitted to DHS.                | 109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.                    | N193 - Specific federal/state/local program may cover this service through another payer. |

If you have a question on a remittance advice (RA) or 835 received from UCare, call UCare’s Provider Assistance Center (PAC) at 612-676-3300 or 1-888-531-1493 toll-free. 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 or 835 received from DHS, call MHCP’s Provider Call Center at 651-431-2700 or 1-800-366-5411 toll-free.

## References

- [DHS Provider Manual - Federally Qualified Health Center and Rural Health Clinics](#)

# Home and Community Based Services – Waiver Services

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The purpose of home and community-based services (HCBS) or waiver services is to allow individuals who meet specific criteria to receive services in their own home or community rather than institutions. HCBS waiver services 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 not typically covered by Medicaid. There are services covered through HCBS waivers that are also covered under Medicaid, as they may exceed the amount, scope and duration of Medicaid state plan services, such as extended home health and extended skilled nursing services.

HCBS service providers must enroll with DHS, unless they are direct delivery or receipt service providers. However, direct delivery and receipt service providers are encouraged to enroll with DHS as well.

UCare contracts directly for some extended waiver services such as transportation, personal care assistants (PCA) and home health services. PCA, home health care or durable medical equipment (DME) provider lists are available through the provider search tool on [UCare's website](#).

Providers must only offer the waiver services 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 members who receive HCBS services must use providers who are enrolled with DHS for HCBS or waiver services. A complete list of enrolled providers is available on [DHS's MnHelp website](#). Provider lists are also available, access the [DHS licensing look-up website](#) or the [MHCP Provider Directory](#).

## 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 M Health Fairview & North Memorial Health, EssentiaCare and UCare Institutional Special Needs Plans
- UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview



**Note:** 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. Counties, tribal entities and health plans administer EW services. All Elderly Waiver services require an authorization from the UCare Care Coordinator before services can begin.

### *Elderly Waiver - HCBS Waiver Requests*

HCBS waiver requests should be directed to the member's care coordinator. These services may be requested by the member, a member's representative, the member's primary care physician or care coordinator. 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 for EW services is to:

- Conduct the requisite assessment to determine member eligibility.
- Develop a plan of care or support plan including the waiver service plan.
- Assist with accessing waiver services.
- Monitor the ongoing provision of waiver services.

The care coordinator must document the need for waiver services in the member's support 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.

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 UCare's MSHO and MSC+ members. UCare does not cover the following:

- Services or items purchased prior to the LTCC/MnCHOICES screening or eligibility start date.
- Services not approved by the care coordinator.
- Services provided or billed for when the member is no longer eligible for coverage.

- Essential Community Support (ECS) Services. The care coordinator assesses the need, then 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 must:
  - Inform and document the notification to the service provider of a termination or reduction of waiver services.
  - Submit the DTR form to UCare for processing and issuing of the member and provider DTR written notification.
- 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 or hospitalization of more than 30 calendar days, a DTR must be sent to the member and provider of services.

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. The only exceptions are 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 USA, and services are limited to direct care staff services determined necessary and authorized in the support plan.

Providers are expected to work with the assigned care coordinator for any waiver service.

Providers should contact UCare's Care Management Intake line at 612-676-6622 or 1-866-242-2497 toll-free for assistance in determining the care coordinator assigned to the member.

Members approved for HCBS waiver services receive service coordination from their assigned care coordinator. The care coordinator 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 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 provides 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 may list the specified code and approved rate. Providers should visit the DHS website for coding and rate information.

Waiver transportation is a type of waiver service that may be offered in addition to medical transportation. Waiver transportation is intended to enable members to gain access to services, activities and resources as specified in the support 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.

## Coding Information for Waiver Service Providers

Coding examples for waiver providers include:

- John Doe attended adult day services all day on April 11
  - Submit claim using S5102 with one 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
  - Submit claim using S5130 with four 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 two 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 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 per visit.

Providing more services than authorized by the care coordinator may result in claim denial.

## Elderly Waiver Billing Information

All claims for Elderly Waiver (EW) services for eligible UCare's 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 attachment, 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 a 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 each provider with; in turn, the clearinghouse providers use should have that same information. If DHS identifies a provider with an UMPI, that is what the provider should give to UCare and the clearinghouse. If DHS identifies a provider with a NPI, the provider should enroll with UCare and the clearinghouse with that information. This is important to help in processing claims correctly.

Should any information about a provider's facility be changed with DHS, UCare should be advised of those same changes within 10 business days from the date of change.

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, providers should complete the Add a Facility or Location form found on the [Manage Your Information](#) page under the Add or Update a Personal Care Attendant, Elderly Waiver, Interpreter or Transportation Provider drop-down 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 for billing 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 the [MHCP Provider Manual](#). Select a chapter, such as home care services, HCBS waiver services or billing policy.

# Home Care Services

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The following information is 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 M Health Fairview & North Memorial Health, EssentiaCare and UCare Institutional Special Needs Plans (I-SNP)*

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.

*UCare's 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) and 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](#), through the Provider Assistance Center (PAC) at 612-676-3300 or 1-888-531-1493 toll-free or on 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 members 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 health therapies (occupational, physical, respiratory and speech languages therapies).
  - A face-to-face visit can occur through telehealth.
  - At the start of 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 (physician).
- Services 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.
- Home Health Provider is responsible for maintaining a 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 [Authorization page](#) to verify home care nursing requirements.

### *UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview*

Home Health Services are eligible and covered only when they are:

- Medically necessary
- Provided as rehabilitative care, terminal care or maternity care
- Ordered by a physician and included in the written home health care plan

Home Health Services are limited to 120 visits per year all visits combined (skilled nursing, home health aide, physical therapy, occupational therapy and speech language pathology).

### *Home Health Services | Transition of Provider*

If a home health 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 member transition to another home health provider. If the termination is a result of sanctions on the provider, the provider must give each member 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 services depends on the member's plan.

For UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health and 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).

For UCare's Minnesota Senior Health Options (MSHO) (Dual Special Needs Plan) and UCare Connect + Medicare:

- Members must meet Medicare coverage criteria and providers must bill Medicare rates.
- Providers must bill specific G-codes along with 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.

For Prepaid Medical Assistance (PMAP), Minnesota Senior Care Plus (MSC+), UCare Connect and MinnesotaCare (Minnesota Health Care Programs 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.

For UCare Individual & Family Plans:

- Home health services are covered when provided as medically necessary rehabilitative or habilitative care, terminal care or maternity care.
- UCare covers home health aide and nursing services when provided in the member's home if the member is homebound.
- These services must be ordered by a doctor and be part of a written care plan.
- Providers 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 and 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 the second visit will be denied as a duplicate claim.



## *Enrollee Rights and Provider Responsibilities*

UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, UCare's Minnesota Senior Health Options 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.

## **Home Infusion Services**

A qualified home infusion supplier must be accredited by a Centers for Medicare & Medicaid Services (CMS) approved accreditation organization prior to providing services under the Medicare Home Infusion Therapy benefit.

Contracted providers must notify UCare when accreditation is received. Email [providercontracts@ucare.org](mailto:providercontracts@ucare.org) to communicate this information to UCare. Include the name of your office, Tax Identification Number (TIN), NPI, name of accrediting organization, accreditation effective date and contact information.

## **Medicare Coverage Termination Regulations**

Home health agencies must provide an advance notice of Medicare coverage termination (NOMNC) to UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plans, EssentiaCare, UCare's Minnesota Senior Health Options 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.

Providers should download the customized denial forms from the [Denial Notice Forms](#) page each time it is needed 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.

If a member requests an expedited review, the QIO contacts UCare and the provider. The QIO decides 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 rendered. Providers should deliver the NOMNC as soon as the service termination date is known. Providers need not agree with the decision that covered services should end, but they are responsible under the 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 notice's contents, 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 decide. Providers must cooperate with the QIO's requests for assistance in gathering required information. The QIO decision should take place by the 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 Medicare Managed Care Enrollee Grievances, Organization Determinations, and Appeals Guidance 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.
- Have a passed status before providing services to UCare members. The agency must provide documentation upon UCare's request.
- Have professional liability coverage at all times. UCare requires a minimum of \$1 million per incident and \$3 million aggregate.
- Have general liability coverage at all times. UCare requires a minimum of \$1 million per incident and \$3 million aggregate.
- 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.
- Have fidelity bond coverage in the amount of \$20,000.
- Have proof of workers compensation insurance.

- Support UCare’s efforts in promoting self-care and independence for all UCare members.
- Be Medicare-certified to serve members who also need ongoing skilled nursing services. Physical therapy, occupational therapy, speech therapy, skilled nursing visits and home health aides must be provided by the Medicare-certified home health service provider.
- Be Medicare-certified to provide private duty nursing services.
- 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.
- Present its internal PCA written policies and procedures as stated under Minnesota Statute 256B.0659 to UCare upon our request.
- Not solicit UCare members or engage in case finding or misrepresentation of its relationship with UCare and/or its relationship with potential clients.
- Not use the UCare name or logo in any marketing efforts. This action by a PCA agency is strictly prohibited without prior approval from UCare.
- Ensure that all timecards are 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 timecard records as documentation of each encounter.
- Follow Minnesota Statute 256B.0659 requirements for initial enrollment of personal care assistance provider agencies.
- Not provide PCA services in homes owned or controlled by the provider of PCA services.
- Provide PCA supervision for all members receiving PCA services.
- Not work more than 310 hours per month. Provider agencies must coordinate weekly work schedules with other agencies that employ the individual to ensure the PCAs’ combined scheduled hours do not exceed this limit.
- 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.
- 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.
- Have a dedicated business phone number and fax number specific to their PCA provider agency. Voicemail greetings must include business information.
- Inform UCare immediately of any ownership changes to your agency, including co-owner information.
- Keep a copy of each UCare member’s service plan on file. It is a requirement.
- Be responsible for the development of 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. This will ensure a member does not exhaust PCA hours before the authorization expires.
- 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.
- Have a signed agreement between two clients who voluntarily choose shared care, as determined at the time of assessment.
- Request a PCA reassessment from UCare at least 60 days before the end of the service authorization.
- Follow all requirements listed under Minnesota Statute 256B.0659, at all times.

- Not require PCAs to sign an agreement not to work with any particular PCA recipient, or for another PCA provider agency, after leaving the agency. The provider agency 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:

- Meet the requirements of the 2009 legislation
- Basic first aid training
- Vulnerable adult or child maltreatment training
- Occupational Safety and Health Administration (OSHA) universal precautions training
- Basic roles and responsibilities of an individual PCA

Upon completion of the training components, the PCA must demonstrate the competency to aid recipients. A copy of the completion of the training must be provided at 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 program. Once a certificate of completion is provided to each required personnel member within the agency, the agency must submit copies to UCare upon request. Visit the DHS website to find more information about the [Steps for Success Training program](#).

Individual PCA providers must register for, and pass, a one-time [Individual Personal Care Assistant \(PCA\) 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 or 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 the Steps for Success Training 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 Provider Time and Activity Documentation Requirements*

PCA services for a member must be documented as outlined in Minnesota Statute 256B.0659 subdivision 12,28 (4), 24 (2)(3) (5) (7). The completed form must be submitted monthly to the provider and kept in the recipient's health record.

A PCA worker must document all time and activity provided to each person daily. Documentation:

- May be web-based, electronic or paper
- Must include all required components

Providers use the documents to bill UCare for authorized PCA services. UCare only pays for PCA time and activity authorized and described in the care plan.

Agencies may either:

- Use [PCA Time and Activity Documentation, DHS-4691 \(PDF\)](#)
- Develop their own documentation format

All PCA time and activity documentation must contain, at a minimum, the following:

- **Provider information:** Agency name and phone number.
- **Recipient information:** Name, Minnesota Health Care Programs identification (MHCP ID) number or date of birth, dates and location of the person's stays in hospital, care facility or incarceration.
- **PCA worker information:** Name, Unique Minnesota Provider Identifier (UMPI).
- **Dates of service:** Day, month and year of each service, in consecutive order.
- **Service information:** Arrival and departure times of each visit, including am and pm notations.
- **Shared services:** Staff-to-recipient ratio and location of visit.
- **All daily activities provided (same or similar categories):** Dressing, grooming, bathing, eating, transfers, mobility, positioning, toileting, health-related needs, behavior observation and redirection.
- **Instrumental activities of daily living (IADLs) (not allowed for people younger than age 18):** Light housekeeping, laundry, meal preparation and other.
- **Total time:** Daily total time and total for timesheet.
- **Fraud statement:** Time and activity documentation must include a fraud statement.
  - Directly above signatures, include the following language:
    - It is a federal crime to provide false information on PCA billing for Medical Assistance payment. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the PCA care plan.
- **Acknowledgement and signatures:** The person receiving services should draw a line through documented dates and times when they did not receive services. This is not required for web-based or electronic documentation.
- **Required signatures:** Person receiving services/responsible party and PCA worker.
  - **Date(s) of signatures:** Date(s) the form is signed by each party.

The PCA provider agency is responsible to make sure time and activity documentation is:

- Separate for each person receiving shared services.
- Filed in the person's health record.

The agency is responsible to:

- Verify documentation of each PCA worker's hours worked.
- Pay PCA workers based on the actual number of hours of services provided.
- Have a template with English translation available when using time and activity documentation in another language.

PCA workers must submit PCA time and activity documentation to the provider agency at least monthly.

## *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*

Member eligibility should be verified monthly via [MN-ITS](#) or the [UCare Provider Portal](#). 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 (Ref: Minnesota Rules 9505.0335 Personal Care Services Subpart 1 [H]).

## *Member Programs with PCA Benefits*

UCare covers PCA services for members enrolled in Minnesota Senior Care Plus and UCare's Minnesota Senior Health Options plans. There is no PCA benefit for members in the following plans:

- UCare Medicare Plans
- MinnesotaCare (adult, non-pregnant members)
- UCare Individual & Family Plans
- UCare Individual & Family Plans with M Health Fairview
- UCare Medicare with M Health Fairview & North Memorial Health

For UCare Connect, UCare Connect + Medicare, Prepaid Medical Assistance Program (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, 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 evaluate eligible UCare members need for PCA Services.

