Network Development: Other Frequently Asked Questions

UnitedHealthcare Community Plan

- **What is the timely filing requirement?**
  Please refer to your contract. Standard 90 days.

- **Can a provider contract with just the Medicaid product?**
  We may offer an all product contract but it is not a requirement.

- **Can a provider contract with the plan directly?**
  Yes, our contracts are a direct agreement. However, certain specialties (i.e. vision, dental, behaivoral health) will contract with our sub-contracted networks.

- **How many separate contracts will be required?**
  This depends on the provider type. Most medical offices will only need the one group agreement but we do have network partner relationships for vision, dental, and behaivoral health. In those cases where providers offer all services, multiple contracts may be necessary.

- **How does a provider opt out of their contract?**
  A provider should refer to their term and termination provision of the agreement.

- **Will KanCare beneficiaries have a unique prefix for their ID numbers?**
  No, the member ID# will actually be their Medicaid ID#.

- **How will a provider look up member benefit information?**
  This can be viewed on www.uhconline.com, using the same search features used today for commercial and Medicare members.

Network Development:
Other Frequently Asked Questions ...*continued*

UnitedHealthcare®
Community Plan

- **When will the provider manual be available?**
  Submission of provider manuals are due to the state by Sept 12. The manual will become available shortly thereafter, post State approval.

- **How will the plan communicate updates?**
  Communication will be posted to the online portal, via newsletters, as well as through advocate interaction.

- **What happens if a contracted Kansas physician sees a Medicaid member from another state where the assigned plan is also contracted, will the Kansas physician be paid? By which fee schedule?**
  We are responsible for paying for Kansas members assigned to our plan. Members of other states will be handled according to that state's plans and processes.

- **Will the plan be promoting a physician incentive program in Kansas?**
  Yes, we will be promoting an accountable care shared savings program. This is pending State approval.

- **Is it a requirement that ER physicians are board certified?**
  No, ER doctors do not need to be Board Certified

- **Is the provider required to use specific lab companies?**
  We expect provider use in-network lab providers

Network Development:
Other Frequently Asked Questions ...*continued*

UnitedHealthcare®
Community Plan

- **How will the plan handle providers who do not meet credentialing guidelines? Will the plan complete access needs waivers?**
  - For Home & Community Based, in the event an applicant fails to meet the verification/credentialing requirements set forth in this P&P, the applicant will be denied and notified in writing. An applicant has the right to appeal an adverse decision within 30 days of notification. Applicants have the right to be notified of the credentialing decision w/in 60 calendar days of the decision. We do not plan to do access needs waivers.
  - For Behavioral Health, all providers must meet credentialing guidelines. Members will be referred to a credentialed provider.
  - For Vision, VSP has criteria such as doctor ownership and contiguous dispensary. These will be waived if needed. Additionally, we will waive our standard requirement that a provider join other VSP networks and will instead allow for a Medicaid only network in KS. However, a provider that does not meet NCQA guidelines will not be approved for KanCare.
  - For Medical Providers, exceptions can be made for practitioners who do not meet criteria. The national credentialing committee carefully reviews the provider's file against the credentialing program requirements, taking into consideration the provider's qualifications, including education and training, board certification status, licensure status, hospital privileges, malpractice and sanction history. While the committee consders all criteria, the Medical Director and Committee may make exceptions when warranted to fill a provider network gap for a clinical specialty or geographic location.
  - For Dental, if a provider does not meet credentialing guidelines, we do not accept them into the network. We take all providers to our credentialing committee and the decision is made there but generally they do not approve providers that do not meet our criteria. We then send the provider a letter explaining the decision. If a provider does not meet criteria at the time of recredentialing, they are termed.
  - For Optum Health/Physical Health, since we have an open network, we do not do access waivers. If the provider does not meet minimal credentialing requirements, they will not become a credentialed provider. They do have the right to appeal or send in additional information and the denial rate is minimal.

Claims Processing & Payment Systems: Frequently Asked Questions

UnitedHealthcare Community Plan

- **Once a claim is denied, what is the timeframe for the provider to submit an appeal?**

  All formal claim appeals must be filed within 60 days of the date of the UnitedHealthcare provider remittance.

- **How will the providers receive their Remittance Advices?**

  The provider can be set up for either paper (PRA)or electronic (ERA). If they are set up to receive PRA vs. ERA, they will be available on both the website and mailed to the providers.

- **How will the plan handle fee schedule changes related to retroactive rate updates by the State.**

  We are actively interpreting the contract language to determine this.

Claims Processing & Payment Systems: Frequently Asked Questions…*continued*

UnitedHealthcare® Community Plan

- **What is the payment cycle?**
  For Medicaid/CHIP, check-write will run twice a week and for Long Term Care it will run daily.

- **Will all claims be filed through MMIS or can they go through a clearinghouse?**
  Claims can come to us through any clearinghouse/vendor the provider is connected to. The Front End Billing Process (known as MMIS) is an option available, but not a requirement.

- **Does the plan cover telemedicine?**
  No

Prior Authorization: Frequently Asked Questions

UnitedHealthcare® Community Plan

- **How does a claim get paid in the event prior authorization is required, but it was not obtained?**
  If a prior auth was required and not obtained, the claim will deny. Providers may use the appeal process to have the situation reviewed.

- **What is the timeframe between a provider submitting an authorization request and receiving notification from the plan? How will this be communicated?**
  - If submitted by phone, the request is entered into the system immediately while the provider is on the phone with intake. The Intake Coordinator will give the provider a pending reference number. If the authorization requires medical review, the case will be routed to the Prior Auth Team who will respond by phone or fax within 3 business days for expedited or 14 calendar days for standard requests.
  - If submitted by fax, the request is entered into the system by Intake. Upon entry into the system, the Intake Coordinator may immediately respond via fax to the provider. If the authorization requires medical review, the case will be routed to the Prior Auth Team who will respond by phone or fax within 3 business days for expedited or 14 calendar days for standard requests.
  - If submitted online, the request is entered into the system immediately. Upon entry into the system, the Intake Coordinator may immediately respond via fax to the provider. If the authorization requires medical review, the case will be routed to the Prior Auth Team who will respond by phone or fax within 3 business days for expedited or 14 calendar days for standard requests.

- **Do admits to nursing homes have to be pre-certified? If so, for what type (skilled care, swing bed, etc)?**
  Inpatient acute, sub-acute, rehab, and SNF admissions require prior authorization. All non-par service require prior authorization. Elective Inpatient Admissions require authorization. All services in the home require prior authorization. Nursing facilities (LTAC, SNF, & Extnd Care) require auth.

- **What services require pre-authorization and what resources are available to assist providers?**
  A prior authorization list will become available, upon approval and posted to the portal. This will also be available in the provider administration guide.

- **What type of inpatient screening software does the plan use?**
  Milliman Care Guidelines