Provider Manual

Your guide to providing service to UCare members

August 22, 2025

Table of contents

Introduction to UCare

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

UCare serves over 597,000 members throughout Minnesota and western Wisconsin.

Working in partnership with health care providers and community organizations, UCare serves:

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

UCare's mission

Mission statement: "UCare 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, creed, religion, national origin, age, disability, gender identity, marital status, sexual orientation 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

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, contact your organization's UCare Provider Portal administrator. The administrator has access rights to add, update and remove user access within your organization and third-party agencies**.

If no designated administrator account is established for your organization, you may request one by clicking the "Request Admin Access" button on the Provider Portal login page.

Requesters will receive a response within five business days.

- If the request is approved, the administrator must activate the administrator account before adding other users within the organization.
- If the request is denied, UCare's response will give possible reasons for the denial.

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

**Currently, information for UCare Medicare Supplement plan members is unavailable on the UCare Provider Portal. Providers should call 1-800-221-6930 toll-free and follow the prompts for information on eligibility, benefits, claims and more for Medicare Supplement plans. Providers can identify UCare Medicare Supplement members if their Member ID number starts with a 7 or higher and they have a 10003397 or 10003398 group number.*

***Providers must submit the UCare Provider NDA Attestation form for adds, updates and terminations (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 using the provider portal's self-service features, 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 assembled a list of provider key contacts to assist providers. It is available on the Policies and Resources webpage under Administrative Resources.

On-site or virtual provider support and education

UCare Provider Liaison

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

- **Five-county metro providers** (Anoka, Dakota, Hennepin, Ramsey and Washington)
  Maryann Mickelson
  mmickelson@ucare.org
  612-719-4989

- **Northern Minnesota providers**
  Kathy Campeau
  kcampeau@ucare.org
  612-246-0505
- **Southern Minnesota providers**
  TBD
  In the interim, contact Kathy Campeau

See the Provider Field Representative Territory map.

Elderly Waiver UCare Provider Liaison

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

- **Brooke Robinson, LADC**
  Brobinson@ucare.org
  952-256-0849

Provider training and education

UCare offers a variety of training options to assist providers in working with us and our members. Visit the Provider training and education webpage for the latest offerings.

Working with UCare's delegated business services

UCare works with delegated organizations responsible for providing pharmacy benefit management, dental, chiropractic and hearing aid or hearing aid assessment services through their provider networks on UCare's behalf.

Pharmacy services

Navitus Health Solutions

Pharmacy network

Navitus Health Solutions (Navitus) is the full-service pharmacy benefits manager for all UCare Health Plans. All covered new and refill prescriptions should be processed through Navitus. They have an extensive retail pharmacy network with more than 63,000 participating pharmacies nationwide. Many of those retail pharmacies also participate in the extended day supply program for applicable benefit plans.

UCare Medicare Plans and EssentiaCare members have access to all pharmacies in the network at a standard cost sharing model. Visit the provider search page for an online pharmacy directory. Costco Mail Order Pharmacy is included in the pharmacy network for all plans.

Contact information for Costco mail-order pharmacy

Costco Mail Order Pharmacy
Fax: 1-877-258-9584
Phone: 1-800-607-6861
NPI: 1073079521
NCPDP: 1569954

Costco Pharmacy #1348
260 Logistics Ave, Ste B

Pharmacy.costco.com

Formulary information, prior authorization and formulary exceptions

Formularies outlining the covered drugs and any associated limitations - such as prior authorization (PA), step therapy or quantity limits - are updated monthly and posted on ucare.org and the Provider Pharmacy webpages. Please refer to the website to access the most recent formulary versions.

Electronic prior authorization (ePA) is the preferred method to submit prior authorization requests to Navitus. Providers may access ePA through Surescripts, CoverMyMeds or the Electronic Health Record.

You can find prior authorization and formulary exception request forms on UCare's Pharmacy webpage. These forms can be faxed to Navitus at the number on the form or called into Navitus directly. If you wish to prescribe a medication that requires prior authorization or a formulary exception, you may reach out to Navitus at:

Prior authorization contacts		
UCare line of business	**Phone line**	**Fax line**
Medicare	1-833-837-4300 toll-free	1-855-668-8552 toll-free
Medical Assistance (Medicaid)	1-833-837-4300 toll-free	1-855-668-8553 toll-free
Health Care Exchange	1-833-837-4300 toll-free	1-833-210-5963 toll-free

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
Medical Assistance	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

Some medical injectable drugs given in the doctor's office require authorization. Visit the Pharmacy page and open the Medical Injectable Drug Prior Authorization Resources drawer to view the Medical Drug Authorization List, coverage policies and authorization request forms.

Participating providers can submit prior authorization, authorization adjustment and *pre-determination requests to Care Continuum in one of the following ways:

- Online (ePA) via the OnePA portal at www.evicore.com. Providers can submit requests, check the status of submitted requests and submit an authorization renewal on the OnePA portal. The website also provides 24/7 access, potential for real-time approvals and email notifications once a decision is reached.
- Fax the prior authorization form to Care Continuum at 1-877-266-1871.
    - Access the prior authorization form in the Medical Injectable Drug Prior Authorization Resources drawer on the Pharmacy page.
- Call Care Continuum at 1-800-818-6747.

*Pre-determination requests are only accepted and reviewed for Medicare members. Requests for State Public Programs and UCare Individual and Family plan members will be returned.

Non-participating and MultiPlan providers can submit prior authorization, authorization adjustment and *pre-determination requests to UCare one of the following ways:

- Fax the prior authorization to UCare Clinical Pharmacy Intake at 612-617-3948.
    - Access the prior authorization form in the Medical Injectable Drug Prior Authorization Resources drawer on the Pharmacy page.
- Mail to:
    - UCare Pharmacy
      PO Box 52
      Minneapolis, MN 55440-0052

*Pre-determination requests are only accepted and reviewed for Medicare members. Requests for State Public Programs and UCare Individual and Family plan members will be returned.