- The member, member's family, member's representative, primary care clinic or physician must contact the member's 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

- Role of the UCare care coordinator.
  - State statute requires use of the Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D) or MnCHOICES Assessment for the PCA Assessment. Ref: Minnesota Statutes 256B. 0659 subdivision 3a.
  - The Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan and MnCHOICES Assessment 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.
    - County waiver case managers may utilize the MnCHOICES Assessment to establish the need for PCA Services.
  - Upon completion of the assessment, the care coordinator will submit to UCare and provide a copy of the service plan to the member.
- Role of the PCA provider agency.
  - Contact UCare for approval **before providing service**.
- Role of UCare.
  - Upon receipt of the completed assessment, UCare will review the assessment recommendations and provide a written response within 14 calendar days or 10 business days.
  - UCare will send a copy of the service plan to the PCA agency.
- PCA qualified professional (QP) authorization.
  - The annual service authorization for each person who receives PCA services includes a 96-unit limit for QP services.
  - **The PCA provider agency may request additional units if a person's circumstances require more than 96 units. These circumstances could include, but are not limited to, when:**
    - The person has increased care needs
    - Multiple agencies provide PCA workers for the person
    - Multiple PCA workers deliver services to the person
    - Prior authorization from UCare is required

## Temporary Start of PCA Services

A temporary start of PCA services requires authorization prior to, or at the start of, service (Minnesota Statutes 256B. 0652 subdivision 9). 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.

A request for increase in services may also be made when a medical or caregiver status changes, which includes, but is not limited to:

- A change in the member's health or level of care.
- A change in physician request for services.
- A recent facility placement change.
- A change in the primary caregiver's availability.

## *PCA Provider Notification or Change Request Form*

A request for 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

This form can be found within the [Care Management pages](#) of the provider website under the PCA Authorization drop down for each respective plan.

## *Transition of Care/Services*

To request continued authorization of services that were previously approved by another health plan, the agency must:

- Fax a copy of the previous health plan or DHS service agreement.
- Provide a copy of the member's current PCA assessment (DHS-3244/3428D) or MnCHOICES Assessment.
- Complete the PCA Authorization Transfer form found on the [medical authorization for State Public Programs and Special Needs Plans](#) webpage under the Personal Care Attendant Forms drop down.

## *Flexible Use of PCA Services*

Members may use their PCA hours or units in a flexible manner to meet their needs within the following limits:

- Total authorized hours or units must be divided between two, six-month date spans.
- No more than 75% of total authorized hours or units may be used in a six-month date span; health and safety must be assured.
- Units cannot be transferred from one, six-month date span to another.
- Additional PCA hours or units cannot be added unless there is a change in condition.



The member or responsible party and PCA provider agency are responsible for monitoring the use of PCA hours or units.

Persons are not eligible for flexible use of PCA hours or units when any of the following occur:

- County denies flexible use
- DHS revokes or denies flexible use
- Person is assigned to the Minnesota restricted recipient program (MRRP)

## *PCA Billing Guidelines*

When billing for PCA services, use the correct agency provider identification number. Your agency could be set up in our system with either a National Provider Identifier (NPI), or a Unique Minnesota Provider Identifier (UMPI).

How to bill PCA services:

- Bill on an 837P EDI Format.
- If you have a NPI, enter the billing entity NPI in loop 2010AA.
- If you have an UMPI, enter the billing entity UMPI in loop 2010BB.
- Submit the rendering provider UMPI (individual PCA number provided by DHS) in loop 2310B.
- PCA supervision claims billed with modifier UA should not have any rendering data on the claim. Including name, address and rendering ID (NPI and/or UMPI).
- 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 bill 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 or Deletions)*

PCA numbers are not automatically updated in UCare 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 one of the following online forms:

- [Personal Care Attendant UMPI Add Form](#) for additions
- [Personal Care Attendant UMPI Change Form](#) for changes
- [Personal Care Attendant UMPI Terminate Form](#) for deletions

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 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 or listing. Send only the information for new or updated PCAs.

# Qualified Professional (QP) Supervision Standards

All PCAs must be supervised by a qualified professional (QP). Authorization is required for all supervision services. A QP must be one of the following:

- Registered nurse, as defined in [Minn. Stat. §148.171 to 148.285](#)
- Licensed social worker, as defined in [Minn. Stat. §148E.010](#) and [Minn. Stat. §148E.055](#)
- Mental health professional, as defined in [Minn. Stat. §245.462, subd.18](#) or [Minn. Stat. §245.4871, subd. 27](#)
- Qualified designated coordinator, as defined in [Minn. Stat. §245D.081, subd 2](#)

QPs 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 in Minnesota Statute 256B.0625. subd.19c. 256B.0659, subd. 13 and subd. 14, subd. 16 (f) (i) and subd.25.

Traditional PCA

- At minimum, the QP must visit the service delivery location and meet with the person and responsible party, if applicable, to evaluate the PCA worker(s) and/or oversee the delivery of PCA services within the following timelines:
- Within the first 14 days the PCA worker(s) begin to provide services to the person
- Every 60 days for PCA workers who are ages 16-17
- Every 90 days during the person's first year of service
- Every 120 days after the person's first year of service.
- **Note:** The person must have a care plan within seven days of starting services. The QP can choose to combine the first visit with care plan development, if appropriate.

PCA Choice

- At minimum, the QP must visit the service delivery location and meet with the person and responsible party, if applicable, to evaluate the PCA worker(s) and/or oversee the delivery of PCA services within the following timelines:
  - Upon request of the person and responsible party (if applicable)
  - Every 60 days for PCA workers who are ages 16-17
  - Every 180 days

## *Qualified Professional Responsibilities*

Minnesota Statute:

- 256B.0625, subd.19c
- 256B.0659, subd.13 and subd.14 and subd.16 (f) (i) and subd.25.

In accordance with Minnesota DHS, a qualified professional (QP) is a person who provides training, supervision and evaluation of an agency's PCA workers and the services they deliver.

A QP performs the following duties:

- 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 QP or physician.
- Develop the recipient's care plan as follows:
- With the recipient and/or responsible party.
  - Within the first week after the 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.
- 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.
- Review the plan of personal care services with the member. **Note:** plan of personal care services means a written plan of care specific to personal care services.
  - 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 can direct 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 needed in consultation with the recipient or responsible party, to meet the recipient's needs.
  - 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

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This section provides information regarding the hospital admission process for all UCare health plans. For information regarding the Swing Bed admission notification process, see the [Nursing Facility Services section](#). For information regarding fiscal and intermediary letters (rate sheet) for Critical Access Hospitals, Federally Qualified Health Centers and Rural Health Clinics, see the [Fee Schedules section](#) of the Claims chapter.

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 M Health Fairview & North Memorial Health, EssentiaCare, UCare Institutional Special Needs Plans (I-SNP), UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members.

## Hospital Admission Notification | All UCare Members

### *Hospital Responsibility*

Hospitals should verify member eligibility prior to providing service.

**Mental Health and Substance Use Disorder Admissions:** Notification of admission can be faxed to UCare Mental Health and Substance Use Disorder department at 612-884-2033 or 1-855-260-9710 toll-free or sent via a secure email to [MHSUDservices@ucare.org](mailto:MHSUDservices@ucare.org). For additional information, refer to the authorization requirements grid on the [MHSUD Authorization](#) page of the UCare provider website or call 612-676-6533 or 1-833-276-1185 toll-free.

**Detoxification Admissions:** In a hospital, this is not a substance use disorder admission. Detoxification for members who need medical stabilization is a medical service, providers should follow the inpatient admission process listed below. If the member needs substance use disorder treatment, contact UCare's Mental Health and Substance Use Disorder department at 612-676-6533 or 1-833-276-1185 toll-free.

**Inpatient Admissions:** Providers should fax the daily inpatient admissions report to the clinical intake line at 612-884-2499 or send a secure email to [ucareadmissions@ucare.org](mailto:ucareadmissions@ucare.org). Refer to the authorization requirements grid on the [Authorization](#) page of the UCare provider website ([www.ucare.org/providers](http://www.ucare.org/providers)) or call 1-877 447-4384 toll-free or fax 1-866-610-7215 toll-free within one business day from the date of admission. Include the member's name, UCare ID number, date of birth, ICD-10 diagnosis, admission date and discharge date when applicable.

**Maternity/Newborn Admissions:** Please complete the Birth Notification Form to report the delivery date and delivery type, birth weight and level of care required. The Birth Notification Form is on the [Policies & Resources](#) webpage, under Clinical Support Resources. Fax to Clinical Intake at 612-884-2499 or 1-866-610-7215 toll-free.

### **Acute Inpatient Rehab and Long-Term Acute Care (LTAC)**

**Admissions:** UCare requires prior authorization for Acute Inpatient Rehab and LTAC hospital admissions for all lines of business. Requests are reviewed for medical necessity in advance and concurrently throughout the admission and through discharge.

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 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 Inpatient 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 612-884-2499 or 1-866-610-7215 toll-free.

## *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 a designated staff member's email address. Once registration is complete, they will receive an email notice when a report has been uploaded. This report will include 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:

- Member ID
- Member name
- Member DOB
- Product
- Primary Care Clinic (PCC)
- Auth - This number is assigned by UCare, and can be used to reference the notification or for tracking purposes
- Facility name
- Admission type
- Admission reason
- Admission date
- Discharge date
- ICD-10 diagnosis codes
- ICD-10 description
- Diagnosis code description

## **Notice of Discharge and Medicare Appeal Rights for UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plans (I-SNP), EssentiaCare, Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare Members**

When a UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, I-SNP, EssentiaCare, MSHO or UCare Connect + Medicare member is admitted to an inpatient level of care in the acute care hospital setting, the facility must provide the member inpatient hospital discharge appeal rights. The [An Important Message from Medicare About Your Rights \(IM\)](#) document is a statutorily required notice explaining the members' hospital inpatient rights, including discharge appeal rights.

**Use of Standardized Notice** - Hospitals must use the standardized IM form (CMS 10065-IM), (Exp.12/31/2022), available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10065-and-10066>. 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 cases where an enrollee has a scheduled inpatient visit, such as an 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 discharged more than two calendar days after receiving the IM at admission, hospitals must deliver the follow-up copy as far in advance of the discharge as possible but no more than two calendar days before the anticipated or planned discharge date.
- Thus, when discharge seems likely within one to two calendar days, hospitals should arrange to deliver the follow-up copy of the notice. That way, the member has a meaningful opportunity to file an appeal if the member does not agree with the discharge plan.

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, a 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 Medicare inpatient hospital stay member 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 decides that inpatient care should end, UCare staff will complete the DND and fax it 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 the delivery time of the DND.

**Use of Standardized Notice** - Hospitals must use the [Detailed Notice of Discharge \(CMS-10066\)](#) (Exp. 12-31-2022, the Centers for Medicare & Medicaid Services will accept this form until a new one has been introduced).

**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** - When the enrollee is not competent or able to receive or comprehend the information, CMS requires that the enrollee's Medicare appeal rights be notified to the enrollee's representative. 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 the purpose of receiving the notices described in this section. Such representatives should have the enrollee's best interests at heart and act in a manner that protects 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 the staff person 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 email. However, hospitals must meet Health Insurance Portability and Accountability (HIPAA) privacy and security requirements when transmitting the IM by email 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 can 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 the 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 it is not possible to obtain the enrollee's signature, please document the reason on the IM form.

**Refusal to Sign the Notice and Notice Annotation** - If an enrollee refuses to sign the notice, hospitals may annotate the notice to indicate the refusal. 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 two 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) 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 their 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 Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance ([Chapter 13](#)) of the Medicare Managed Care Manual.

## Care Transitions

For UCare members moving from one setting to another, such as when a member is discharged from a hospital (including MHSUD admissions) to a home or from a hospital to a skilled nursing facility or rehabilitation unit, the organization is responsible for facilitating safe transitions.

All members of UCare's Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Institutional Special Needs Plans (I-SNP) products are automatically assigned a care coordinator. Members enrolled in Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview are assigned a case manager based on specific criteria including acute complex medical need and identified diagnoses. UCare Connect (SNBC) and UCare Connect + Medicare (SNBC) members are offered a care coordinator and/or health risk assessment at least annually. The care coordinator or case manager is responsible for facilitating safe transitions for members from one setting to the next. Case managers or care coordinators must make themselves available to members, family members, facilities, providers or others to assist with both planned and unplanned transitions. Care coordinators or case managers coordinate care when members move from one setting to another, such as when a member is discharged from a hospital to a home or from a hospital to a skilled nursing facility. In some cases, members may also need assistance after an outpatient procedure.

While the care coordinator or 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 or case manager and the member and their family. This is to ensure that 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 or support plan 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 communicating verbally with the receiving facility.
- For planned and unplanned transitions from one setting to another, the facility or provider should communicate with the member or member's responsible party about the transition process and any changes to the member's health status and plan of care or support plan.

UCare requires that facilities such as hospitals, skilled nursing facilities, or rehabilitation units communicate with the member's primary care provider regarding both planned and unplanned transitions.

### **Care Transition Protocols for Institutional Special Needs Plan (I-SNP) Members**

In addition to the Care Transition requirements above, for members in the UCare I-SNP product, the delegate providing primary care will be involved in decisions regarding care transitions and provide guidance to the facility and staff, when feasible. They are responsible for timely involvement and will review the transition need and the associated action steps required. They will be instrumental in the determination of the most viable setting of care required to address the change of condition triggering the need for a care setting transition. The PCP will work closely with the care coordinator to monitor the transition and determine treatment adaptations that may be required. The level of involvement will be intensive throughout the transition event, the discharge and the immediate post-discharge timeframe, and will be facilitated by the care coordinator.

