Nov. 1, 2022 Network News

News from UnitedHealthcare

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United Healthcare

November

What's New for Michigan?

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https://www.uhcprovider.com/en/resource-library/news.html

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Schedule follow-up after ED visit for substance use

Improve care delivery by scheduling post-discharge appointment within 7 days of ED visit

Patients with behavioral health problems who do not receive timely follow-up care after substance use emergency department (ED) visits are much more likely to be readmitted to the ED. Lack of timely follow-up can result in negative outcomes such as continued substance use, relapse, high utilization of intensive care services or even mortality.

The Follow-Up After Emergency Department Visit for Substance Use (FUA) HEDIS® measure is used to measure attendance to a qualified post-discharge appointment within 7 days of discharge for members ages 13 or older. A visit with a provider must have the principal diagnosis of substance use (FUA) on the follow-up visit claim. It is essential for patients to attend a follow-up visit within 7 days of discharge. The day of discharge also counts as a qualified follow-up visit. To count toward the FUA measure, the aftercare visit must occur between the day of discharge and day 7.

Qualified post-discharge appointments include:

- Outpatient appointment with primary care provider
- Outpatient appointment with behavioral health provider
- Partial hospitalization programs, intensive outpatient programs, outpatient electroconvulsive therapy
- Telemental health appointments

How you can impact the HEDIS FUA measure
To impact the HEDIS FUA measure and improve care delivery, be sure to:

- Use correct documentation and coding
- Maintain appointment availability for your patients with recent ED visits
- Contact patients who cancel their follow-up appointments and reschedule them as soon as possible and within 7 days

Additionally, if you suspect one of your patients may be struggling with substance use or abuse, we recommend screening them prior to diagnosis. By screening patients, you can help identify those who may need additional care to recover.

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STAR+PLUS billing unit change

FMSA unit now 1 per month

As a reminder, as of Sept. 1, 2022, you should bill Financial Management Services Agency (FMSA) units for STAR+PLUS as 1 unit per month. You can continue to bill using your normal billing process, however, update the unit from per 15 minutes to per month for the FMSA fee.

Consumer directed service	Payment rate	Unit
FMSA fee – New rate effective Sept. 1, 2022	$210.08	1 month

Background
Texas Health and Human Services Commission (HHSC) reviewed FMSA payment rates and methodology. As a part of the review, HHSC approved the billing unit change, effective Sept. 1, 2022.

You can find additional information about this change in HHSC's Information Letter No. 2022-46 or view the most up-to-date payment rates for accurate billing.

What happens next
We are working to update our claims system to properly process these FMSA claims to reflect the unit and rate change. If your claims process prior to the system update, we will reprocess the claims automatically. Please do not re-submit incorrectly paid FMSA claims with dates of service after Sept. 1, 2022, as they will be denied as duplicate claims.

Questions?
For answers to specific questions, contact your provider advocate.

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Reconsiderations and appeals going digital

Affects network commercial and Medicare Advantage health care professionals and facilities

In 2023, our work to replace paper with digital tools will shift to eliminating paper you send to us. This change will eliminate postal wait times and may help you get decisions faster.

As a result, beginning Feb. 1, 2023, you'll be required to submit claim reconsiderations and post-service appeals electronically. This change affects most* network health care professionals (primary and ancillary) and facilities that provide services to commercial and UnitedHealthcare® Medicare Advantage plan members. This does not affect pre-service clinical appeals.

Please share the following changes and digital workflow options with your team, including outside vendors, such as revenue cycle management companies.

Electronic submission options
1. UnitedHealthcare Provider Portal:

- Go to **UHCprovider.com** > Select Sign In at the top-right corner
- Sign in to the portal with your One Healthcare ID and password
  - If you don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
- In the menu, click Claims & Payments > Look up a Claim to search by the claim number and click Act on Claim

Claim Follow-Up Interactive Guide

2. Application Programming Interface (API): Consider submitting reconsiderations and appeals through API. Data can be distributed to your practice management system or any application you prefer. API requires technical programming between your organization and UnitedHealthcare.

To get started:

- Go to the **API Marketplace**
- Under Start up with APIs, click **Get Started**
- Under Get started today, select Sign In to request a meeting with an API consultant
  - Enter your One Healthcare ID and password
- Select **Complete Request**
- To complete the Request an API Subscription form:
  - Under API(s), select All Claims and enter Reconsiderations and Appeals in the Business Value section
  - Complete the rest of the form and click **Request Now** to have our API team contact you

Please note: Attachments cannot be sent for other types of claim submissions.

Learn about API

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Reconsiderations and appeals going digital (cont.)

Reminder: Submission requirements
There is a 2-step process for network health care professionals and facilities if they don't agree with the outcome of the original claim payment or denial. (Claim reconsiderations don't apply to some states based on applicable state law.)