An adjustment to an existing prior authorization can be requested if:

- The authorization is active or expired.

- An end date extension is needed 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).
- There has been a change in dosing or treatment schedule and additional quantity and/or dates of service are needed.
- Include the reason for the extension, requested end date, current dosing and any other pertinent clinical information.

Authorization adjustments are not approved, and a new or renewal authorization request is required, for the reasons listed below:

- An additional drug is being requested
- An authorization is expiring or has expired and will need renewal

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 UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare plans	72 hours	24 hours
Medical Assistance	24 hours	24 hours
Health Care Exchange	5 business days	48 hours (which includes at least one business day)

For post-service or retrospective authorization requests, use the Online Provider Claim Reconsideration Request form on the Claims and Billing page under the Forms and Links accordion.

UCare handles appeals and grievances and should follow the member appeal process outlined in the Member appeals and grievances chapter of this manual.

Specialty medications

UCare works exclusively with Fairview Specialty Pharmacy for Medical Assistance, 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:
Phone: 612-672-5260 or 1-800-595-7140 toll-free
Fax: 1-866-347-4939 toll-free
www.specialtypharmacy.fairview.org

Minnesota Department of Human Services (DHS) cash payment policy for Minnesota Health Care Programs (MHCP) covered drugs

Providers should not accept cash payments from a member or 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, Subdivision (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 Minnesota Restricted Recipient Program.
- The pharmacist has reviewed all available covered alternatives with the member.
- The pharmacy obtains an Advance Member Notice of Noncovered Prescription (DHS-3641).
- The prescription is not for a controlled substance (other than weight loss medications, which 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) signed by the prescriber and all criteria have 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 an 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.

Pharmacy claims

For assistance with processing Pharmacy claims, call the Navitus Pharmacy Help Desk at 1-833-837-4300 toll-free.

Vaccines covered by Medicare Part D

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

UCare denies claims for providers administering Part D vaccines for Medicare + Medical Assistance 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 are 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 and EssentiaCare

UCare denies 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 are 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.

Part D vaccines and administration

Providers should follow one of the following steps for Part D vaccines and administration:

- **Part D Vaccination Provided at the Pharmacy**
  - A 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**
  - The 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.

Dental services

UCare partners with DentaQuest to serve the dental needs of UCare members throughout Minnesota. For credentialing information and more, visit www.dentaquest.com.

Dental Providers may call DentaQuest at 888-260-5152.

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. UCare Dental Connection aims to help members manage their dental care with one phone call. The program 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:

- **Medical Assistance (PMAP, Minnesota Care, UCare Connect, MSC+)**: 1-888-227-3310
- **Duals (Connect + Medicare and MSHO):** 1-855-209-3155, TTY-800-466-7566

Dental providers should submit claims electronically through a clearinghouse to DentaQuest.

Dental claims

If you have questions about dental claim submissions, email DentaQuest at denclaims@DentaQuest.com.

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 maintains contractual relationships with chiropractic providers. Fulcrum also offers an online provider directory at www.fulcrumhealthinc.org. Contact the Provider Services department at Fulcrum Health at www.fulcrumhealthinc.org/contact-us or call 1-877-886-4941 toll-free.

Chiropractic claims

If you have questions about chiropractic claim submissions, call the Provider Services department at Fulcrum Health at 1-877-886-4941 toll-free.

Therapeutic massage

UCare covers up to six therapeutic massage visits per year for Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members with back, neck and shoulder pain; headache; carpal tunnel syndrome; osteoarthritis; or fibromyalgia.

Therapeutic massage claims

If you have questions about massage therapy claim submissions, call the Provider Services department at Fulcrum Health 1-877-886-4941 toll-free.

Hearing aid and hearing aid assessment services

TruHearing

UCare contracts with 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
- 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
- Eyewear upgrade replacement due to loss, theft, damage

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 www.speccheckrx.com or they can mail or fax approved UCare forms from Eye-Kraft to:

Mail:

Eye-Kraft
8 McLeland Rd.
St. Cloud, MN 56303

Fax:

1-800-950-7070

For assistance with ordering or getting set up SpecCheck, call Eye-Kraft at 320-251-0141 or email admininfo@eyekraft.com.

For replacement frames, orders should be placed through Eye-Kraft's online portal. A link to both SpecCheck and Eye Kraft's online portal can be found at orders.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.

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 questions.

Provider responsibilities

Appointment availability standards

To ensure members receive timely care, UCare established appointment availability standards for primary care, mental health, substance use disorder and high-impact or 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 or 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 or High-Volume Specialty Care

(Cardiovascular, general surgery, OBGYN, ophthalmology, oncology, orthopedic surgery or neurology)

- Established patient follow-up care: within 60 days
- New patient: within 60 days

Change of ownership

Provider agrees to notify UCare within 60 days prior to the effective date of a change in its ownership status due to the following:

- The removal, addition or substitution of a partner, owner or managing employee.
- The transfer of title of property to another party in the case of 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 Network Management, PO Box 70, Minneapolis, MN 55413) or email communication should be sent to UCare's provider contracts mailbox at 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 the 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. In addition, the provider agrees to ensure the accuracy of an enrollee's medical, health, enrollment information and records, as applicable.

Demographic data updates

Provider agrees to notify UCare no less than 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.

Minnesota Health Care Programs provider enrollment requirement

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

UCare will use its standard process for determining the effective date of a new contract and/or provider location.

For entities or locations already contracted, if a provider's enrollment for services or enhanced rates is retroactive by DHS, UCare will honor the DHS effective date. However, it is the responsibility of the provider to identify and resubmit any claims that were impacted by the retroactive enrollment date.

Ineligible providers

Contracted UCare providers shall ensure that they, their company, owners, managers, practitioners, employees and contractors are not on the UCare Ineligible Providers List. Providers should search the list of UCare Ineligible Providers on the Provider portal (click "Resource Center," then the Resources tab and then "Ineligible Provider List."). Use the list regularly 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 does not include 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.