# Interpreter Services

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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

UCare provides interpreters in a medical or dental setting for non-English-speaking members of our Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+), UCare Connect, UCare Connect + Medicare and UCare's Minnesota Senior Health Options (MSHO) plans. UCare's Provider Relations and Contracting (PRC) Department continually evaluates its interpretation network to ensure appropriate geographic, language and culturally congruent coverage. PRC consults with UCare's Customer Service department, Health Equity 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:
  - When using contracted interpreters, clinic staff will need to review and sign interpreter work orders.
  - Schedule any follow up appointments or specialty or ancillary services the member needs while the interpreter is present.
  - 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 toll-free.
- **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, the [Provider Search](#) page will display the language(s) spoken by a specific provider.

# 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 interprets, 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 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 or she can 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 their role before you begin.
- Urge them to speak directly to you and the other party, using the first-person pronoun to refer to the speaker.
- Instruct them not to add or delete anything, and especially not to add their 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.

**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 regarding 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.

## 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.

| Agency   | Languages   | Service Area<br>(By MN Counties)  |
|--|---|---|
| ASL Interpreting Services<br>5801 Duluth Street, Suite 106<br>Golden Valley, MN 55422<br>763-478-8963<br><a href="http://www.aslis.com">www.aslis.com</a>                                    | American Sign Language (ASL)  | All counties in Minnesota   |
| Claro Interpreting Services<br>3355 Hiawatha Ave - Ste 115 Minneapolis,<br>MN 55406<br>651-705-8890  | Amharic, Arabic, Armenian,<br>Burmese, French, Karen,<br>Kiswahili, Oromo, Romanian,<br>Russian, Somali, Spanish,<br>Swahili, Thai, Ukrainian,<br>Vietnamese  | Anoka, Benton, Blue Earth, Carver, Dakota, Hennepin, Kandiyohi, Le Sueur, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright     |
| AZ Friendly Languages, Inc.<br>1113 East Franklin Avenue, Suite 210A<br>Minneapolis, MN 55404<br>763-566-4312<br><a href="https://friendlylanguages.net/">https://friendlylanguages.net/</a> | Albanian, Amharic, Arabic, Armenian, Azerbaijani, Bassa, Belarusian, Bengali, Bosnian, Bulgarian, Cambodian (Khmer), Cantonese, Cebuano, Croatian, Czech, Edo, Ewe, Farsi, French, Georgian, German, Gion, Grebo, Greek, Hindi, Hmong, Hungarian, Igbo, | Anoka, Blue Earth, Carver, Dakota, Freeborn, Goodhue, Hennepin, Nicollet, Olmsted, Ramsey, Scott, Sherburne, Steele, St. Louis, Stearns, Washington |

| Agency  | Languages  | Service Area<br>(By MN Counties) |
|---|--|----------------------------------|
|   | Japanese, Kisi, Korean, Kpelle, Krahn, Kru, Laotian, Latvian, Liberian, Lithuanian, Lorma, Mandarin, Mandingo, Mano, Mina, Moldovan, Oromo, Pashto, Polish, Portuguese, Pulaar, Punjabi, Romanian, Russian, Sapo, Somali, Spanish, Susu, Swahili, Tagalog, Telugu, Thai, Tibetan, Tigrinya, Toisanese, Turkish, Twi, Ukrainian, Urdu, Vietnamese, Yoruba, Zulu   |                                  |
| CareInt<br>4033 Abbott Avenue South<br>Minneapolis, MN 55410<br>612-922-0587  | Russian  | Hennepin, Ramsey                 |
| Global Language Connections<br>3618 East Lake Street<br>Minneapolis, MN 55406<br>612-249-6100<br><a href="https://globallanguageconnections.com/">https://globallanguageconnections.co<br/>m/</a> | American Sign Language (ASL), Amharic, Anuak, Arabic, Arabic (Egyptian), Arabic (Sudanese), Belarusian, Bengali, Berber, Bosnian, Bulgarian, Burmese, Cambodian (Khmer), Cameroon (Mina), Cantonese, Czech, Dari, Dinka, Eritrean, Ethiopian, Ewe, Farsi, Filipino, French, French Canadian, Fula, Fulani, German, Greek, Gujarati, Haitian Creole, Harari, Hausa, Hebrew, Hindi, Hmong, Hungarian, Ibo, Igbo, Indonesian, Italian, Japanese, Karen, Kashmiri, Kisi, Korean, Krio, Kru, Kuku, Kurdish, Laotian, Lebanese, Liberian, Maay Maay, Mandarin, Mano, Micronesian/Kosrean, Mien, Moldovan, Mongolian, Nepali, Nepalese, Nigerian Pidgin English, Norwegian, Nuer (Sudanese), Oromo, Pashto, Persian, Pidgin English, Polish, Portuguese, Punjabi, Romanian, Russian, Samoan, Senegalese, Serbian, Somali, | All counties in Minnesota        |

| Agency   | Languages   | Service Area<br>(By MN Counties)   |
|--|---|--|
|  | Spanish, Swahili, Swedish, Tagalog, Taiwanese, Tamil, Telugu, Thai, Tibetan, Tigrinya, Turkish, Twi, Ukrainian, Urdu, Vietnamese, Yoruba  |  |
| <p>Intelligere</p> <p>10000 Highway 55, Suite 400<br/>Plymouth, MN 55441<br/>952-920-6160<br/>1-877-859-8800 toll-free<br/><a href="http://intelligeresolutions.com/">http://intelligeresolutions.com/</a></p> | <p>Albanian, Amharic, Arabic, Armenian, Ashanti, Azeri, Bassa, Belarusian, Bengali, Bosnian, Bulgarian, Burmese, Cambodian/Khmer, Cantonese, Creole, Croatian, Czech, Dan, Dari, Dinka, Dutch, Estonian, Ewe, Farsi, Filipino, French, Fulani, Georgian, German, Ghana, Grebo, Greek, Guajarti, Haitian Creole, Hausa, Hebrew, Hindi, Hmong, Hungarian, Indonesian, Italian, Japanese, Karen, Khmer, Kisii, Kpelle, Korean, Krahn, Krio, Kru, Kurdish, Laotian, Latvian, Liberian, Loma, Luganda, Mai Mai, Malayalam, Mina, Mano, Mandingo, Mandarin, Moldovan, Nepali, Nuer, Oromo, Pashto (Central), Persian, Polish, Portuguese, Romanian, Russian, Serbian, Sinhalese, Somali, Spanish, Sudanese, Swahili, Tagalog, Thai, Tibetan, Turkish, Ukrainian, Urdu, Vietnamese, Wolof, Yiddish, Yoruba</p> | <p>Anoka, Beltrami, Benton, Carver, Chisago, Cottonwood, Dakota, Dodge, Goodhue, Hennepin, Isanti, Jackson, Kandiyohi, Le Sueur, Olmsted, Ramsey, Rice, Scott, Sherburne, Stearns, Steele, Traverse, Wabasha, Waseca, Washington, Winona, Wright</p> |
| <p>Intercultural Mutual Assistance Association (IMAA)</p> <p>2500 Valleyhigh Drive Northwest<br/>Rochester, MN 55901<br/>507-289-5960<br/><a href="http://www.imaa.net">www.imaa.net</a></p>                   | <p>Amharic, Anuak, Arabic, Bosnian, Dinka, Filipino, French, German, Greek, Hindi, Hmong, Italian, Kannada, Karen, Khmer, Laotian, Luganda, Mai Mai (Somali), Mende, Nepali, Neur, Oromo, Portuguese, Quecha, Russian, Somali, Spanish, Swahili,</p>  | <p>Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca, Winona</p>   |

| Agency   | Languages  | Service Area<br>(By MN Counties)  |
|--|--|---|
|  | Tagalog, Tamil, Telugu, Thai, Turkish, Vietnamese  |   |
| Itasca Interpretation Services<br>475 Etna Street, Suite 1<br>Saint Paul, MN 55106<br>651-457-7400<br><a href="http://www.itascacorp.biz">www.itascacorp.biz</a>               | Amharic, Arabic, Arabic Egyptian, Burmese, Cambodian, Cantonese, Chinese, Farsi, French, Hindi, Hmong, Italian, Japanese, Karen, Karenni, Korean, Laotian, Mandarin, Nepali, Oromo, Russian, Somali, Spanish, Taiwanese, Thai, Tigrinya, Ukrainian, Vietnamese | Anoka, Dakota, Goodhue, Hennepin, Lincoln, Lyon, Murray, Olmsted, Ramsey, Redwood, Rice, Scott, Stearns, Wabasha, Washington, Winona                |
| Kim Tong Translation Services<br>2994 Rice Street<br>Little Canada, MN 55113<br>651-252-3200<br>1-877-408-2431 toll-free<br><a href="http://www.kttsmn.com">www.kttsmn.com</a> | Amharic, Arabic, Bosnian, Burmese, Cambodian, Cantonese, Croatian, Dari, Farsi, Filipino, French, Gujarati, Hindi, Hmong, Japanese, Karen, Korean, Laotian, Mandarin, Persian, Polish, Romanian, Russian, Somali, Spanish, Ukrainian, Vietnamese               | Anoka, Blue Earth, Carver, Dakota, Hennepin, Le Sueur, Nicollet, Ramsey, Sherburne, Washington, Wright  |
| Vadim Genov DBA Health Management Services<br>700 Washington Ave N. Suite 504<br>Minneapolis, MN 55401<br>612-670-2147<br>Fax: 612-498-6056                                    | Arabic, Russian, Turkish, Ukrainian  | Hennepin  |
| Project FINE<br>202 West 3rd Street<br>Winona, MN 55987<br>507-452-4100<br><a href="http://www.projectfine.org">www.projectfine.org</a>  | Arabic, Bosnian, Bulgarian, Cambodian, Chinese, Czech, Dari, French, German, Hmong, Italian, Japanese, Korean, Laotian, Nepali, Pashto, Portuguese, Romanian, Russian, Somali, Spanish, Thai   | Minnesota counties:<br>Filmore, Goodhue, Houston, Olmsted, Wabasha, Winona<br><br>Wisconsin counties:<br>Buffalo, La Crosse, St. Croix, Trempealeau |
| Slavic Translation Services<br>6770 28 <sup>th</sup> SE<br>Buffalo, MN 55313   | Amharic, Anuak, Arabic, Armenian, Belarusian, Berber, French, Georgian, Khmer, Moldovan, Oromo, Romanian,  | Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Rice, Scott, Sherburne, Stearns,  |



| Agency  | Languages   | Service Area<br>(By MN Counties)   |
|---|---|--|
| 612-618-6642  | Russian, Spanish, Somali,<br>Sudanese, Swahili, Ukrainian   | Washington, Wright   |
| Surad Interpreting and Translation Co.<br>2025 Nicollet Avenue, Suite 101<br>Minneapolis, MN 55404<br>612-872-8059  | Afar, Amharic, Arabic, Berber,<br>Bosnian, Burmese, Cambodian,<br>Chinese, Dari, Dinka, Farsi,<br>French, Hindi, Hmong, Karen,<br>Karenni, Khmer, Kiswahili,<br>Korean, Laotian, Mandarin,<br>Nuer, Oromo, Pashto, Russian,<br>Somali, Spanish, Swahili, Thai,<br>Tigrinya, Ukrainian, Urdu,<br>Vietnamese  | Anoka, Carver, Cass,<br>Crow Wing, Dakota,<br>Hennepin, Leech Lake<br>Band of Ojibwe<br>reservation, Morrison,<br>Ramsey, Scott, Todd,<br>Wadena, Wright |
| The Bridge World Language Center, Inc.<br>110 2nd Street South, Suite 213<br>Waite Park, MN 56387<br>320-259-9239<br>1-800-835-6870 toll-free<br><a href="http://www.bridgelanguage.com">www.bridgelanguage.com</a> | Amharic, Anuak, Arabic,<br>Belarusian, Bengali, Bulgarian,<br>Burmese, Cambodian,<br>Cantonese, Chinese, Creole,<br>Croatian, Farsi, French,<br>Gujarati, Hindi, Hmong,<br>Indonesian, Italian, Japanese,<br>Javanese, Kissi, Korean, Krahn,<br>Kurdish, Laotian, Nuer, Oromo,<br>Polish, Portuguese, Punjabi,<br>Russian, Sapo, Serbo-Croatian,<br>Spanish, Somali, Swahili,<br>Tagalog, Thai, Tigrinya,<br>Ukrainian, Urdu, Vietnamese,<br>Yoruba                           | Anoka, Benton, Clay,<br>Hennepin, Koochiching,<br>Ramsey, Sherburne,<br>Stearns  |
| The Language Banc, Inc.<br>1625 Park Avenue<br>Minneapolis, MN 55404<br>612-588-9410<br>1-888-588-1904 toll-free<br><a href="http://www.thelanguagebanc.com">www.thelanguagebanc.com</a>                            | Afar, Amharic, Anuak, Arabic,<br>Armenian, American Sign<br>Language (ASL), Bambara,<br>Bassa, Bengali, Bosnian,<br>Burmese, Cambodian,<br>Cantonese, Cebuano, Creole,<br>Croatian, Dari, Ewe, Fanti, Farsi,<br>Filipino, French, Fulani, Fuzhou,<br>Ga, German, Gio, Gola, Grebo,<br>Grebo, Gujarati, Hebrew, Hindi,<br>Hmong, Ibo, Igbo, Italian,<br>Japanese, Karen, Karenni,<br>Khmer, Kissii, Kiswahili,<br>Konyaka, Korean, Kpelleh,<br>Krahn, Krio, Kru, Kru-Liberian, | All counties in Minnesota  |

| Agency  | Languages  | Service Area<br>(By MN Counties)   |
|---|--|--|
|   | Kunama, Kurdish, Laotian, Lebanese, Liberian, Mai Mai, Mandarin, Mandingo, Mandinka, Mano, Marka, Mina, Moldovian, Mon, Nepali, Nigerian, Oromo, Pashtu, Persian, Pidgin, Polish, Portuguese, Pullo, Punjabi, Romanian, Russian, Serbian, Shanghainese, Somali, Soninke, Spanish, Swahili, Tagalog, Taishanese, Taiwanese, Telugu, Temne, Teochew, Thai, Tibetan, Tigre, Tigrinya, Turkish, Twi, Ukrainian, Urdu, Vietnamese, Visayan, Wolof, Yoruba |  |
| The Minnesota Language Connection<br>1327 County Road D, Circle E<br>Saint Paul, MN 55109<br>651-644-7100<br><a href="http://www.minnesotalanguageconnection.com">www.minnesotalanguageconnection.com</a> | Amharic, Arabic, Belarusian, Burmese, Cambodian, Cantonese, Creole, French, Georgian, German, Haitian, Hindi, Hmong, Karen, Korean, Laotian, Mandarin, Oromo, Portuguese, Russian, Somali, Spanish, Swahili, Thai, Tibetan, Turkish, Vietnamese  | Anoka, Blue Earth, Carver, Chisago, Dakota, Dodge, Faribault, Fillmore, Hennepin, Isanti, Itasca, Jackson, Kandiyohi, Le Sueur, Lyon, Olmsted, Rice, Ramsey, Scott, Sherburne, Stearns, Washington, Winona, Wright |
| West Central Interpreting Services<br>309 Litchfield Avenue Southwest<br>Willmar, MN 56201<br>952-487-4945<br>612-254-8545 (fax)<br><a href="https://wcinterpreters.com/">https://wcinterpreters.com/</a> | Afar, Afghani, Amharic, Anuak, Arabic, Armenian, Belarus, Bosnian, Burmese, Cambodian, Cantonese, Chinese, Cuchi, Dioula, Farsi, French, German, Hindi, Hmong, Igbo, Italian, Karen, Korean, Laotian, Malinke, Mandarin, Mandingo, Nuer, Oromo, Pashto, Pidgin English, Portuguese, Punjabi, Russian, Serbian, Somali, Spanish, Swahili, Tagalog, Thai, Trigrinya, Turkish, Ukrainian, Urdu, Vietnamese, Yoruba                                      | Counties in Minnesota  |

## *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/>.

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/>. In addition, the ASL interpreter must be RID certified.

