UnitedHealthcare®
Community Plan

Provider Frequently Asked Questions (MEDICAID ONLY)

Claims

Is the specialist required to bill with the written referral form?
Our plan does not need the written referral form to process the in network specialist claims. The written referral is only to let the in-network physicians know that the patient was referred to their service.

What is the claim-filing time limit?
The claim-filing limit is determined by your contract with UnitedHealthcare Community Plan. For the majority of providers, it is 6 months from the date of service for original claims. For claims non-par providers please contact Customer Service at 1.800.903.5253.

What is the filing limit for claim corrections?
Resubmission filing limit related to Provider Billing Errors is 12 months from the date of service if the original claim was received with the filing limit.

What is the filing limit for claims in which coordination of benefits apply?
We extend the filing limit for claims with another carrier's explanation of benefits (EOB) when the EOB identifies payment or denial of the claim and the claim is received within six months from the notification date of the other carrier's EOB or the claim is received within eighteen months from the claim date of service.

What is the filing time limit for appeals?
Initial appeals must be made to UnitedHealthcare Community Plan within 180 days of the initial denial. Second Level appeals must be initiated within 60 days of the Level One denial.

Do you pay for motor vehicle accidents (MVAs)?
UnitedHealthcare Community Plan is the payor of last resort. MVAs are not covered unless:

- An auto carriers EOB is attached to the claim.
- Provider submits proof of attempt to obtain payment from the auto insurer AND it has been more than six months form the date of service.

When will a provider receive his cap check?
The beginning of each month for the prior month's enrollment.

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Where can I get information on electronic billing?
Web MD payer ID: 95467
BCBS Payer ID: 383293040
BCBS Help Line: 248.486.2292
www.netwerkes.com click on Provider Enrollment option

Where can I get information on Uniform Billing?
The Uniform Billing Guidelines are included in the MSA manuals or you can find them at Michigan Department of Community Health's website, www.mdch.state.mi.us. Your association should also have a copy available for you.

Contracting

Do you have any incentives for physicians?
This varies by contract. However, there are benefits in becoming a UnitedHealthcare Community Plan participating provider; please contact our Contracting department at 1.877.842.3210.

How do I become a part of UnitedHealthcare Community Plan's network?
Please call our Contracting department at 1.877.842.3210 to request a conract and a credentialing application.

How does your plan reimburse their in-network providers?
According to their contract. UnitedHealthcare Community Plan offers an exciting pay for performance for Primary Care providers. For more information, contact our Contracting Department at 1.877.842.3210.

What are the contracting requirements?
Providers must complete a credentialing application and go through the credentialing process, which includes primary source verification of all information and may require a site review (for some PCPs and some high volume specialties). Once these processes are complete, an Agreement (contract) must be signed.

What are the participating hospitals?
The list of participating hospitals is available on our web site or you can call our Customer Service department at 1.800.903.5253.

How does your plan reimburse non-contracted providers that see UnitedHealthcare Community Plan members?
All authorized services are reimbursed at current Medicaid FFS rates for non-contracted providers.

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Customer Service

How can I become a provider with UnitedHealthcare Community Plan?
You can contact the Contracting department at 1.877.842.3210
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Can a member switch PCPs?
Yes, they must contact the Customer Service department at 1.800.903.5253 directly with the request. They may only change PCPs once per month, unless there are special circumstances.

Can a PCP discharge a member from his/her practice?
Members may be discharged provided that the PCP notifies the member via certified mail of their intent. This letter should also be sent to our Customer Service department. In addition, the physician is required to treat the member for 30 days after notification of intent to discharge the patient. In situations involving a member threatening to do harm, a police report must be made and our Customer Service department will reassign the member.

Can members switch plans every month?
No, Medicaid open enrollment is in May; members are allowed to change plans during these 30 days. After 90 days with a plan, they are locked in until the next open enrollment period.

What if I receive cap and the member included in that cap payment moves to another plan or PCP?
The next cap check will be appropriately adjusted.

When a member switches PCPs, which provider receives the capitation for that month?
Capitation payments are prorated on a daily basis and are computed on the member's effective date of eligibility with the PCP. Regardless of when, during a month, a member changes PCPs, each PCP will receive capitation for each day the member was assigned to him/her. In the same way, the capitation payment of a newborn will be prorated from the date of birth.

What are the copays or deductibles for your plan?
There are no copays or deductibles for UnitedHealthcare Community Plan services.

Information Technology

Is there a link that enables us to print the appeal or other frequently used forms directly from your website?
Yes, this website includes the entire Provider Administrative Manual. The forms can be found in the Appendix. Click here (PDF 417.73 KB) to view the Provider Administrative Manual.

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Pharmacy

How can I obtain authorization for non-formulary prescriptions?
If a physician would like to request a non-formulary prescription, they should call our Customer Service at 1.800.903.5253 or you may complete a Prior Authorization Request Form and fax back to 1.866.940.7328. The Physician can also get a copy of the form on our website at www.uhccommunityplan.com. Our Pharmacy department will review the request for prior authorization and approve the request if evidence of medical necessity exists. The Plan could also send back formulary alternatives, when appropriate. If more information is needed to make a decision about the authorization, the physician will be contacted stating what information is needed and where it should be sent. Physicians should expect to receive responses back within 24 hours from time the request is received.

General

When are you going to print the newest formulary?
The formulary is in two places. One is on our website. You can view the entire formulary as well as use the drug look up function on our website. Physicians can also view our entire formulary on the Epocrates website at www.epocrates.com.

Provider Services

How do I acquire a provider directory?
There is a provider search available on our website. Click here to search our provider directory.

Utilization Management

Can a specialist get authorization for services that they are ordering?
Yes, a specialist may request authorization for any services that he/she may be ordering that requires prior authorization from the Plan. The specialist has the clinical data that the plan will need to make the authorization determination. The specialist can also refer and write orders for the patient for any further testing that is required such as a CT Scan or MRI. If a specialist needs to refer the patient to another physician, the referral needs to be coordinated through the patient's PCP.

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Does your plan know when a patient is referred to my (a specialist) office? How does the specialist know that the PCP has referred the patient?
We are not notified when a member is referred to an in network specialist. The only time we will be notified is if it is a service that requires prior authorization. It is the right of the specialist to request a referral form from the PCP so that they know the PCP has referred the patient. However a referral is not required by the Plan for payment purposes. This referral, if requested by the specialist, is only a means of formal, written communication between the PCP and Specialist.

Is an authorization for mental health/pharmacologic review needed when done by the PCP?
Yes, all mental health services require authorization. This is true however a straight pharmacologic review by the PCP would be done during a PCP visit and wouldn't require auth. Not sure if there is a code used by the PCP to bill for this type of visit though.

What immunizations are covered?
All routine childhood immunizations are covered. A schedule of immunizations is included in the provider administrative manual. Free vaccines are available through the Vaccines for Children Program. To enroll, call your local health department.