Notification of Medicare deactivation

Providers contracted with UCare are required to provide a 10-day written notification of changes in participation status with Medicare, Medical Assistance 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 and should include the provider's name, tax ID, NPI and the deactivation date. Providers should also

indicate whether deactivation is effective at the entity or 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.

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 permits UCare 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, title and other location information are also required on the acknowledgment form.

The UCare Provider NDA Attestation form is on the Claims & Billing page in the Third-Party Agreement section.

Additional instructions for third-party billers:

- 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 acknowledgment form on file.
- Following HIPAA and state requirements, as well as internal processes, UCare is not authorized to release information to a third-party until the provider has submitted the UCare Provider NDA Attestation form.

Model of Care training

UCare and CMS require that all providers complete Model of Care (MOC) training for all Special Needs Plans (SNP) when initially contracting with UCare and annually after that. 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 includes a population description, care coordination requirements, UCare's provider network, 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 for Providers webpage. 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. The provider agrees to cooperate with UCare's QI activities to improve the quality of care, quality of services and member experience. Cooperation includes data collection, evaluation 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 the provider, including its practitioners, for purposes 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 overviews eligibility, key benefits and provider resources. Providers can often 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 Product and Benefit Tip Sheets page.

Minnesota Health Care Programs (MHCP)

Product	Application submission	Eligibility determination or renewal
Prepaid Medical Assistance Program (PMAP)	MNsure or counties via paper application	Counties via MNsure
MinnesotaCare	MNsure	DHS via MNsure
Minnesota Senior Care Plus (MSC+)	MNsure or counties via paper applications	DHS via MNsure
UCare's Minnesota Senior Health Options (MSHO)	Counties, UCare	DHS, CMS
UCare Connect (SNBC)	UCare, MNsure (non-duals)	DHS, non-duals via MNsure
UCare Connect + Medicare	UCare	DHS, CMS, some via MNsure

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

MSHO, UCare Connect or UCare Connect + Medicare: an applicant interested in enrolling in these plans 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.

Primary care clinics: 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.

Pregnant members: 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 the 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.

To apply: visit the DHS Applying for Medical Assistance (MA) or MinnesotaCare page or the MNsure home page.

To renew: visit Renewing MA and MinnesotaCare eligibility.

MNsure Navigators can help members apply and renew their eligibility. Visit Help from a Navigator or MNsure to find a local navigator.

Medicare programs

UCare Medicare Plans, UCare Your Choice, EssentiaCare, 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. The chances to make changes 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 Advocate Choice (HMO-I-SNP) or UCare Advocate Plus (HMO-I-SNP) plans. If a member is enrolled in a Medicare Supplement plan and changes to a Medicare Advantage plan they are **required to cancel their Medicare Supplement plan**.

UCare Medicare Plans, UCare Your Choice, and EssentiaCare

Individuals who are eligible for Medicare and wish to enroll in a UCare Medicare Plans, UCare Your Choice or EssentiaCare plan must submit a completed enrollment application to UCare during the annual enrollment period (AEP) or a special election period. 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 toll-free 1-877-523-1518
- **UCare Your Choice Plans:** 612-676-6627 or 1-833-951-3188 toll-free
- **EssentiaCare**: 612-676-6630 or toll-free 1-855-432-7027

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 can call the UCare Sales department to enroll at 612-676-6532 or 1-833-276-1188 toll-free, can use a paper application or the DocuSign form found on the 2025 Medicare Supplement Plan Documents and Forms page.

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 receive or be 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 can enroll for coverage through MNsure or directly through UCare. Consumers must enroll through MNsure to be eligible for financial help (subsidies). Consumers can access MNsure through MNsure.org. 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 Individual and Family Plans:** 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 partner 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 on 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 following:
    - 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 the UCare 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
      PO 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.
    - **Note:** The UCare Provider Portal must be used for MSHO and UCare Connect + Medicare verification. The D-SNP members have 90 days of extended coverage following Medical Assistance (Medicaid) termination.
- 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 or UMPI number, UCare member ID, member's date of birth and the claim date of service ready.
- Access the 270/271 transaction via Availity. If your clearinghouse has not done so, they can enroll with Availity Essentials to transmit these transactions to your organization. Have your clearinghouse contact Availity at 1-800-282-4548 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 eligibility information.

For MHCP 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.

- **Note:** If MN-ITS shows Medical Assistance inactive for D-SNP members, the provider must verify the UCare enrollment status via the UCare Provider Portal as these members have 90 days of coverage following loss of Medical Assistance eligibility.

MN-ITS has the most current eligibility information and can reflect a member's eligibility changes before the health plan is notified, except for D-SNP members as indicated above. Providers 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 the primary clinic or the member's UCare ID number. If UCare is the patient's health plan, providers 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 or restricted member program

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 the criteria for program enrollment are met as defined by Minnesota 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 cost-effectively.

- All restricted recipients have designated providers that must provide all services, including a primary care provider (PCP), clinic, hospital (including emergency room) and pharmacy. The designated PCP manages referrals to non-designated providers such as specialty providers.
- Initial placement in the restricted recipient program lasts for 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 to obtain equipment, supplies, health services or medications.
- Continuing to engage in abusive practices of the program after receiving UCare's written warning that the conduct must cease.
- Duplicating or altering prescriptions.

In addition, DHS or another health plan can restrict MHCP recipients. MHCP recipients under restriction who change plans remain under restriction with the new MHCP plan until they satisfy the period of the restriction and meet the criteria for discharge.

Prescription monitoring

All prescriptions for restricted recipients must be written by their designated PCP or by a provider whom the recipient has been referred to by the PCP 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 the criteria for program enrollment.
- Once the recipient meets the program enrollment criteria, the RRC sends the Notice of Agency Action, which gives the member an opportunity to select their own providers. If the recipient does not select a provider, the assigned RRC will choose one for the recipient.