## **Interpreter Services Requirements and Performance Expectations**

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.

- 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/> and System for Award Management (SAM) at <https://www.sam.gov/SAM/> (for either web address use IE 11 or higher, Chrome or Firefox browsers).
  - 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 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.
- 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 health care 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 health care 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.
- 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 or 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.
- 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.
- 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 the interpreter service agency to comply with this request.
- 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 the interpreter service agency to comply with this request.
- 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.
- 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.
- 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.
- The interpreter service agency must document all appointments through their schedule and tracking systems.

- 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.
- The interpreter service agency will monitor and assess the quality of the 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 policies and/or procedures.
  - Schedule appointment that was not requested by the member, clinic or health plan.
  - Unethical conduct and/or inappropriate behavior.
  - False representation of one's identity, including the agency that they are representing at the time of service.
- 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. For video or phone interpreting, the signature requirement is waived.
- 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.

- Verification of UCare enrollee eligibility must be done prior to each appointment by the interpreter service agency and not the individual interpreters.
- The interpreter service agency must, at all times, record and maintain a written record of all interpreter services. Records must be kept for at least 10 years. The agency must provide the written records to UCare upon request.
- 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 30, July 31, 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 and ZIP code)
  - n. Type of Appointment or 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 [Policies & Resources webpage](#) under the Interpreter Provider Resources drop-down. Click the link above and download the report and then open the Excel document. A copy can be saved to a personal/business computer for use.
- 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 or SAM Last Verified
  - v. Immunizations Current
  - w. Date of Individual Training or 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 [Policies & Resources webpage](#), under the Interpreter Providers Resources drop-down.
  - 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.
  - The interpreter service agency is responsible to make sure a gender appropriate interpreter is being provided if requested by the patient or clinic.
  - 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.
  - The interpreter is required to arrive 10 minutes early for an appointment.
  - 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-minute 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.
  - The interpreter must assist the enrollee with checking in and scheduling follow-up appointments, as necessary.
  - If the interpreter needs to leave 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.
  - 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.
  - The interpreter service agency must respond to requests with one or more days notice as well as to urgent (same-day) requests.
  - The interpreter service agency must provide the following for:

- **Same-day requests:** Call the requesting clinic as soon as the appointment is filled with an accurate estimated time of arrival for the interpreter (keep traffic and parking delays in mind).
  - **Future requests** (next day and beyond): Provide verbal confirmation to the requesting clinic by 4 pm on the day the request is made.
- The interpreter service agency must respond to requests during daytime operations (6 am - 6 pm on weekdays) as well as after hours (6 pm - 6 am on evenings, weekends and holidays).
- 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
- 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 they can fill the request and provide an accurate estimated time of arrival.
- 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.
- 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
- 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.
- The interpreter service agency must have written documentation to support their business operations and relationship with interpreters, including policies and procedures.
- The interpreter service agency must require each individual interpreter review the UCare Provider Manual overview PowerPoint yearly. Attestation documentation must be kept on file and available upon request by UCare within 10 days of request.
- The interpreter service agency must cooperate with site visits or document requests from UCare to ensure all requirements and expectations are being met.

### *Interpreter Service Expectations*

- UCare will reimburse sign and oral language interpreter agencies for services provided at authorized UCare providers.
- 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.
- The interpreter is not required to provide transportation to UCare members.
- The interpreter is expected to arrive 10 minutes before the scheduled appointment.



- 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-minute 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.
- If the interpreter needs to leave during the appointment, they must inform the provider or staff a minimum of 15 minutes before they leave to give the provider or staff the opportunity to notify the interpreter service agency and find a replacement interpreter.
- 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.
- 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.
- 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.
- Gender appropriate interpreters must be provided, if requested by the patient or the clinic.
- The sign and oral language interpreter services UCare **will not** reimburse include, but are not limited to:
  - Services provided at inpatient 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 an 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 provider and/or other clinic staff speak the patient's language, if available.
  - 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](#).

## Reimbursement and Claims Processing Guidelines for Interpretive Services

The following are reimbursement and claims processing guidelines applicable to interpreter agencies:

- For Minnesota Health Care Program (MHCP), 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
- Interpretation services will be reimbursed only for covered services listed in the member's Certificate of Coverage or Evidence of Coverage.
- UCare will reimburse for actual time, on site, interpretation services. "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.
- 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.
- UCare follows the MHCP billing code(s). One unit equals 15 minutes. To be reimbursed for one unit, the number of minutes must be eight or more. Less than eight 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.
- Claims must be submitted on the 837P format through a clearinghouse that works directly with UCare for electronic data interchange (EDI) claim transmission. Please see the [Claims chapter](#) for details.

### *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.

| Loop and Segment         | What to Enter | Place on the Claim Image |
|--------------------------|---------------|--------------------------|
| Loop 2300, segment REF01 | G1            | Box 23                   |
| Loop 2300, segment REF02 | MDH Roster ID | Box 23                   |

**Exception:** A Roster ID number is not required for American Sign Language interpreters.

- A work order must accompany each claim and have all the following information completed 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 and 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 the above pieces of information is missing or incomplete, the claim is not valid for reimbursement.
- 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, 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 the 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 provider or other clinic staff speaks the patient's language, if available.
  - 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.
- 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 Mileage Request Form from the [Policies & Resources webpage](#), under Interpreter Provider Resources. 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.
- 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.
- 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 must 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.

- UCare will not pay for services that are rendered in a manner inconsistent with the “Interpreter Services Performance Expectations” described in the previous section.
- Interpreter services provided by the same interpreter to multiple enrollees or members simultaneously must be billed as a single visit.
- 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.
- 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.
- 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.
- 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.
- Interpreter service for American Sign Language (ASL) should be referred to the provider’s contract for covered services and reimbursement requirements.
- 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.
- 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 to schedule appointments or transportation service are not covered as part of a medical telephone conference.
- All interpreter claims are subject to post-payment audits, which require the provider’s cooperation.

## **Clinic Staff Interpreters | Reimbursement and Claims Processing Guidelines**

The following are reimbursement and claims processing information for interpreter services provided by clinic staff:

- Clinics, hospitals or care systems must have a contract or amendment to provide interpreter services and must only bill for interpretation services provided within their facility only. If the patient fails to show for the appointment, UCare will not reimburse for no show time.
- Reimbursement will only be made for clinic visits and outpatient hospital services.

- 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.
  - **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.
- Internal clinic or hospital staff are subject to the same performance and expectation guidelines as the interpreters working with an interpreter service agency.
- Interpreter service provided by an outside agency is not billable and will not be reimbursed.
- Reimbursement will not be made for inpatient hospital services.
- 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 1-888-531-1493 toll-free.

## *Minnesota Community Coding Practice or 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 and/or no show or cancellation per 15 minutes

**Note:** Drive time or wait time is not covered by UCare. Modifier 52 is only to be used for no show by a patient or physician.

If the 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. For example, 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. This is not applicable to ASL interpretation.

Find these and other resources on the [Policies & Resources webpage](#), under Interpreter Providers Resources.

- Place of Service Codes
- Interpreter Quarterly Report
- Add, Update or Remove an Interpreter
- Interpreter Mileage Request Form

# Nursing Facility Services

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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 Prepaid Medical Assistance Program (PMAP) or MinnesotaCare plans. 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 M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plans, 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, the skilled nursing or skilled rehabilitation personnel to assure the member's safety and 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 M Health Fairview members. Members require daily skilled services for post-acute treatment and rehabilitative care of illness or injury following 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 supervising medication administration 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 or non-skilled care is available for qualifying members of MSHO, UCare Connect + Medicare, Minnesota Senior Care Plus (MSC+) 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, beyond the standard amount for routine accommodation services

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, except for 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 according 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-language pathologists.
- The skilled care must be provided directly by or under the supervision of the skilled nursing and/or rehabilitation personnel.

Skilled care coverage may be considered medically necessary when all 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 member's safety and achieve the medically desired result.
- Services are provided under a plan of care established and periodically reviewed by a physician.
- Services are appropriate for treating the illness or injury expecting the patient's condition to improve reasonably and generally predictably. The services must be necessary for establishing a safe and effective maintenance program. One or more of the following types of skilled services are required:
  - Skilled nursing services: Services necessary when the member's condition continues to require skilled assessment, treatment, and management or 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).

- 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 are 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 the 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 [Authorization](#) page of the [UCare provider website](#).

Skilled nursing facility stays require authorization 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 or 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 M Health Fairview & North Memorial Health
- UCare Institutional Special Needs Plans
- EssentiaCare

- UCare’s Minnesota Senior Health Options
- UCare Connect + Medicare

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 the qualifying event leading to the need for a 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 long-term care, is discharged from an inpatient hospital stay, and presents to a clinic, emergency room, or urgent care setting. Or the member has been evaluated by a physician, physician assistant, or nurse practitioner at their residence or via telehealth visit.
- All 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 the 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 a nursing facility to a skilled nursing facility level of care, the physician, physician assistant, 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.

The three-day hospital stays requirement and presumption of coverage apply to members with the following UCare Supplemental Plans:

- UCare Senior Select
- UCare Medicare Supplement

## **UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Institutional Special Needs Plans and EssentiaCare Coverage Details**

### *Benefit Periods*

- 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 after 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*

- A separation period is 60 or more consecutive days when the member has not been an 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 a 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*

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 must identify skilled nursing facilities within their region and determine the availability of skilled nursing facility beds before requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities. 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 Medicare Supplement, 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 of 60 consecutive days begins with the first day of admission to a hospital, skilled nursing facility, or intermediate care facility.
- A new benefit period may begin after 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 SeniorSelect*

- A separation period is 60 or more consecutive days, and the member has not been an 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, the 60-day separation period starts over upon discharge. 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 Minnesota Senior Health Options (MSHO) Coverage Details**

### *180-Day Skilled Nursing Facility (SNF) or Nursing Facility (NF) Benefit Period*

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 benefit days that are not assigned to UCare.

The 180-days begin when the member is admitted to a nursing facility. Days counted toward the 180-day benefit include:

- Medicare skilled nursing facility days
- Swing bed days
- Medicaid custodial or 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 days per calendar year and 18 consecutive days for each separate and distinct episode of medically necessary hospitalization.

## *Skilled Nursing Facility Benefit Periods*

- 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 after 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*

- 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, the 60-day separation period starts over upon discharge. 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*

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. Medicare necessity criteria are included on the medical services [authorization grids](#).

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 must identify skilled nursing facilities within their region and determine the availability of skilled nursing facility beds before requesting authorization.

Hospital providers may have existing transfer agreements with area skilled nursing facilities. 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 responsible for 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

benefit has been exhausted, and further custodial days are the responsibility of Medicaid. UCare will continue to cover Medicare skilled care days, up to 100 days per 60-day separation period.

## **Minnesota Senior Care Plus (MSC+) Coverage Details**

UCare covers 180 days of custodial nursing facility care (non-skilled).

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 is responsible for nursing facility benefit days not assigned to UCare.

The 180-day benefit will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 180-day benefit include:

- Medicare skilled nursing facility days
- 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 days and 18 hospitals leave bed hold days.

UCare is responsible for 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 responsibility has been exhausted, and all further custodial days will be paid by Medicaid.

## **UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview Coverage Details**

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 or 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) Coverage Details

UCare covers 100 days of nursing facility care, including days used under the 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 is responsible for nursing facility benefit days not assigned to UCare.

The 100-day benefit will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 100-day benefit include:

- Medicare skilled nursing facility days except for Medicare skilled nursing facility days paid for in full by original Medicare and other insurance (for example: Medicare Supplement), and for which UCare paid nothing.
- Swing bed days (billed to Medicare).
- Medicaid custodial or 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 days and 18 hospital leave bed hold days.

UCare notifies the Department of Human Services when the health plan benefit has been exhausted, and all further custodial days will be paid by Medicaid.

For additional information regarding Nursing Home Authorization, see the [State Public Programs & Special Needs Plans Medical Services Authorizations page](#) under the Nursing Home Forms and Information drop-down.

## UCare Connect + Medicare Coverage Details

UCare covers 100 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 is responsible for nursing facility benefit days not assigned to UCare.