Step 1 is to file a claim reconsideration request. Step 2 is to file an appeal if you disagree with the outcome of the claim reconsideration decision. The 2-step process allows for a total of 12 months for timely submission of both steps. More information can be found in the Network Administrative Guide at **UHCprovider.com/guides.**

What's ahead in paperless
Going into 2023, you can expect more paper submissions and mailings we send you to go digital. Later in 2023, we'll require you to submit claims and claim attachments electronically. We'll also continue to encourage UnitedHealthcare commercial members to use digital ID cards.

All required paperless transitions will be announced in **Network News** at least 90 days prior to the change. We encourage you to explore our digital solutions and review your workflows so that your team is prepared. Review the most up-to-date information, exclusions and schedule at **UHCprovider.com/digital.**

Questions?
Please contact UnitedHealthcare Provider Services at **877-842-3210,** TTY/RTT **711,** 7 a.m.–5 p.m. CT, Monday–Friday.

For help accessing the portal and technical issues, please contact UnitedHealthcare Web Support at **providertechsupport@uhc.com** or **866-842-3278,** option 1, 7 a.m.–9 p.m. CT, Monday–Friday. Primary Access Administrators may also contact Web Support for help updating notification emails.

*Currently excludes: UnitedHealthcare commercial and Medicare Advantage Plans of Colorado, Pharmacy, Behavioral Health, Overpayment Reconsiderations & Appeals requests, Capitated and delegated health care professionals, All Savers, OneNet PPO, Preferred Care Network, Preferred Care Partners (delegated), Rocky Mountain Health Plan, Sierra Health & Life, Student Resources, Surest (formerly Bind), UnitedHealthcare FlexWork, UHC Global, UHC West, UMR, and UHOne/Golden Rule.

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VCP statements going digital starting Feb. 3

If you receive virtual card payment (VCP) statements in the mail, **beginning Feb. 3, 2023**, we'll no longer mail VCP statements. Instead, you'll be able to view them 24/7 through the UnitedHealthcare Provider Portal or an Application Programming Interface (API) that permits you to automate document retrievals.

This change only applies to network commercial and UnitedHealthcare® Medicare Advantage health care professionals (primary and ancillary) and facilities who are receiving VCPs* It doesn't affect those using automated clearinghouse (ACH).

Please share the following changes and digital workflow options with those who are affected, including outside vendors such as revenue cycle management companies.

View virtual card payment statements 1 of 2 ways

1. **Document Library** in the **UnitedHealthcare Provider Portal**:

- Go to **UHCprovider.com** > Sign In
- Sign in to the portal with your One Healthcare ID and password
  - If you don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
- In the menu, select Documents & Reporting > Document Library > Payment Documents folder

Tips:

- We encourage you to set up a daily task to check Document Library for updates
- **Finding documents:** Use Advanced Search and search by Member Name, Case ID or Claim No. to help you find what you need. For letters available after June 30, 2022, you can also search by Member ID.
- **Notifications:** When new letters are available in Document Library, an email notification will be sent to the address on file, which is typically the Primary Access Administrator
  - **Need to notify multiple staff members?** Document Library notifications are limited to 1 email address per letter type. If multiple staff members require notification, the Primary Access Administrator can consider using a group email address. See our Paperless Delivery Options for Primary Access Administrator for more information.

2. **API:** Consider retrieving documents through API by automating system-to-system transactions. Data can be distributed to your practice management system or any application you prefer. API requires technical programming between your organization and UnitedHealthcare.

To get started:

- Go to API Marketplace
- Under Start up with APIs, click **Get Started**
- Select **Sign In** to request a meeting with an API consultant, then enter your One Healthcare ID and password
- Select **Complete Request**
- To complete the Request an API Subscription form:
  - Under API(s), select All Claims and enter Documents/Virtual Card Payment statements in the Business Value section
  - Complete the rest of the form and click **Request Now** to have our API team contact you

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VCP statements going digital starting Feb. 3 (cont.)

What's ahead in paperless
Letters we mail you aren't the only communications going digital. Looking ahead to 2023, we'll continue to provide and promote member health plan ID cards in digital formats, which may require changes in your patient intake process. In addition, contracted health care professionals and facilities will be required to submit most claims, claim attachments, reconsideration requests and appeal requests electronically.

All required paperless transitions will be announced in **Network News** at least 90 days prior to the change. We encourage you to explore our digital solutions and review your workflows so that your team is prepared. Review the most up-to-date information, exclusions and schedule at **UHCprovider.com/digital**.