- Each member enrolled in the MRRP is offered case management services by their assigned RRC. The RRC assesses the member's needs, including medical, mental health, substance use, and social determinants of health and develops a member-centric care plan.

Provider involvement

- The designated PCP is responsible for holistically overseeing the recipient's health care.
- The designated PCP authorizes referrals to other providers as medically necessary.
- UCare's Restricted Recipient Program only accepts specialty provider referrals submitted within 90 days of the service being rendered. Referrals are required from the recipient's assigned PCP for any specialty provider visits for a UCare member enrolled in the Restricted Recipient Program.
- The designated PCP may authorize some or all the other providers in the primary care clinic to see and prescribe for the recipient if the PCP is unavailable.
- All visits to non-assigned hospitals for emergency room visits will be denied. We do not accept specialty referrals for emergency room visits.

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 PCP, the claim may not be paid.

Use the following forms to refer recipients to the UCare Restricted Recipient Program. They are located on the Authorization webpage, under Restricted Recipient Program:

- Restricted Recipient Program Intake Form
  - A referral form used to refer UCare recipients to the Restricted Recipient Program
- Specialty Referral Form
  - A referral form used to refer 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 or vision care (unless the provider is prescribing medication)
    - Routine vaccination administered at pharmacies
    - Durable medical equipment
    - Diagnostic procedures at an independent diagnostic testing facility (unless the provider is prescribing medication)
- Prescribing Privileges for PCP Partners
  - A referral form used to allow 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 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 PCP, primary care clinic, hospital and pharmacy for coordination of services if UCare determines a member received health care services or prescription drugs in a manner that may be harmful to their health.

There is no restriction for emergency care.

The forms below 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

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 DentaQuest)
- DDS-Medical — Dentist
- DC — Doctor of Chiropractic (delegated to Fulcrum)
- 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)
- LBA — Licensed Behavior Analyst (MN only, must be a certified BCBA)
- 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
- LPC — Licensed Professional Counselor (WI only)
- 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.
- Telehealth Practitioners see the Telehealth requirements section.
- Locum tenens practitioners (all types) require credentialing.

Practitioners who do not require credentialing

- AuD — Audiologist
- AAAE — 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 Registered Behavioral Technicians (MN only)
- EIDBI — Board-Certified Assistant Behavior Analysts (BCaBA) (MN only)
- MD — Doctor of Anesthesiology (pain management practicing in a clinic setting requires 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 or 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 or 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. UCare's Credentialing Plan governs all actions related to acceptance, denial, discipline and termination of participation status for a practitioner or organization. This provider manual section is not intended to supersede the credentialing plan.

Providers should not provide service to UCare members until their credentialing process has been completed. UCare has no obligation to reimburse claims submitted for a practitioner's services until the practitioner has successfully completed the credentialing process. UCare will collect and verify all credentialing criteria in accordance with the National Committee for Quality Assurance (NCQA),

Centers for Medicare & Medicaid Services (CMS) and Minnesota Department of Health (MDH) standards. Applicants need to cooperate fully in providing all documents requested by UCare.

Credentialing and recredentialing application submission process

Practitioners

For credentialed type practitioners, the Minnesota Uniform Credentialing and Recredentialing Application can be submitted through Credential Smart at 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 Credential Smart at credentialsmart.net. 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.

Telehealth requirements

To practice telehealth, providers must meet all Federal and State requirements. Requirements may include licensing, education exams and background checks.

Many states are revisiting their licensure process for telehealth; therefore, it is imperative that providers follow the requirements.

Health professionals must meet any applicable licensure requirements of the state where they are located and be licensed and or legally permitted to practice in the state where the patient is located. The licensure process is intended to protect the general public and to ensure patient safety. Health care providers are expected to maintain and renew their license(s).

Maintenance may require an annual fee, continuing education and self-reporting disciplinary actions.

Organizations

Organizations that require credentialing are required to complete the MN Uniform Facility Credentialing Application located in the Organization or Facility Forms section of the Credentialing and Recredentialing page on UCare's Provider website. The application and supporting documents can be submitted to credentialinginfo@ucare.org.

Credentialing and recredentialing process

- UCare's Credentialing staff evaluates completed applications 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 or 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, sanctions and Medicare Opt-Out actions taken with respect to its participating providers. If such licensure actions indicate a disciplinary action or OIG or Preclusion List exclusion, UCare will take whatever disciplinary or termination actions are appropriate in view of the information obtained.

More information

- Credentialing forms: visit the Credentialing and Recredentialing page.
- Credentialing questions: Contact UCare's Credentialing department at credentialinginfo@ucare.org.
- Claims and contracting questions: Contact UCare's Provider Assistance Center at pac@ucare.org or 612-676-3300 or 1-888-531-1493 toll-free.

Delegated provider contacts

Chiropractic

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

Dental

DentaQuest
Website: www.dentaquest.com
Email: NetworkDevelopment@dentaquest.com
Phone: 1-855-873-1283 toll-free

Hearing

TruHearing, Inc.
Website: www.truhearing.com
Phone: 1-855-286-0550 toll-free

Claims and payment

Claim submission

All Minnesota providers are required to submit claims electronically. **Mailed paper claims from Minnesota providers will be rejected for all products** including Medicare, Individual & Family Plans and Minnesota Health Care Programs. See this manual's Electronic Data Interchange chapter for details on the submission process and guidelines.

For UCare Medicare Supplement Plan members, submit claims directly to Medicare as shown on the member's Medicare ID card.

- The Medicare provider will submit a claim directly to Medicare.
- Medicare will crossover the 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.

For delegate claim information on chiropractic, dental, hearing aids and hearing aid assessment, therapeutic massage, vision and pharmacy services, please see the Working with UCare's delegated business services chapter.

Clearinghouse or trading partner information

A clearinghouse allows you to submit secure claims electronically to the insurance payer.
For more information on electronic claims transactions and HealthEC, visit the Electronic Data Interchange chapter.

Paper claims - available for non-Minnesota providers

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. We use an optical character reader (OCR) for paper claims. Faxed copies of claims may not be accepted if the image quality is poor.