The 100-day benefit will count cumulatively, beginning at the time the member is admitted to the nursing facility. Days that count toward the 100-day benefit include:

- Medicare skilled nursing facility days.
- Swing bed days.
- Medicaid custodial or 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 days and 18 hospitals leave bed hold days.

### *Skilled Nursing Facility Benefit Periods*

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 after 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*

- 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, the 60-day separation period starts over upon discharge. 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*

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 must identify skilled nursing facilities within their 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. 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 responsible 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 benefit has been exhausted, and further custodial days are the responsibility of Medicaid. UCare will continue to cover Medicare skilled care days, up to 100 days per 60-day separation period.



# Minnesota Department of Health (MDH)

## Nursing Home Report Card

UCare follows the MDH Report Card as provided by the Minnesota Department of Human Services (DHS) when Medicaid payment is evaluated in the claim's reimbursement process for the following products: Minnesota Senior Care Plus (MSC+), UCare Connect, UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare. See link: <http://nhreportcard.dhs.mn.gov/SearchLS.aspx>.

Since the Nursing Home Report Card does not support historical data, UCare will apply real-time rates as of the claim processing date. Should a provider not be listed on the MDH website, the claim will be denied with a code of **CARC CO163: Attachment/other documentation referenced on the claim was not received**, indicating the provider rate letter needs to be provided.

Providers should contact MDH directly to be added to the MDH website.

For payment dispute or claim denial due to not being listed on the MDH website:

- Submit an appeal via the Provider Claim Reconsideration Request form. The form is found on UCare's [Claims & Billing](#) webpage under "Forms & Links," with several options based on the submission type.
- Attach the DHS rate letter that would be applicable to the claim date of service.

## Denial and Discharge Notices

Denial and discharge notices for skilled nursing facility services are issued by nursing facilities for UCare members. A copy of the completed denial notice is required to be sent to UCare.

- UCare Clinical Services fax: 612-884-2247
- UCare Clinical Services email: [snf\\_fax@ucare.org](mailto:snf_fax@ucare.org)

### *UCare Medicare Plan and EssentiaCare | Denial Forms*

Find the customized forms on our [Denial Notice Forms](#) page.

## Notice of Medicare Non-Coverage (NOMNC)

- Issued by skilled nursing facility staff when ongoing services will be terminated.
- Must be delivered two days prior to discharge or service termination.

## Detailed Explanation of Non-Coverage (DENC)

- 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.

## Notice of Denial of Medical Coverage or Payment (NDMCP)

*Issued by Skilled Nursing Facility Staff When:*

- Admission to a skilled nursing facility is denied prior to or at admission.
- A member exhausts the 100 days 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 Minnesota Senior Health Options (MSHO) (Dual Special Needs Plan) and UCare Connect + Medicare | Denial Forms*

Find the customized forms on our [Denial Notice Forms](#) page.

**Note:** For MSHO and UCare Connect + Medicare, if a service is denied under Medicare but is covered under Medicaid, the Medicare denial notice is not needed.

### **Notice of Medicare Non-Coverage (NOMNC)**

- Issued by skilled nursing facility staff when ongoing services will be terminated.
- Must be delivered two days prior to discharge or service termination.

### **Detailed Explanation of Non-Coverage (DENC)**

- 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 the 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 found in the respective sections of the [UCare Denial Notice Forms page](#).

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 on the UCare-specific denial forms for UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare.
- The provider is responsible for providing the QIO and members 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 decide by close of business on the day coverage is to end.
- The provider and UCare must cooperate with the QIO to provide the review information.
- 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 Health Insurance Portability and Accountability (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 UCare or the delegated approval authority's direction and must not delay the notice's delivery.

The facility must use the most current UCare version of the denial notice for UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, EssentiaCare, MSHO and UCare Connect + Medicare whenever a notice is delivered to a member. Find the customized forms on our [Denial Notice Forms](#) page.

The facility must ensure that the notice and delivery are valid. Notices cannot be altered in any way.

# Maternity, Obstetrics and Gynecology

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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 gynecologic or obstetric visits determined to be medically necessary by the examining provider.
- Maternity care.
- Evaluation and necessary treatment for acute gynecologic or obstetric 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. If a provider furnishes a family planning service to a UCare member and that provider is not a part of the member's health plan provider network, the provider must contact UCare for payment. Treatment for medical conditions that cause infertility is not an open access service and must be obtained from a UCare contracted provider.

Review the [Department of Human Services \(DHS\) Minnesota Health Care Programs \(MHCP\) Provider Manual](#) for a list of covered and noncovered services.

## 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 CFR 441.250-441.259) outlines the requirements the member must meet for sterilization to be covered:

- At least 21 years old when the [Consent for Sterilization 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 by the patient being sterilized, an interpreter if one is present, the person obtaining the consent and the physician performing the procedure.

## *Timeline and Exceptions*

The informed consent must be signed and dated no less than 30 days, or more than 180 days, prior to the date of the surgical procedure, with the following exceptions:

- Emergency abdominal surgery
  - When the member to be sterilized requires emergency abdominal surgery, the sterilization may be covered at the time of emergency abdominal surgery if at least 72 hours have passed since the member signed the consent form. An emergency Cesarean section is not considered an emergency abdominal surgery.
- Premature delivery
  - The sterilization may be covered if at least 72 hours from the “From date” of admission have passed since the member signed the consent form and it was signed at least 30 days before the expected date of delivery.

## *Transfer of Consent*

If a member moves or changes providers, the sterilization consent form may be transferred to the new provider. However, the physician who performs the surgery must complete the physician section and sign within the appropriate timeline.

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 substances that affect the member’s state of awareness.
- In a situation where the provider believes the member is unable to give informed consent.

The signed consent form must be retained in the member’s medical record.

# **Abortion Services | UCare Minnesota Health Care Programs (MHCP)**

Medical Assistance and MinnesotaCare members are eligible for induced abortions and abortion-related services coverage under the following conditions:

## *Medical Assistance (MA)*

- The 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 the abortion is performed.
- Pregnancy resulted from rape.
- Pregnancy resulted from incest.
- Other health or therapeutic reasons.

## *MinnesotaCare*

- Pregnancy resulted from rape.
- Pregnancy resulted from incest.

- For prevention of substantial and irreversible impairment of a major bodily function.
- Continuation of the pregnancy would endanger the member's life.

Members enrolled in MinnesotaCare and seeking an abortion for other health or therapeutic reasons must apply for, and be covered by, Medical Assistance prior to the procedure.

UCare does not provide coverage for abortion services or make coverage decisions for MHCP members, except under certain circumstances.

All induced abortion and abortion-related services should be billed to the Minnesota Department of Human Services (DHS) with a [Medical Necessity Statement](#) (DHS-2327) with all induced abortion claims, following the [Electronic Claim Attachments](#). 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 because of the abortion (including treatment for an incomplete abortion).
- Drugs (anti-anxiety, narcotics, anesthetics, antibiotics, etc.).

Non-abortion-related services and services performed for the pregnancy prior to, on the day of, or after an 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 titer
- Gonadotropin levels (hCG)
- Hemoglobin and hematocrit
- GAM (TM)
- Pap smear
- Laboratory examinations to detect 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, spontaneous abortion or similar services, are not subject to this process and should be billed to UCare.

## **Abortion Services | UCare Medicare Plans**

Members are allowed access without a referral to UCare providers who perform abortion services. Services are covered under the standard Medicare benefit if the member meets certain circumstances.

Members in these Medicare Advantage plans (UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health and EssentiaCare) have coverage for abortion services under the following conditions:

- 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.
- Pregnancy resulted from rape.
- Pregnancy resulted from incest.

## **Abortion Services | UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview**

Members are allowed access without a referral to UCare providers who perform abortion services. UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview members have coverage for abortion services under certain circumstances:

- 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.
- Pregnancy resulted from rape.
- Pregnancy resulted from incest.

## **UCare's Maternal Child Health Program | Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Connect, UCare Connect + Medicare, UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview Members**

UCare's Maternal Child Health 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
- Identification of risk factors such as age, history of preeclampsia, anemia, previous c-section, high blood pressure, diabetes, etc.
- Risk behaviors such as maternal use of tobacco, alcohol or street drugs

- SDoH (Social Determinants of Health) Screening
- Depression and Anxiety Screening
- Access to UCare-provided benefits and resources
- Ongoing telephonic support from a Registered Nurse to monitor high risk indicators throughout pregnancy and the postpartum period

UCare's efforts are directed toward integration of services and to increase communication among those providing care to members. UCare implemented the following services and processes to address focus areas:

- Early prenatal care - UCare members are encouraged to receive early prenatal care. Several processes were designed to encourage identification of pregnancy, including:
  - A \$75 reward to members for initiating care in the first trimester or within 42 days of joining UCare.
  - 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.
- Assessment and referral for risk behaviors.
  - The telephonic outreach or public health home visit program assesses members for smoking cessation, nutrition, mental health, chemical or alcohol use, medical risk factors and unmet social service needs.
  - The call or visit includes an immediate referral to appropriate services.
  - UCare offers a tobacco and nicotine quit line program for members who are planning a pregnancy, currently pregnant or postpartum, with specially trained coaches who provide outbound calls throughout the pregnancy and into postpartum. Additionally, a \$25 reward incentive is offered for pregnant and postpartum (less than one year after delivery) smokers to complete an assessment with UCare's Tobacco and Nicotine Quit line.
- Preparing for childbirth and caring for the new infant - Pregnant members enrolled in UCare Connect, UCare Connect + Medicare, PMAP or MinnesotaCare 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)
- Postpartum visits ensure that members receive needed follow-up education, assessment and encouragement to seek routine well-baby checkups.
  - The telephonic outreach reminds members to schedule a postpartum visit and promotes routine well-baby checkups.
  - A \$75 reward to members for completing the postpartum visit between one week to 12 weeks after giving birth.
  - Public health postpartum home visits are offered to all newly delivered members within several weeks of delivery.
- 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 Pump Coverage***

Members who are breastfeeding can order a breast pump at no cost. A medical order is required.

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 Neonatal Intensive Care Unit and is unable to nurse, the hospital grade rental pump is the best choice as it will enable 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.
- Dual electric pumps (E0603)
  - Dual electric pumps are available through UCare-contracted DME providers. These are purchased, not rented. A medical order is required.
- Manual pumps (E0602)
  - Manual pumps are available through UCare contracted DME providers. These are purchased, not rented. A medical order is required.
- A new breast pump is covered with every pregnancy, upon request.

**Note:** breast pumps are covered for members only after their babies are born. Diagnosis codes must be one of the postpartum codes.

## ***Breast Pump Billing Information***

- Claims for breast pumps must be filed under the mother's UCare ID number.
- Claims must include procedure codes E0604, E0603 or E0602, diagnosis codes Z39.0, Z39.1 or 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 ID number.

## ***Doula Services***

MHCP members are eligible for doula services. Services must be provided by a certified provider per guidelines from the [DHS MCHP Provider Manual](#). Limits apply.

- All non-labor and non-delivery sessions must be billed with S9445 and the U4 modifier (limited to six sessions).
- Bill the labor and delivery session with 99199 and the U4 modifier (limited to one session).

## ***Maternity 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 number of units when billing for more than one of these services on the same date of service.

## *Description of Enhanced Services*

- At-Risk Antepartum Management
  - Primary care provider (MD/CNM) will be eligible for a reimbursement if the pregnant member is determined to be at-risk.
- Care Coordination
  - Includes development, implementation and ongoing evaluation of a plan of care for the at-risk pregnant member.
- 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.
- Prenatal Health Education II
  - Supplements Prenatal Health Education I for members 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.
- 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, Second Harvest Heartland and Supplemental Nutrition Assistance Program (SNAP).
- Postpartum Follow-up Home Visit
  - A home visit that is to be made within the first two weeks of the member'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.
- Enhanced Package
  - All the above prenatal care services are provided.

## **Rewards, Incentives and Resources**

UCare's Management of Maternity Services (MOMS) booklet is available in English and Spanish (online only).

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.

## *UCare Medicare Members*

### **UCare Medicare, UCare Nurseline**

1-888-778-8204 toll-free

TTY: 1-855-307-6976 toll-free

### **UCare Medicare with M Health Fairview & North Memorial Health**

1-888-618-2595 toll-free

TTY: 1-800-688-2534 toll-free

### **EssentiaCare**

1-855-432-7025 toll-free

TTY: 1-800-688-2534 toll-free

## *UCare Individual & Family Plans*

### **UCare Individual & Family Plans**

1-888-778-8204 toll-free

TTY: 1-855-307-6976 toll-free

### **UCare Individual & Family Plans with M Health Fairview**

1-877-903-0069 toll-free

TTY: 1-800-688-2534 toll-free

## *Minnesota Health Care Programs*

### **Prepaid Medical Assistance Program, MinnesotaCare, Minnesota Senior Care Plus, UCare Connect, UCare Connect + Medicare and UCare's Minnesota Senior Health Options**

1-800-942-7858 toll-free

TTY: 1-855-307-6976 toll-free

Additionally, the UCare Maternal & Child Health Program Line is available to pregnant members and caregivers. Members can work with a Care Management Registered Nurse who can offer support, answer questions and connect to UCare and/or community resources, as needed. There is no charge for use of this service. The Maternal & Child Health Program Line is available for non-urgent calls and can be reached at 612-676-3326 or 1-855-260-9708 toll-free, Monday through Friday 9 am-5 pm.

# Contacts

## *Mental Health and Substance Use Disorders*

612-676-6533

1-833-276-1185 toll-free

## *Clinical Services*

612-676-6705

1-877-447-4384 toll-free

## *24-hour Nurse Advice Line*

1-800-942-7858 toll-free

## *UCare Maternal & Child Health Program Line*

612-676-3326

1-855-260-9708 toll-free, Monday through Friday, from 9 am-5 pm

# Public Health

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Local public health agencies provide a range of services for UCare members and the community at large. According to the [American Public Health Association](#) “Public health promotes and protects the health of people and the communities where they live, learn, work and play.”

This section is for both referring providers and local public health providers.