Questions? For help accessing the portal and technical issues, please contact UnitedHealthcare Web Support at **providertechsupport@uhc.com** or **866-842-3278,** option 1, 7 a.m.–9 p.m. CT, Monday–Friday. Primary Access Administrators may also contact Web Support for help updating notification emails.

*Currently excludes: UnitedHealthcare commercial and Medicare Advantage Plans of Colorado; and Behavioral Health.

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Complete Special Needs Plan MOC training

The Centers for Medicare & Medicaid Services (CMS) requires all special needs plans (SNPs) to provide initial and annual Model of Care (MOC) training to network providers contracted to see SNP members and out-of-network providers who routinely see SNP members. Every year, the deadline for training completion is Dec. 31.

Our SNP MOC training is available as a self-paced course on UHCprovider.com/training, and it takes about 10 minutes to complete.

Access the training

Training requirements
CMS requires MOC training if you're a health care professional contracted to see SNP members or an out-of-network licensed independent practitioner (LIP) who routinely treats and/or provides services to UnitedHealthcare SNP members.

There's one exception – if you only see UnitedHealthcare commercial members, you don't have to complete the training.

MOC training overview
An MOC is a document, reviewed and approved by CMS, describing the structure, processes and systems used by a SNP to coordinate care for members with special needs. It must include these 4 elements:

- SNP population description
- Care coordination elements
- Care provider overview
- Quality measurement and performance goals

CMS requires all SNPs to provide MOC training. Care management processes vary across insurers and CMS doesn't offer centralized SNP MOC training. This means you may be asked to complete multiple trainings.

View more information about the types of SNPs in the UnitedHealthcare Administrative Guide, Chapter 4.

Questions?
If you have questions about the training, contact the UnitedHealthcare SNP MOC training team:

- **Email: snp_moc_providertraining@uhc.com**
- **Phone: 877-842-3210**
- **Fax:** 855-281-1299

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Individual Exchange PDL update

Beginning **Jan. 1, 2023**, we're making prescription drug list (PDL) updates for UnitedHealthcare Individual Exchange plans, also referred to as Individual and Family plans. This will include medication tier updates, moves to non-formulary statuses and exclusions from coverage.

Access the PDL updates

To see a list of the PDL updates, please see the **Individual Exchange plans: Pharmacy benefit coverage updates** guide.

How we'll notify members

We'll communicate with members in advance to allow time for prescription adjustments prior to the effective date.

Questions?

If you have questions, please visit **UHCprovider.com/exchanges**.

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New medical necessity criteria for HBOT

Updated medical policy for Individual Exchange plans

Effective Jan. 1, 2023, we will only consider hyperbaric oxygen therapy (HBOT) services for CPT® codes 99183 or G0277 medically necessary for UnitedHealthcare Individual Exchange plan members with one of the listed diagnosis codes in the new hyperbaric oxygen therapy medical policy.

Providers will be required to submit an appropriate diagnosis code on the claim for services to be covered.

Impacted plans
These changes affect UnitedHealthcare Individual Exchange plans, also referred to as Individual and Family plans.

Important points
Please note that:

- We may deny HBOT claims for unproven diagnosis codes
- These requirements apply to new and current HBOT users that do not have an appropriate diagnosis in their medical claims
- This change won't affect any existing authorizations on file for HBOT, unless the member's eligibility changes
- This change will go into effect for UnitedHealthcare commercial plans on Dec. 1, 2022

Questions?
Contact Provider Services at 866-416-6594 if you have any questions.

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The return to normal — focus on annual visits

It's good news that, as the COVID-19 public health emergency eases, people can return to more familiar routines, including getting their annual wellness check-ups.

Between now and the end of the year, we will increase the reimbursement you receive on completed annual wellness visits for UnitedHealthcare Community Plan (Medicaid) patients.

Important things you need to know

- **Between now and Dec. 31, 2022,** we are increasing reimbursement for completed annual wellness visits for UnitedHealthcare Community Plan (Medicaid) members, excluding Dual Eligible Special Needs Plans (D-SNP) members, by 50% of the allowed amount on your claim. Some exclusions apply.*

- The increase applies to claims with dates of service Oct. 1, 2022–Dec. 31. 2022, with a claim receipt date no later than March 31, 2023. Claims must be billed with the appropriate CPT®/DX code.

- Appropriate CPT/DX codes are 99381-99387 and 99391-99397 and the appropriate Healthcare Effectiveness Data and Information Set (HEDIS®) measure Adult Access to Preventative Ambulatory Health Services (AAP), Well Child Visit (WCV) and Well Child Visit within first 30 months of life (WV30) DX codes.

Questions?
For more details, you can check our Frequently Asked Questions.

*Exclusions include providers paid via capitation, providers participating in our Nevada and Colorado health plans and certain provider-type exclusions within Louisiana including Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and Indian Health Centers (IHC).

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