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.

Mail paper claims and completed W-9 to:

UCare
Attention: Claims
PO Box 70
Minneapolis, MN 55440-0070

Fax:

612-884-2261

Timely filing

- Medical Assistance (Medicaid) products (including dual plans where UCare is the primary payer) - Effective for dates of service August 1, 2023, initial claims must be received no later than six months after the date of service.
- All other product lines (including Medicare and IFP) - 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 Claim adjustments and appeals.

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.

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.

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).

Remittances

UCare accompanies all payments with a remittance that outlines UCare claim processing and billing information. We list payment or non-payment code explanations on each remittance.

Explanation of payment (EOP)

Review remittances 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 remittances or EOPs according to your business record retention policies.

Select the Administrative Resources accordion on the Claims page to access the Explanation of Payment (EOP) Provider Guide.

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

UCare offers EFT and 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.

Submission guidelines and 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 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 the Claim adjustments and appeals section of this chapter.
- 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.
- There are certain billing providers that do not require a rendering provider NPI and taxonomy on a claim. "Rendering Provider" information on the claim is for practitioner information only, not the location where the service was rendered. A current list of the most common billing providers that do not require a rendering NPI and taxonomy on the claim is available on UCare's Claims & Billing webpage under "Taxonomy Requirements."
- 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 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 Reference Number.
    - UB-04-Form field 64 Document Control Number.

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

Taxonomy code requirements

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 health care provider type, classification and specialization. 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.

Taxonomy on claims

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. A claim will be rejected when taxonomy is not reported on a claim that includes a NPI number(s).

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

- Professional claims (submitted via 837P or CMS-1500) - billing and rendering taxonomy
- Institutional claims (submitted via 837I or UB-04) - billing and attending taxonomy

For services that require rendering NPI and taxonomy, do not submit billing NPIs and taxonomy in the rendering fields. Many services require an individual practitioner to render the service. In these instances, the NPI and taxonomy should reflect the practitioner delivering services, 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 or 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 coordinated with UCare coverage that 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. 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 chapter for more details.

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

Reporting taxonomy on claims

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

Taxonomy type	Paper claim box	837P loop professional	837I loop institutional
Billing provider	CMS-1500 Box: 33B with ZZ indicator UB-04 Box: 81CC, box a First box - Qualifier B3 Second box over - taxonomy number	**2000A** - Billing provider specialty information PRV01 - BI for billing provider PRV02 - PXC (Health Care Provider Taxonomy) PRV03 - Taxonomy number	**2000A** - Billing provider specialty information PRV01 - BI for billing provider PRV02 - PXC (Health Care Provider Taxonomy) PRV03 - Taxonomy number
Rendering provider	CMS-1500 Box: 24J with ZZ indicator	**2310B** - Rendering Provider Specialty Information PRV01 - PE for performing provider PRV02 - PXC PRV03 - Taxonomy number	N/A
Attending provider	N/A - taxonomy not required on paper claims	N/A	**2310A** - Attending provider specialty information PRV01 - AT for attending provider PRV02 - PXC (Health Care Provider Taxonomy) PRV03 - Taxonomy number

The rendering provider NPI and taxonomy should be reported when required and it is different than the billing provider NPI or 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.

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**. Providers must regularly verify and update their enumeration with CMS and NPPES. Confirm that the taxonomies linked to your NPPES and CMS enumeration are current and accurately reflect the provider specialties billed under each NPI.

Currently, UCare does not require 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 those 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 in the Taxonomy Code Requirements drawer on the Resources for Electronic Transactions webpage.

Duplicate claim submission

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

- Consult 277CA response reports from your clearinghouse.
- Check the 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.

UCare's standard practice is 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 and appeals 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.

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).

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)
- Minnesota National Correct Coding Initiative (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 and modifiers. UCare requires providers to use Healthcare Common Procedural Coding System (HCPCS) codes, International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM), Procedure Coding System (ICD-10-PCS) and Current Procedural Terminology (CPT) codes as well as Revenue codes. Code sets must be reported in accordance with the type of claim submitted.

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.

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

Delegates

For claim information for chiropractic, dental, hearing aids and hearing aid assessment, vision and pharmacy services, see the Working with UCare's delegated business services chapter.

Notifying UCare of contracts with third-party billers

Visit the Provider responsibilities chapter for information.

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.

UCare claims edits

The following edits apply to all UCare plans.

UCare claims editing and prospective payment system

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)
- Home Health Agency (HHA)
- Professional Services

These edits align with CMS and DHS guidelines and UCare's published Payment Policies.

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), Home Health Agency (HHA), and Professional Services. This change brings greater efficiency to the claims payment process and consistency to provider payments.

Strategic National Implementation Process (SNIP) edits

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 or 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 or 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) service edits

UCare uses version 6.0 of the Claims Edit System (CES) in the claims adjudication system.

Local Coverage Determinations and National Coverage Determinations 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 and NCD updates to UCare bi-weekly. Once UCare receives the updates, we implement them within 15 business days.

The published LCD and 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 and/or 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'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.