## Information for Referring Providers

UCare does not require a provider referral to any of the services below. To connect a member to public health services, providers should contact the local county public health agency. Contact information is available on the [Minnesota Department of Health](#) website.

Providers can connect UCare members with local public health agencies for the following services:

### *Family Home Visiting*

Public health agencies offer family home visiting prenatally through the first few years of childhood to provide social, emotional, physical and parenting support to families. There are several models of family home visiting, including culturally specific models. Learn more about [Family Home Visiting](#).

UCare does not require authorization for, nor limit, the number of public health family home visits provided to meet a member’s identified needs.

Contact your [county public health agency](#) to make a referral.

See [UCare’s Management of Maternity Services \(MOMS\) Program](#) page for more information on supports for pregnant and parenting members.

### *Child and Teen Checkups (C&TC)*

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 Health C&TC website](#)). See the [Child & Teen Checkups section](#) for more information if you are a C&TC provider.

C&TC visits are a covered benefit for all eligible UCare members. There is no copay or charge for these visits.

Local public health agencies conduct outreach to certain Prepaid Medical Assistance Program (PMAP), UCare Connect and UCare Connect + Medicare members via phone and mail who are due for a C&TC visit. Staff assist with arranging C&TC visits, transportation, interpreters and follow-up care. Children that are attributed by the Department of Human Services to an [Integrated Health Partnership \(IHP\)](#) are assigned to the IHP for outreach. Agencies also conduct C&TC provider trainings on recent periodicity changes and screening components. [Contact your local C&TC Coordinator](#) to learn more about how counties support C&TC.

## *Tuberculosis (TB) Case Management and Directly Observed Therapy*

TB case management services are covered if provided by a certified public health nurse employed by a community health board. For additional information about reporting TB to MDH and other TB procedures, [visit MDH TB Information for Health Professionals](#).

## *Vaccines For Children Program*

The [Minnesota Vaccines for Children \(MnVFC\) program](#) is an enhanced version of the federally funded Vaccines for Children (VFC) program. The program's goal is to ensure accessible and affordable vaccines for all children within their medical homes.

## *Enhanced Asthma Care Services for Children*

UCare Minnesota Health Care Program members under the age of 21 for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members under the age of 19 with poorly controlled asthma are eligible for home assessments and certain allergen-reducing products. A home assessment is not required for a provider to order supplies as long as there is documentation of medical necessity for product use kept in the member's record.

A child is defined as having poorly controlled asthma when they have received emergency care services or hospitalization for the treatment of asthma within the past year and they have received a referral and standing orders from a qualified provider. Asthma services must be referred and ordered by one of the following MHCP-enrolled providers:

- Physician
- Physician Assistant
- Advanced Practice Nurse

Contact your [local public health agency](#) to make a referral.

## **For Local Public Health Providers**

### *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.
- **UCare does not require authorization for health promotion or public health counseling services.**

**Medication Management:** Review of current medications and adherence to the prescribed medication regimen. 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. This 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.

UCare covers both evidenced-based home visiting and universal home visiting models as approved by DHS and MDH. UCare does not require authorization for nor limit the number of public health nurse home visits provided to meet a member's identified needs.

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 screening services

## Enhanced Asthma Care Services and Allergen-reducing Products for Children

UCare covers enhanced asthma care services and allergen-reducing supplies per the Minnesota Health Care Program (MHCP) manual. See the [Physician's Services](#) section of the MHCP manual: [Enhanced Asthma Care Services](#) for more detail.

UCare Minnesota Health Care Program members under the age of 21 for Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members under the age of 19 with poorly controlled asthma are eligible for home assessments and certain allergen-reducing products. A home assessment is not required for a provider to order supplies as long as there is documentation of medical necessity for product use kept in the member's record.

A child is defined as having poorly controlled asthma when they have received emergency care services or hospitalization for the treatment of asthma within the past year and they have received a referral and standing orders from a qualified provider. Asthma services must be referred and ordered by one of the following MHCP-enrolled providers:

- Physician
- Physician Assistant
- Advanced Practice Nurse

Home assessment must be provided by the following credentialed local public health workers:

- Healthy homes specialist defined and credentialed as a [Healthy Home Evaluator](#) by the Building Performance Institute
- [Lead Risk Assessor](#) as credentialed and defined by the Minnesota Department of Health
- [Registered Environmental Health Specialist](#) as defined and credentialed by the Minnesota Department of Health

Local public health agencies are eligible providers for providing allergen-reducing products for children with poorly controlled asthma. See the MHCP Provider Manual [Equipment and Supplies: Allergen Reducing Products for Children](#) section for more detail about covered products.

## *Fluoride Varnish Application (FVA)*

UCare reimburses primary care clinics and county public health agencies for [fluoride varnish](#).

## *Child and Teen Check Ups (C&TC)*

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 Health C&TC website](#)). See the [Child & Teen Checkups section](#) for more information if you are a C&TC provider.

C&TC visits are a covered benefit for all eligible UCare members. There is no copay or charge for these visits, and transportation to C&TC visits and follow up care is covered for PMAP, UCare Connect, UCare Connect + Medicare and MinnesotaCare children (up to age 19).

Resources for county C&TC staff:

- **Interpreter Services:** UCare provides interpreters for non-English speaking members enrolled in our MHCP products. Learn more about [UCare's Interpreter Services](#).
- **Health Promotion Programs:** UCare is committed to helping keep our members healthy and safe. Learn more about the [health promotion programs and resources](#) available to eligible UCare members.
- **Transportation:** To assist in arranging transportation for eligible members, call 1-800-864-2157 toll-free to request a bus pass or schedule a ride. Health Ride is open 7 am - 8 pm, Monday - Friday. Visit [Health Ride](#) or see the [Transportation Services section](#) of this manual for more information.



## *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).

## *Communication Between Public Health Agencies and Primary Care Providers (PCP)*

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.

## **Tips for Public Health Providers**

### *Convenient Way for Providers to View Claims*

UCare wants to remind providers that you can review submitted claims information via the [UCare Provider Portal](#).

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](#) to receive UCare's *Health Lines* provider newsletter.
- Read the latest [News for Providers](#).
- Visit the [UCare County Partners page](#) for the latest news and updates from the UCare County Team.

- Counties can contact the County Team Representative assigned to your county (see the County Team Coverage Map on the [County Partners](#) page), or email [UCareCountyRelations@ucare.org](mailto:UCareCountyRelations@ucare.org).
- Community Relations: Are you interested in having UCare involved in an event in your community? Contact us at [mgossett@ucare.org](mailto:mgossett@ucare.org).
- 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](#) webpage for more information.

# Transportation

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## External Resources and Links

[Minnesota Statutes, section 256B.0625, subd. 17 and subd. 18h \(Medicaid Covered Services; NEMT\)](#)  
[Minnesota Statutes, section 174.29 \(Coordination of Special Transportation Service\)](#)  
[Minnesota Statutes, section 174.30 \(Operating Standards for Special Transportation Service\)](#)  
[Minnesota Rules, Chapter 8840 \(Transportation Operating Standards\)](#)  
[Minnesota Department of Transportation \(MnDOT\) Special Transportation Services Page](#)  
[DHS Provider Manual, Nonemergency Medical Transportation \(NEMT\) Services](#)  
[DHS Provider Manual, Elderly Waiver Transportation Services](#)  
[DHS Managed Care Contracts](#)

## Definitions

Below are the terms and 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 Services definition. 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, taxicab 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

**Driver:** An employee or independent contractor of a transportation provider who transports members in special transportation service vehicles.

**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 medical transport contract.

**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 for UCare members who qualify for this level of service that are provided by an Ambulance Transportation provider approved by UCare. 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):** Same definition as provided in Minnesota Statutes § 256B.0625, subd. 17: "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services. Minnesota Statute § 256B.0625, subd. 17 requires that all NEMT providers must comply with the operating standards for special transportation service in Minnesota Statutes §§ 174.29 to 174.30 and Minnesota Rules Chapter 8840.

**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 of the following criteria:

- 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.
- 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):** Same definition as Minnesota Statutes § 174.29 and Minnesota Administrative Rule 8840.5100, Subpart 17. 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.

# Transportation Benefits by Type of Enrollee Coverage

There are seven Modes of NEMT:

- Mode 1: Client Reimbursement (This mode is covered through the county)
- 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.”

|  | Ambulance Transportation | Unassisted Transportation (Modes 1-3) | Assisted Transportation (Modes 4-7) | Extended Transportation (Waiver Services) | Supplemental Benefits Transportation |
|--|--------------------------|---------------------------------------|-------------------------------------|---|--------------------------------------|
| <b>Prepaid Medical Assistance Program (PMAP)</b> | Covered                  | Covered                               | Covered                             | Not covered                               | Not covered                          |
| <b>MinnesotaCare</b>                             | Covered                  | Limited coverage*                     | Limited coverage*                   | Not covered                               | Not covered                          |
| <b>Minnesota Senior Care Plus (MSC+)</b>         | Covered                  | Covered                               | Covered                             | Covered for members with EW               | Not covered                          |

|   | Ambulance<br>Transportation | Unassisted<br>Transportation<br>(Modes 1-3) | Assisted<br>Transportation<br>(Modes 4-7) | Extended<br>Transportation<br>(Waiver<br>Services)                 | Supplemental<br>Benefits<br>Transportation  |
|---|-----------------------------|---|---|--|---|
| <b>UCare's<br/>Minnesota<br/>Senior Health<br/>Options<br/>(MSHO)</b> | Covered                     | Covered                                     | Covered                                   | Covered for<br>members with<br>EW                                  | Three<br>rides/week to<br>covered fitness,<br>Juniper classes<br>(all modes), one<br>ride/day to AA or<br>NA meetings for<br>members with<br>SUD (all modes),<br>one ride/week to<br>participating<br>Health Food<br>Allowance<br>grocery store<br>sites for<br>members with<br>qualifying<br>condition(s)<br>(congestive heart<br>failure, diabetes,<br>hypertension, or<br>ischemic heart<br>disease).*** |
| <b>UCare Connect<br/>(SNBC)</b>                                       | Covered                     | Covered                                     | Covered                                   | Covered by<br>county for<br>members with<br>disability<br>waiver** |   |

|   | Ambulance Transportation | Unassisted Transportation (Modes 1-3) | Assisted Transportation (Modes 4-7) | Extended Transportation (Waiver Services)              | Supplemental Benefits Transportation  |
|---|--------------------------|---------------------------------------|-------------------------------------|--|---|
| <b>UCare Connect + Medicare (HMO D-SNP)</b>   | Covered                  | Covered                               | Covered                             | Covered by county for members with disability waiver** | Three rides/week to covered fitness, Juniper classes (all modes), one ride/day to AA or NA meetings for members with SUD (all modes), one ride/week to participating Health Food Allowance grocery store sites for members with qualifying condition(s) (congestive heart failure, diabetes, hypertension, or ischemic heart disease).*** |
| <b>UCare Medicare Plans</b>   | Covered                  | Not covered                           | Not covered                         | Not covered  | Not covered   |
| <b>UCare Advocate Choice and UCare Advocate Plus (I-SNP)</b>  | Covered                  | Not covered                           | Not covered                         | Not covered  | 16 one-way rides per year, all modes covered - through UCare Mastercard   |
| <b>UCare Individual &amp; Family Plans and UCare Individual &amp; Family Plans with M Health Fairview</b> | Covered                  | Not covered                           | Not covered                         | Not covered  | Not covered   |

\*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.

\*\*\*Effective January 1, 2024: Added coverage for qualifying members by plan for Nonemergency Medical Transportation (NEMT) rides to and from the grocery store.

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.

All MHCP plans: Effective August 1, 2023, UCare covers rides to MNSure Navigator Organizations and County or Tribal Agencies within 90 days of member's renewal date.

## Section One: Assignment Requirements and Process

The following are requirements and expectations for transportation providers regarding UCare's transportation assignment process. Failure to follow them is a breach of the UCare participating agreement and may result in corrective action, up to and including termination of the UCare contract.

UCare's HealthRide department uses a transportation software called ORyde to manage the assignment of rides to transportation providers.

- Contracted agency's designated QRyde administrator requiring access to ORyde must submit an access request form to UCare. To receive assistance on submitting this form, email the HealthRide department at [health\\_ride@ucare.org](mailto:health_ride@ucare.org).
- If a contracted agency's users experience issues with access or when using ORyde that cannot be resolved by reading the ORyde User Guide, they may receive assistance by contacting the HealthRide department at 612-676-6878 or 1-833-276-1183 toll-free. If the issue is not urgent, they may email the HealthRide department at [health\\_ride@ucare.org](mailto:health_ride@ucare.org). Billing and Claims questions should be directed to UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free.
- If a contracted agency needs to update their daily ride capacity, they must submit a capacity update form to UCare. To receive assistance on submitting this form, email the HealthRide department at [health\\_ride@ucare.org](mailto:health_ride@ucare.org).

### Common Carrier Ride Assignment Information

- All common carrier transportation services, NEMT Modes 2-3, must be coordinated and arranged by UCare's HealthRide department before the service is rendered. Providers and/or drivers are prohibited from contacting UCare on behalf of the member to schedule transportation. UCare's HealthRide department will not provide retroactive assignment for services.