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

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***
			In-patient	**Out-patient**	**In-patient**	**Out-patient**	
Prepaid Medical Assistance Program (PMAP)	• Semi-Annual January and July MHCP file • Vaccines: as notified	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other services: Semi-Annual January and July MHCP file	Per provider contract	Semi-Annual January and July MHCP file	Annual	Semi-Annual January and July MHCP file	As notified
Minnesota Care	• Semi-Annual January and July MHCP file • Vaccines: as notified	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other services: Semi-Annual January and July MHCP file	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+)	• Semi-Annual January and July MHCP file • Vaccines: as notified	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other services: Semi-Annual January and July MHCP file	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	• Semi-Annual January and July MHCP file • Vaccines: as notified	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other services: Semi-Annual January and July MHCP file	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 or ambulatory surgical centers (ASC)**	**Mental health**	**Hospital**		**Skilled nursing facility**		**Specialized providers or services paid outside published MHCP and CMS fee schedules***
			In-patient	**Out-patient**	**In-patient**	**Out-patient**	
UCare's Minnesota Senior Health Options (MSHO)	• CMS Services Quarterly or DHS Services • Semi-Annual January and July MHCP file	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other: CMS Services Quarterly or DHS Services Semi-Annual January and July MHCP file	Annual	Quarterly	Annual	Quarterly	As notified
UCare Connect + Medicare (SNBC) Integrated	• CMS Services Quarterly or DHS Services • Semi-Annual January and July MHCP file	• Services per DHS Mental Health Codes and Max Adjusted FFS Rate Grid: as notified • EIDBI and CCDTF Services: as notified • Other: CMS Services Quarterly or DHS Services Semi-Annual January and July MHCP file	Annual	Quarterly	Annual	Quarterly	As notified
UCare Medicare Plans	Quarterly	Quarterly	Annual	Quarterly	Annual	Quarterly	As notified
EssentiaCare	Quarterly	Quarterly	Annual	Quarterly	Annual	Quarterly	As notified
UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview	Quarterly	• State Only Services: Annual • Other Services: Quarterly	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 on 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 Minnesota Statute § 295.52 (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.

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 Program (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 Minnesota Department of Human Services Provider Manual.

A remittance advice from the primary payer(s) must be submitted and received by UCare within 12 months of the remittance advice date.

For specific loop and segment submission guidelines, 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 fax supporting documentation, including the Administrative Uniform Committee (AUC) cover sheet, to 612-884-2261 with Unsuccessful TPL Billing as the subject.

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 by product

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 the following 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 or Item (DHS-3640) Form.
- See the DHS policy on billing MHCP 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:

- All MHCP members, except for MinnesotaCare members, do not have any cost-sharing for state plan Medical Assistance benefits.
- **MinnesotaCare:** American Indian members enrolled in a federally recognized tribe who are under 21 and pregnant do not have copays. Other MinnesotaCare members do have cost sharing. Refer to the UCare State Public Programs tip sheet within the 2025 Product/Benefit Tip Sheets accordion on the Provider Tip Sheet page for cost sharing amounts. There are no family deductibles for MHCP members.
- **UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare:** Depending on income, enrollees are responsible for Part D prescription drug copays if they reside in the community and do **not** receive home and community-based services (waiver services).
- **UCare's Minnesota Senior Care Plus (MSC+), MSHO, UCare Connect and UCare Connect + Medicare:** Members with medical or institutional spenddowns and waiver obligations will continue to have that cost sharing responsibility.

Medicare Advantage Plans

UCare Medicare Plans 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 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)I; 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, copayments will be 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 Medicaid providers 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 beneficiaries 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 can identify patient QMB statuses 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.

Claims payable calendar

The Claims Payable Calendar is available on the Claims & Billing webpage under the Payment & Remittance section.

Claim adjustments and appeals

UCare has the right to make, and providers have the right to request, adjustments to any previous payment for, or denial of, a claim for covered services. However, any corrections initiated by UCare, or requests for corrective adjustments made by the provider must occur within twelve months from the date the claim was paid or denied by UCare. Requests received from providers outside of this established timeline will result in a timely filing denial.

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 or 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 or 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 the Void and replacement claim section.

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:

- Visit the Claims & Billing webpage, under Forms & Links open the Provider Claim Reconsideration Form, select "Refund" and submit; 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 or void claim is more appropriate to correct payment.

Mail refund checks to:

UCare
Attn: Accounting
PO Box 52
Minneapolis, MN 55440

Provider adjustment requests

Providers may submit a request for claim adjustment if they believe a claim was processed and paid incorrectly on initial review. Providers should use the Provider Claim Reconsideration Form under Forms & Links on the Claims & Billing webpage to request an adjustment when the original claim was processed incorrectly, even though correct information was provided.

Provider appeals

Providers can request an appeal to UCare to resolve administrative and contractual determination issues. An appeal will be accepted after the above adjustment request process has been completed. If, after the review of an adjustment request, a provider still believes a claim is processed incorrectly, an appeal request must be submitted to UCare. Providers must submit a completed Provider Claim Reconsideration Form found 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. If a UCare member has 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 regularly updated 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 with 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 appeals

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
PO Box 405
Minneapolis, MN 55440-0405

Fax:

612-884-2186

Include the following: the UCare Provider Claim Reconsideration Form found 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 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 and Provider Claim Reconsideration Form can be faxed to 612-884-2186. A Claims Attachment Cover Sheet should not be sent.

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 an overpayment has been determined, the amount is a debt the provider owes 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 made to a non-contracted provider, a recovery letter is sent to the servicing provider requesting the return of the overpaid amount. The provider has 30 days to return the amount owed. UCare will recoup the amount due if no response is received within 30 days. No recovery letter is sent to contracted network providers prior to recoupment if UCare identifies an overpayment.

If you have questions regarding a claim overpayment letter you receive, call the Claims Recovery line at 612-676-6511.

Non-participating 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 UCare's Authorization page for related authorization grids).

Identification of non-participating provider services eligible for in-network benefits:

- UCare will review the Service Facility submitted in Loop 2310C - 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 resolve the claim 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.

Note: UCare is unable to process this request if the service facility information is missing on the original claim, or if the place of service information is not a participating provider in the member's network.

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

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
- UCare's Federally Qualified Health Center - Rural Health Clinic carve-out process
- Home and community based services or waiver services
- Interpreter services
- Maternity, obstetrics and gynecology
- Transportation

Electronic Data Interchange (EDI)

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

Minnesota law requires electronic claim submission

Minnesota statute, section 62J.536, requires 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 (DHS)
- Minnesota Office of the Revisor of Statutes

Electronic claims submission (837)

All UCare claims should be submitted to Payer ID 55413.

UCare's electronic claims transactions are received directly through two different trading partners. Providers or their clearinghouse must contact our trading partners directly to enroll. Contact information is listed below:

Availity

- To register, visit Availity's website
- Phone: 1-800-282-4548 toll-free, Monday through Friday, 8 am – 8 pm EST
- Chat and e-ticketing is available through Availity's Client Services website

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

- To register, visit MN E-Connect or Health EC
- Phone: 1-877-444-7194 toll-free
- On the MN E-Connect or Health EC application, a provider should only indicate UCare in the Payer Name (Insurance company name) section for the request form to receive access to the free DDE (Direct Data Entry) version (Individual Claim Submissions)
    - Costs may be associated if using the application for other payers
- Additional charges may be incurred if indicating "yes" for additional services: Eligibility Services (Request/Response), 837 Batch Claims Submissions, Electronic Remittance Advice (ERA) or Claim Attachments

Clearinghouse set up

Provide the key information below to your clearinghouse to ensure proper transmission of claims to UCare.

Element	Value
ISA07	ZZ
ISA08	UCAREMN
GS03	UCAREMN

If DHS identifies you with an UMPI, you should enroll with UCare and the clearinghouse using your UMPI. If DHS identifies you with an NPI, you should enroll with UCare and the clearinghouse using your NPI.

Type of billing ID	Loop or segment
UMPI	2010BB REF01-G2 REF02-UMPI
NPI	2010AA NM109

Reporting taxonomy on claims

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

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

The rendering provider NPI and taxonomy should be reported when required and it is different than the billing provider NPI or 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.

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 must 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 outlined in the AUC best practice for claims attachments.

See the Claims and Billing page for specifics on adjustment attachments.

EDI transactions or reports

Transaction or report	Definition
Eligibility and benefits (270/271)	Providers can access UCare's eligibility and benefit information through Availity. • If your clearinghouse has not already done so, it can enroll with Availity to transmit these transactions to your organization. • Clearinghouses working directly with the provider can contact Availity to begin the enrollment and provisioning process.
Health care claim status (276/277)	At this time, providers may check individual claim status through UCare's Provider Portal. We are working to make the 276/277 transaction available through Availity in 2025.
Electronic claims or claims response* (837/277CA)	When claims reject for missing information, the rejected claims will be reported to providers by their clearinghouses on acknowledgment 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. A 277CA report validates the claims at the pre-processing stage. The report will show the following for each claim line: • Claim is accepted, will receive a claim number and be processed, or • Claim was rejected along with the reason why.
Implementation acknowledgements (999)	A 999 acknowledges that the EDI batch submitted to UCare is "packaged" appropriately. • Batch is readable and will move on, or • Batch is unreadable and is being returned.
Electronic remittance advice or remit (835)	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: • Denied, or • Paid (payment information will be listed).

**Taxonomy rejections: 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 or encounter is missing the information specified in the status details and has been rejected) and error code 145 (entity's specialty or taxonomy code). To avoid payment delays on these claims, add taxonomy to the claim and resubmit it to UCare.*

Additional information and companion guides can be found on the Resources for Electronic Transactions webpage.

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 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. Find it in the Other Resources accordion on the EDI webpage.

X12
Chartered by the American National Standards Institute for over 40 years, X12, develops and maintains EDI standards and XML schemas that 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

This chapter provides information regarding authorization and notification requirements for UCare and 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 within a designated time frame.

Pre-determination: 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 the plan will cover an item or service.

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, if it is an appropriate eligible expense and that other alternatives have been considered.

General guidelines

Some services require authorization or notification; 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 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 members utilize 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 determining each service type. 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 to the appropriate approval authority via fax, mail or secure email. 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 this manual's Medical necessity criteria section. Additional information regarding documentation required for authorization and notification review is outlined there.

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

Note: UCare does not require photographs.

Reminders when submitting authorization requests

All fields on the authorization request forms 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 request forms for Medical and Mental Health and Substance Use Disorders (MHSUD) can be found on the Authorization page of the UCare provider website. To view authorization request forms, choose the appropriate service category and scroll to Forms.

Note: Providers should fax each member's authorization request separately to comply with HIPAA and internal compliance requirements. When authorization requests are faxed in bulk, it increases the risk of information getting lost or inappropriately filed.

Services that require pre-determination (PD)

A PD is needed to hold a UCare Medicare Plans 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 and EssentiaCare providers should not use the Advanced Beneficiary Notice (ABN).

Timelines for decision and notification for authorization requests

Medicare

Standard review

- The timeframe for an authorization decision for medical items or services is within 14 calendar days from the date the request was received. UCare considers the 14-calendar-day timespan to begin on the day of receipt, which is counted as day one. The standard decision timeframe for medical injectable drug requests is 72 hours from the date the request was received.
- Notification to the requesting, attending or ordering provider is made via fax, telephone or secure email, followed by a written decision, when applicable. That disclosure is to be made within one business day of the decision but not to exceed a total of 14 calendar days from the date the request was received for a medical item or service and 72 hours from the date the request was received for a medical injectable drug.
- 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 from the date the request was received for a medical item or service and 72 hours from the date the request was received for a medical injectable drug.

Expedited review

- The timeframe for urgent or emergent medical items or service requests is 72 hours from the date the request was received and 24 hours from the date the request was received for medical injectable drug requests. **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 for a medical item or service and 24 hours from the date the request was received for a medical injectable drug.
- 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.

Medical Assistance (Medicaid)

Standard review

- The timeframe for an authorization decision is 24 hours from receipt of the request.
- 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.
- Written notification of the decision is sent to the member via U.S. mail or a confirmed secure email within ten (10) business days following receipt of the request.

Expedited review

- The timeframe for urgent or emergent requests is 24 hours from receipt of the 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.

- 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 ten (10) business days following receipt of the request.
- **Do not** submit **expedited requests** for post-service or retrospective authorizations.