- UCare's HealthRide department will assign each ride within ORyde. Providers are required to login and review ride assignments daily. HealthRide staff will book all same day rides over the phone by calling the provider dispatching office. The ride assignment notifications will include the following information:
  - Mode
  - Mobility aids (if any)
  - Disability (if any)
  - Member identification number
  - Member name
  - Number of passengers (if any)
  - Vehicle type exclusions (if any)
  - Appointment type
  - Phone number
  - Site name (origin)
  - Origin address
  - Origin Lat (Latitude) and Lon (Longitude)
  - Site name (Destination)
  - Destination address
  - Destination Lat and Lon
  - Direct distance
  - Date of service
  - Time of pickup
  - Appointment time
  - Phone number of the requestor (if different from the member)
  - QRyde Booking ID (assignment number)
  - Any other information the transportation provider will need

#### Special Transportation Services (STS) Ride Assignment Information

- To obtain a UCare Ride Assignment and CON Authorization Number for STS, the authorized STS provider representative may contact UCare's HealthRide department by emailing [stscon@ucare.org](mailto:stscon@ucare.org) or calling 612-676-6830 or 1-800-864-2157 toll-free. Ride assignments are sent to providers to confirm the ride and they contain the required assignment numbers only if the member has a valid CON on file with UCare.
- The STS Ride Notification template is found on the [Policies & Resources webpage](#), under Transportation Provider Resources. Provider must include:
  - Transportation provider
  - Member identification number
  - Member first and last name
  - Date of service
  - Mode of transportation
  - Pickup time
  - Appointment time
  - Appointment type
  - Origin address
  - Destination address
  - CON number

- Transportation companies providing NEMT Modes 4-7 may work directly with UCare members, UCare Customer Service, nursing homes, UCare's HealthRide department, primary care clinics, hospitals or UCare Clinical Services staff. Providers **are still** required to obtain ride assignments and CON authorization numbers to receive payment from UCare for NEMT Modes 4-7.
- 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 HealthRide department to initiate the authorization process. UCare will provide a CON authorization number for each member who qualifies for NEMT Modes 4-7.
- Transportation companies providing NEMT Mode 6: Protected Transport will follow the requirements for ride assignments as outlined in this section as well as proving UCare with the required Level of Service Assessment (LOS) that is required for all Protected Transportation.
- **Pre-Service (ride) Request Requirements:** Providers are required to obtain a copy of the LOS completed by a qualifying treating healthcare provider and submit the copy to UCare's HealthRide Team for approval. Provider will send via email the LOS assessment to UCare's HealthRide Team for approval. If approved, UCare's HealthRide Team will email back an approval and booking ID notifying the provider they have been approved to provide Protected Transport to UCare's member. If denied, communication will be sent back to the provider from UCare's HealthRide team notifying them their ride request was denied.
- **Post Service Ride Requirements:** Providers are required to obtain a copy of the LOS completed by a qualifying treating healthcare provider and submit the copy to UCare for approval. When emailing UCare's HealthRide team for an authorization code/ride assignment post service/ride, Provider must also send a copy of the LOS with the ride assignment request. If approved, UCare's HealthRide Team will email back an approval and booking ID notifying the provider they have been approved to provide Protected Transport to UCare's member. If denied, communication will be sent back to the provider from UCare's HealthRide team notifying the provider their ride request was denied.

Providers should report emergency room, hospital discharge, skilled nursing facility (SNF) appointments, same day or urgent appointments to UCare's HealthRide department within 72 hours of the provided ride. All other rides should be reported to UCare's HealthRide department at least 48 hours before the member's appointment.

- 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.
- 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 Two: Transportation Provider Requirements

Minnesota Statute § 256B.0625, subd. 17 requires that all NEMT providers must comply with the operating standards for special transportation service in Minnesota Statutes §§ 174.29 to 174.30 and Minnesota Rules Chapter 8840.

In addition to the above requirements in law, the following are service expectations and requirements for transportation providers in UCare's network. Failure to follow the service expectations and requirements is a breach of the UCare participation agreement and may result in corrective actions, up to and including termination of the UCare contract.

#### A. Exclusion Searches

- Transportation providers must check each driver's status using the Office of Inspector General Exclusion (OIG) at <https://exclusions.oig.hhs.gov/> on the following schedule:
  - **Time of hire** - This documentation must be kept in the individual driver's file in a hard copy format, prior to starting assigned rides.
  - **Monthly basis** - These monthly checks may be maintained either as above or in an electronic exclusion report file for the entirety of the driver's affiliation with the company. 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 who performed the review.
  - **Annual basis** - This search documentation must be in hard copy format and saved in the individual provider's file for the entirety of the driver's affiliation with the company.
- Transportation providers must check each driver's status using the System of Award Management (SAM) available at <https://www.sam.gov/> at the following schedule:
  - **Time of hire** - This documentation must be kept in the individual driver's file in a hard copy format, prior to starting assigned rides.
  - **Monthly basis** - These monthly checks may be maintained either as above or in an electronic exclusion report file for the entirety of the driver's affiliation with the 2023 UCare Provider Manual 31-9 company. 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 who performed the review.
  - **Annual basis** - This search documentation must be in hard copy format and saved in the individual provider's file for the entirety of the driver's affiliation with the company.

#### B. Policies and Procedures

- Transportation providers must have established policies and/or procedures, which are documented in a format that may be readily available to a UCare representative upon request. All staff, drivers, contractors and management must be aware of and knowledgeable about these policies and/or procedures and must be able to demonstrate how 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

### **C. Documentation & Records**

- Transportation providers must maintain documentation and records as specified under Minnesota Statutes § 256B.0625, subdivision 17 and Minnesota Rule Chapter 8840. Transportation providers must disclose to UCare any documentation and records required to be maintained by Chapter 8840 in response to an audit or investigation related to the transportation provider's services. Such documentation and records may include:
  - W-9
  - Automobile Insurance Certificate(s)\*
  - General Liability Insurance Certificate\*
  - Current Vehicle Roster\* and records of vehicle standards
  - Current Driver Roster\* and records of driver and attendant qualifications
  - Trip log documentation (e.g., driver dispatch records, drive manifests, driver assignments, all documentation as required by Minn. Stat. § 256B.0625, subd. 17b)
  - Complaint records
  - Accident/Incident records
  - Special Transportation Certificate (STS) or MnDOT Certifications\*
  - Driver Files and attendant training records\*
    - Signature logs of annual fraud, waste and abuse training
    - Copy of driver's license
    - Completed application and/or resume for staff
    - If applicable, signed contract or lease agreement
    - Special Transportation Driver Qualification Checklist
    - Copy of ID Badge
    - Tracking and auditing performance standards
    - Copy of background study clearance letter

- If applicable, copies of UCare members' Special Transportation Certificate of Need forms\*

*\*County and volunteer providers may be exempt from this specific requirement.*

#### **D. Restrictions Regarding Subcontractors and Marketing**

- 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.
- The use of the UCare name or logo in any marketing efforts by the provider is strictly prohibited without prior approval from UCare.

#### **E. UCare's Scheduling Software**

- Transportation providers must login to UCare's HealthRide Scheduling Software (QRyde) to review ride assignments daily.
- Transportation providers are responsible for managing provider user access to QRyde. Unauthorized access requests are subject to review by UCare.

#### **F. Transportation Requirements**

- 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.
- Transportation providers must take members to the health care provider using the most direct route and only to the location(s) listed on the HealthRide assignment. Transportation providers must refer members back to UCare if they need to be taken to a location different than what has been assigned.
- Transportation providers need to carefully manage pickup times to ensure that passengers arrive at least 10 minutes before the appointment time.
- Drivers must wait 10 minutes past their scheduled arrival time and make an attempt to contact the member prior to leaving.
- Transportation providers who are unable to provide a ride to a UCare member must contact UCare's HealthRide 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.
- The office staff of the transportation company must coordinate the dispatch of 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 can call for their return ride. Companies smaller than four drivers and volunteer driver agencies are exempt from this guideline.
- Drivers are prohibited from working directly with interpreters and/or UCare members to arrange transportation.
- 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 HealthRide Department to coordinate alternative transportation for the member.
- 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.*

- 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.
- A driver cannot also be the member's Personal Care Assistant (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/gatewayweb/login>
    - (Click on Provider lists – Individual PCAs)
  - Interpreters: <https://pgc.health.state.mn.us/hci/searchInterpreter.jsp>
- 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.
- 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.
- 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 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. 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.*

#### **G. Transportation Provider Responsibilities**

- 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.
- Transportation providers are required to complete and return a HealthRide Provider Profile Form, found on the [Policies & Resources page](#), under Transportation Providers Resources. Any changes to the information included on the HealthRide 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](mailto:Trans-Prov@ucare.org).
- Service area updates and/or changes made on the HealthRide 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 response will be provided upon determination.
- All providers are subject to post-payment claim audits and must fully cooperate with UCare requests.
- 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](mailto:Trans-Prov@ucare.org).

Please complete and maintain the Excel file, per the instructions in the file. It must be in an Excel format.

- The Driver and Vehicle Roster File is found on the [Policies & Resources page](#), under Transportation Provider Resources. Click the link above to download the report, then open the Excel document. You can save a copy to your own computer for your use.
- 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 who have been terminated. Changes 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.
- 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.
- 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.
- Transportation providers must conduct federal and state exclusion screening on drivers as required. All drivers must be individually enrolled with DHS and reported on a claim as the individual who provided the NEMT service as required by Minnesota Statutes § 256B.0625 subd. 17.

#### **H. Unaccompanied Minors**

- Transportation providers must obtain written parental consent prior to allowing any minor less than 18 years of age to be transported without being accompanied by a parent or legal guardian.
- Transportation providers must obtain an authorized person's signature on their trip log upon drop off location(s) when dropping off an unaccompanied minor.
- Transportation provider must notify and coordinate with UCare if any parental consent is received for an unaccompanied minor less than five years old to determine appropriateness and necessity of such minors being unaccompanied by a parent or legal guardian for transportation services.
- If the signed authorization does not specify a shorter timeframe, the signed authorization is valid for no more than one-year from the date of signature.
- Minors receiving family planning services may not require parental consent for the unaccompanied minor transport; transportation provider must contact UCare with any questions on whether this exception applies.
- Transportation drivers are required to obtain the signature of an authorized adult on the trip log when dropping an unaccompanied minor off at their destination.
- Transportation providers 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.



## I. Multiple Riders

- Transportation providers may, but are 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.
  - 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 who rides in the vehicle.
  - For members who may be picked up at any time during the trip, the provider may only bill for the pick-up and/or drop-off charges.

## Section Three: Fraud, Waste and Abuse Requirements

Transportation providers are responsible for ensuring its compliance with fraud, waste and abuse (FWA) requirements and all applicable laws and regulations. Regardless of criminal or regulatory action, UCare may implement corrective action plans or terminate the provider agreement if transportation providers and/or its drivers have engaged in prohibited activities such as, but not limited to, attempts to steer UCare members to particular medical, mental health or other providers, or directly market to or pressure UCare members to use transportation services.

Transportation providers and drivers should not submit claims for the following transportation services:

- Rides you did not provide.
- Rides to services not covered by UCare (such as social worker visits or grocery shopping).
- Mileage submission that is more than the actual miles of the trip.
- Mileage for each rider when there are multiple riders on the trip.
- Any service if you do not have a required HealthRide assignment, certificate of need and supporting documentation such as trip logs and special transportation forms.
- Any service if your HealthRide 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.

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. **You should contact UCare immediately at 1-877-826-6847 toll-free.**

Transportation providers shall conduct a thorough internal investigation and take appropriate remedial action upon notice from UCare regarding suspected FWA or safety concerns. 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.

Providers must fully cooperate with any UCare investigation.

## Section Four: Billing and Claim Requirements

See the [Claims section](#) for general claim submission guidelines. The following is **not** billable to UCare:

- "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.

The below information is needed to properly bill UCare for transportation services.

- **Provider Identification:** Beginning with services rendered on or after Jan. 1, 2022, all providers must bill using either their NPI or UMPI. If your agency is contracted for both special transportation (NEMT Modes 4-7) and common carrier transportation services (NEMT Modes 23), you will need to include the appropriate billing taxonomy to drive the proper payment. The taxonomy for Common Carrier is 344600000X, and the taxonomy for Special Transportation is 343900000X.
  - **Note:** If you do not know which billing ID UCare is expecting (NPI or UMPI), please contact our Provider Assistance Center at 612-676-3300 or 1-888-531-1493.

| Type of Billing ID | Loop/Segment                               | Place on Claim Image |
|--------------------|--|----------------------|
| If billing NPI     | Loop 2010AA<br>NM109                       | Box 33a              |
| If billing UMPI    | Loop 2010BB<br>REF 01 - G2<br>REF02 - UMPI | Box 33b              |

| Taxonomy Type    | 837P Loop Professional  | Place on Claim Image   |
|------------------|---|--|
| Billing Provider | 2000A - Billing Provider<br>Specialty Information<br>PRV01 - BI for billing provider<br>PRV02 - PXC<br>(Health Care Provider<br>Taxonomy)<br>PRV03 - Taxonomy Number<br><br>If CC - enter 344600000X<br>If STS - enter 343900000X | CMS - 1500<br><br>Box 33b - with ZZ indicator<br><br>Double entry in box 33b may not be allowed on electronic claim submissions. You will need to contact your clearinghouse to add the taxonomy to the loop.<br>If CC - enter 344600000X<br>If STS - enter 343900000X<br><br>UB04<br>Box: 81CC, Box a<br>First Box - Qualifier B3<br>Second box over - taxonomy |

- **Place of Service Code:** Always use code 99 for the place of service code for Transportation Services.
- **Diagnosis Code:** Always use either Z00.8 or Z02.89 as the diagnosis code for Transportation Services.
- **Ride Assignment Numbers:** Claims that do not contain this information are subject to deny.
  - UCare HealthRide (Booking ID) ride assignment number(s) are required for ALL claims.
  - **Note:** QRyde assigns a Booking ID to each leg of a round trip. The loop and segment listed below is mapped to a raw data field that does not apply by line item. When entering the booking ID in this loop and segment, submit the Booking ID for the initial leg of an itinerary.

| Loop/Segment | What to Enter | Place on Claim Image |
|--------------|---------------|----------------------|
| 2400 - NTE01 | ADD           | N/A - in raw data    |
| 2400 - NTE02 | Booking ID#   | N/A - in raw data    |

- A Certificate of Need (CON #) authorization number is required for STS, NEMT Modes 47 claims only.

| Loop/Segment | What to Enter | Place on Claim Image |
|--------------|---------------|----------------------|
| 2300 - Ref01 | G1            | N/A - in raw data    |
| 2300 - Ref02 | CON #         | Box 23               |

- **Standard Transportation Procedure Codes:** Your contract determines which codes are approved and applicable.

| NEMT Level     | Service  | Service Codes |          |         |          |
|----------------|--|---------------|----------|---------|----------|
| Not applicable | City bus service                               | Pick up       | A0110    |         |          |
| Not applicable | County bus service                             | Pick up       | A0120    |         |          |
| NEMT Mode 2    | Volunteer services                             | Pick up       | T2003    | Mileage | A0080    |
| NEMT Mode 3    | Employed common carrier (unassisted transport) | Pick up       | T2003    | Mileage | S0215    |
| NEMT Mode 4    | Assisted transport                             | Pick up       | T2003    | Mileage | S0215    |
| NEMT Mode 5    | Wheelchair                                     | Pick up       | A0130    | Mileage | S0209    |
| NEMT Mode 6    | Protected transport                            | Pick up       | T2003 UA | Mileage | S0215 UA |
| NEMT Mode 7    | Stretcher                                      | Pick up       | T2005    | Mileage | T2049    |

- **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 the following:
  - “P” for the medical appointment
  - “R” for the residential location
  - “D” or “P” for Pharmacy runs
- Each leg (line of claim) gets two modifiers.
- When authorization is received and billing unloaded (dead) miles, you must submit with the TP modifier. Unloaded (dead) miles pay at a reduced rate.

| Origin/Destination Modifier | Description<br>(for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination) |
|-----------------------------|--|
| D -                         | Diagnostic or therapeutic site other than ‘P’ or ‘H.’ This includes dental appointments, chiropractic services and childbirth or pregnancy education classes |
| E -                         | Residential, domiciliary, custodial facility (other than a SNF)  |
| G -                         | Hospital based ESRD facility (Dialysis)  |
| H -                         | Hospital emergencies or hospital discharges  |
| J -                         | Freestanding ESRD facility (Dialysis)  |
| N -                         | Skilled nursing facility (SNF)   |
| P -                         | Physician’s office or medical appointment  |
| R -                         | Residential address  |

|      |  |
|------|--|
| X -  | Intermediate stop at physician's office en route to the hospital (destination code only) |
| 76 - | Repeat procedure by same provider  |
| 77 - | Repeat procedure by another provider   |
| TP - | Unloaded (dead) miles  |

## EXAMPLES SHOWING THE BOTTOM OF A TRANSPORTION CLAIM

### Ambulatory Round Trip

| MM | DD | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |  |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|----|----|----|----|----|------------------|-----------|-----------|--|--|--|------------------|---------------|----|-----------------------|
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | T2003     | RP        |  |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0215     | RP        |  |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | T2003     | PR        |  |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0215     | PR        |  |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |

### Wheelchair Round Trip

| MM | DD | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |  |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|----|----|----|----|----|------------------|-----------|-----------|--|--|--|------------------|---------------|----|-----------------------|
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | RP        |  |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | RP        |  |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | PR        |  |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | PR        |  |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |

### Ambulatory 3 Leg Trip (Pharmacy Run)

| MM | DD | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |    |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|----|----|----|----|----|------------------|-----------|-----------|----|--|--|------------------|---------------|----|-----------------------|
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | T2003     | RP        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0215     | RP        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | T2003     | PR        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0215     | PR        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | T2003     | RD        | 76 |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0215     | RD        | 76 |  |  | \$\$\$\$\$\$     | 5             | G2 | XXXXXX                |

### Wheelchair 3 Leg Trip (Pharmacy Run)

| MM | D D | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |    |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|-----|----|----|----|----|------------------|-----------|-----------|----|--|--|------------------|---------------|----|-----------------------|
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | A0130     | RP        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0209     | RP        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | A0130     | PR        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0209     | PR        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | A0130     | RD        | 76 |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0209     | RD        | 76 |  |  | \$\$\$\$\$\$     | 5             | G2 | XXXXXX                |

### Ambulatory 2 Round Trips on Same Day

| MM | D D | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |    |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|-----|----|----|----|----|------------------|-----------|-----------|----|--|--|------------------|---------------|----|-----------------------|
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | T2003     | RP        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0215     | RP        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | T2003     | PR        |    |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0215     | PR        |    |  |  | \$\$\$\$\$\$     | 15            | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | T2003     | RP        | 76 |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0215     | RP        | 76 |  |  | \$\$\$\$\$\$     | 5             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | T2003     | PR        | 76 |  |  | \$\$\$\$\$\$     | 1             | G2 | XXXXXX                |
| 1  | 1   | 15 | 1  | 1  | 15 | 99               | S0215     | PR        | 76 |  |  | \$\$\$\$\$\$     | 5             | G2 | XXXXXX                |

## Wheelchair 2 Round Trips on Same Day

| MM | DD | YY | MM | DD | YY | Place of Service | CPT/ HCPC | Modifiers |    |  |  | Total \$ Charges | Units (Miles) | ID | Rendering Provider ID |
|----|----|----|----|----|----|------------------|-----------|-----------|----|--|--|------------------|---------------|----|-----------------------|
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | RP        |    |  |  | \$\$\$\$\$       | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | RP        |    |  |  | \$\$\$\$\$       | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | PR        |    |  |  | \$\$\$\$\$       | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | PR        |    |  |  | \$\$\$\$\$       | 15            | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | RP        | 76 |  |  | \$\$\$\$\$       | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | RP        | 76 |  |  | \$\$\$\$\$       | 5             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | A0130     | PR        | 76 |  |  | \$\$\$\$\$       | 1             | G2 | XXXXXX                |
| 1  | 1  | 15 | 1  | 1  | 15 | 99               | S0209     | PR        | 76 |  |  | \$\$\$\$\$       | 5             | G2 | XXXXXX                |

# Appendix A: Provider Manual Updates

## May 5, 2023 Update

| Page                 | Chapter   | Topic Changes   | Type of Change (s) |     |           |       |
|----------------------|---|---|--------------------|-----|-----------|-------|
|                      |   |   | Update             | New | Deletions | Other |
| <a href="#">2-2</a>  | Provider Assistance   | Under On-site or Virtual Provider Training and Education, removed one UCare Field Representative.   |                    |     | X         |       |
| <a href="#">3-5</a>  | Working with UCare's Delegated Business Services                | Under Dental Services, updated contact information for Delta Dental.  | X                  |     |           |       |
| <a href="#">5-3</a>  | Provider Responsibilities                                       | Updated text within the Model of Care Training section.   | X                  |     |           |       |
| <a href="#">7-1</a>  | Restricted Recipient/Restricted Member Program                  | Updated text within the Minnesota Health Care Program Products, Program Management and Provider Involvement sections.   | X                  |     | X         |       |
| <a href="#">10-1</a> | Electronic Data Interchange (EDI)                               | Updated URLs within the Electronic Claims Submission (837) Payer ID List, Taxonomy Code Requirements and the X12 link.  | X                  |     |           |       |
| <a href="#">12-1</a> | Medical Necessity Criteria for Services Requiring Authorization | Updated text within the Overview of Medical Necessity for Medical, Mental Health and Substance Use Disorder Services section.   | X                  |     |           |       |
| <a href="#">13-5</a> | Member Appeals and Grievances                                   | Added standard reconsideration guidance text within the Required Resolution Timeframe and How the Resolution is Communicated with the Member section, for UCare Medicare Plans, Minnesota Senior Health Options and UCare Connect + Medicare. |                    | X   |           |       |

| Page                 | Chapter  | Topic Changes  | Type of Change (s) |     |           |       |
|----------------------|--|--|--------------------|-----|-----------|-------|
|                      |  |  | Update             | New | Deletions | Other |
| <a href="#">19-1</a> | Medication Therapy Management (MTM) Program  | Added notes regarding Medicare eligibility and Continuity of Care document records.  |                    | X   |           |       |
| <a href="#">21-3</a> | Mental Health and Substance Use Disorder Services  | Updated text within the Substance Use Disorder Treatment with Medication for Opioid Use Disorder (SUD-MOUD) section.   | X                  |     |           |       |
| <a href="#">24-1</a> | UCare's Federally Qualified Health Center (FQHC) – Rural Health Clinic (RHC) Payment Carve-Out Process | Updated text within the Notes section of the services billed by FQHCs and RHCs.  |                    |     | X         |       |
| <a href="#">27-5</a> | Hospital Services  | Updated the Care Transitions section.  | X                  |     |           |       |
| <a href="#">30-4</a> | Maternity, Obstetrics and Gynecology   | Renamed the Management of Maternity Services (MOMS) program to UCare's Maternal Child Health Program and updated the focus areas, services, processes, breast pump coverage information and renamed the Pregnancy Advisor Nurse Line to UCare Maternal & Child Health Program. | X                  |     |           |       |



## August 7, 2023 Update

| Page                | Chapter  | Topic Changes   | Type of Change (s) |     |           |       |
|---------------------|--|---|--------------------|-----|-----------|-------|
|                     |  |   | Update             | New | Deletions | Other |
| <a href="#">1-1</a> | Introduction to UCare                          | Moved the contents of the UCare Nondiscrimination Policy chapter to this chapter.   | X                  |     |           |       |
| <a href="#">2-1</a> | Provider Support                               | Renamed this chapter from Provider Assistance to Provider Support. Changed the “training” references throughout the chapter to “support.”   | X                  |     |           |       |
| <a href="#">4-1</a> | UCare Nondiscrimination Policy                 | Deleted this chapter. Chapter contents were moved to the Introduction to UCare chapter.   |                    |     | X         |       |
| <a href="#">4-2</a> | Provider Responsibilities                      | Added the MHCP Provider Enrollment Requirements section.  |                    | X   |           |       |
| <a href="#">5-1</a> | Member Enrollment and Eligibility              | Added a link to the Product/Benefit Tip Sheet page and updated hyperlinks within the chapter.   | X                  | X   |           |       |
| <a href="#">6-2</a> | Restricted Recipient/Restricted Member Program | Added the “referrals to non-assigned hospital emergency room visits will not be accepted” bullet to the Provider Involvement section. Added details around the Specialty Referral Form. |                    | X   |           |       |
| <a href="#">7-2</a> | Provider Credentialing                         | Added the “Level I, II and III for MN only” text to the EIDBI Non-License Behavioral Technicians/Analysts List within the Practitioners Who Do Not Require Credentialing section.       |                    | X   |           |       |
| <a href="#">8-1</a> | Claims and Payment                             | Added that paper claims are available for non-Minnesota providers only. Updated the Child and Adolescent Case Management (CACM) guidance.   | X                  | X   |           |       |
| <a href="#">9-5</a> | Electronic Data Interchange (EDI)              | Updated the hyperlinks within the Electronic Claim Attachments section.   | X                  |     |           |       |

|                      |   | Topic Changes  | Type of Change (s) |     |           |       |
|----------------------|---|--|--------------------|-----|-----------|-------|
| Page                 | Chapter   |  | Update             | New | Deletions | Other |
| <a href="#">20-3</a> | Mental Health and Substance Use Disorder Services   | Updated the Substance Use Disorder Assessments (Comprehensive Assessment) section. Updated the Child and Adolescent Case Management (CACM) guidance. | X                  |     |           |       |
| <a href="#">24-3</a> | Home and Community Based Services - Waiver Services | Updated the guidance pertaining to if a member becomes ineligible for waiver services within the Denial of Waiver Service Requests section.          | X                  |     |           |       |
| <a href="#">26-1</a> | Hospital Services                                   | Added to the Daily Inpatient Admissions Report Requirement list within the Inpatient Admissions section.   |                    | X   |           |       |
| <a href="#">27-8</a> | Interpreter Services                                | Replaced the N&N Interpreter Company with Vadmin Genov DBA Health Management Services.   | X                  |     |           |       |
| <a href="#">31-5</a> | Transportation                                      | Replaced references to NovusMed with QRYde.  | X                  |     |           |       |

## November 14, 2023 Update

| Page                 | Chapter   | Topic Changes  | Type of Change (s) |     |           |       |
|----------------------|---|--|--------------------|-----|-----------|-------|
|                      |   |  | Update             | New | Deletions | Other |
| <a href="#">2-2</a>  | Provider Support                                    | Added the contact information for UCare's Elderly Waiver Liaison.  |                    | X   |           |       |
| <a href="#">5-2</a>  | Member Enrollment and Eligibility                   | Added and updated contact information within the Medicare Programs section.  | X                  | X   |           |       |
| <a href="#">7-2</a>  | Provider Credentialing                              | Added to the Practitioners Who Do Not Require Credentialing section.   | X                  | X   |           |       |
| <a href="#">9-4</a>  | Claims and Payment                                  | Revised the Timely Filing content.   | X                  |     |           |       |
| <a href="#">20-5</a> | Mental Health and Substance Use Disorder Services   | Updated the criteria for case management within the UCare Mental Health and Substance Use Disorder Case Management section.  | X                  |     |           |       |
| <a href="#">24-2</a> | Home and Community Based Services - Waiver Services | Removed and revised content from the Elderly Waiver section, removed content from the Denial of Waiver Service Request section and revised content from the Elderly Waiver Identification Information section. | X                  |     | X         |       |
| <a href="#">26-5</a> | Hospital Services                                   | Revised the Care Transitions section.  | X                  |     |           |       |
| <a href="#">27-4</a> | Interpreter Services                                | Updated the chart within the UCare Contracted Interpreter Service Agencies section.  | X                  |     |           |       |
| <a href="#">29-7</a> | Maternity, Obstetrics and Gynecology                | Removed text notifying Somali UCare members that they may receive a DVD in Somali. That DVD is no longer available.  |                    |     | X         |       |

## December 7, 2023 Update

| Page                | Chapter  | Topic Changes  | Type of Change (s) |     |           |       |
|---------------------|--|--|--------------------|-----|-----------|-------|
|                     |  |  | Update             | New | Deletions | Other |
| <a href="#">3-7</a> | Working With UCare's Delegated Business Services | Updated Eye-Kraft benefit information.   | X                  |     |           |       |
| <a href="#">31</a>  | Transportation                                   | Added coverage for NEMT rides; included information related to providing protected transportation; clarified the requirements for transporting unaccompanied minors and changed what needs to be retained within provider's administrative and driver file requirements. Also restructured and reformatted entire chapter. | X                  |     |           |       |