UCare's Individual and Family Plans

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, which 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 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 from receipt of the 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

Fax requests to UCare:
612-884-2033 or 1-855-260-9710
Attn: UM Mental Health and Substance Use Disorder Services

Mail requests to:
UCare
Attn: UM Mental Health and Substance Use Disorder Services
PO Box 52
Minneapolis, MN 55440-0052

Direct questions to 612-676-6533 or 1-833-276-1185 toll-free.

Medical requests

Fax requests to UCare:
612-884-2499 or 1-866-610-7215
Attn: UM Medical Services

Mail requests to:

UCare
Attn: UM Medical Services
PO 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).

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 this manual's Medical necessity criteria chapter and are available upon request. Specific criteria for medical necessity may be obtained by submitting the Medical Necessity Criteria Request Form via the UCare website. 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 the 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 result in the 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.

Coverage policies

Coverage Policies are developed to clarify coverage for UCare benefits under UCare's health plans. Coverage policies accompany the coverage and benefit information in UCare's member contracts.

Coverage policies are intended to serve as a general reference regarding UCare's administration of health benefits. They are not intended to address all issues related to coverage for health services provided to UCare members.

Providers can access UCare Coverage Policy information by going to the Policies and Resources page and selecting Coverage Policies within the Policies accordion. Here, providers can learn more about the Coverage Policy team and specific coverage policies.

Medical necessity criteria for services requiring authorization

For services to be eligible for payment by UCare, they must meet UCare's standards for coverage, including medical necessity criteria. Coverage and benefits vary significantly among 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
- 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, a column for Medical Necessity Criteria is included, outlining the relevant criteria and reference sources for medical procedures or services.

Medical necessity overview 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 Medicare Plans and Institutional Special Needs Plans

1. 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 National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
3. American Society of Addiction Medicine (ASAM) Criteria powered by Change HealthCare InterQual as appropriate for substance use disorders (SUD)
4. Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance
5. Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services
6. Medicare Benefit Policy Manual Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
7. UCare medical policy (when none of the above is appropriate)
8. When medical necessity criteria are unavailable from InterQual, CMS, ASAM or UCare medical policy, medical necessity determinations are based on credible scientific evidence, which include:
    - Published peer-reviewed literature

- Consensus statements or guidelines from national medical alliances or specialty societies
- HAYES Technology Assessment

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

1. MSHO and UCare Connect + Medicare follow 1-2 and 5 above in ranked order, which are:
    - InterQual
    - Written criteria developed and published by the Centers for Medicare & Medicaid Services (CMS) including NCDs and LCDs
    - UCare medical policy (when none of the above is appropriate)
2. Medicare Benefit Policy Manual Chapter 1, Inpatient Hospital Services Covered Under Part A
3. Medicare Benefit Policy Manual Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance
4. Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services
5. Medicare Benefit Policy Manual Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
6. 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
7. ASAM criteria powered by InterQual as appropriate for SUD
8. When medical necessity criteria are not available from InterQual, CMS or UCare medical policy, medical necessity determinations are based on credible scientific evidence, which include:
    - Published peer-reviewed literature
    - Consensus statements or guidelines from national mental health or substance use disorder alliances or specialty societies
    - HAYES Technology Assessment

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

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

UCare Individual & Family Plans

1. InterQual, a nationally recognized evidence-based medical necessity criteria guideline
2. ASAM criteria powered by InterQual as appropriate for SUD
3. UCare medical policy (applied when none of the above is appropriate)

4. When medical necessity criteria are unavailable from InterQual or UCare medical policy, medical necessity determinations are based on credible scientific evidence, which include:
    - Published peer-reviewed literature
    - Consensus statements or guidelines from national mental health or substance use disorder alliances or specialty societies
    - HAYES Technology Assessment
5. Member Contract

General references

- Clinical criteria resources:
    - Medical Assistance (Medicaid): Minnesota Health Care Programs (MHCP) Provider Manual
    - Medicare: CMS Medicare Coverage Database at National Coverage Determinations (NCD), Local Coverage Determinations (LCD)
- Medicare Benefits Policy Manual & Medicare National Coverage Determinations Manual: CMS Gov Regulations and Guidance IOM

Member appeals and grievances

Member rights and responsibilities

UCare takes members' rights and responsibilities seriously, and practitioners are expected to be familiar with them. Find Member Rights and Responsibilities for each plan in the Evidence of Coverage, Member Handbook or Member Contract. These documents are available by plan on the Plan Documents and Information page.

The 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 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 facilities, home health agencies, 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 or in the waiting room, clinic, hospital or 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 65 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 decisions 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: 1-888-524-9900 toll-free
      Fax: 1-833-868-4059 toll-free

Member appeals | definitions and overview

Plans: UCare Medicare Plans (UCare Aware, UCare Classic, UCare Complete, UCare Essentials Rx, UCare Standard, 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), 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 the 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 65 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 and 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 Medicare Group Plan, UCare Your Choice and UCare Your Choice Plus), EssentiaCare (EssentiaCare Access, EssentiaCare Grand and EssentiaCare Secure), 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 the 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 65 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 decisions 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: 1-888-524-9900 toll-free
      Fax: 1-833-868-4059 toll-free

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 65 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 who 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 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, 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: 1-888-524-9900 toll-free
      Fax: 1-833-868-4059 toll-free

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 pursuance to Minnesota Statute, related to the delivery of health services or participation in UCare, denial (full or partial) of a claim or service, failure to make an initial determination in 30 days, or any other action or grievance.

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 who 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
PO 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
PO 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 Medical Assistance (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 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 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 pursuance to Minnesota Statute, related to the delivery of health services or participation in UCare, denial (full or partial) of a claim or service, failure to make an initial determination in 30 days, or any other action or grievance.

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, childcare, 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 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 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
PO 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 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. 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 72 hours of receipt of the request.

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, Utilization Management 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 1-866-283-8045 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 the 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 the 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

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

For more information, visit the Clinical Practice Guidelines webpage.

Quality program

Quality Program goals and standards

UCare's mission is to improve the health of our members through innovative services and partnerships across communities. To achieve this, we embody five goals: enhance member experience, improve member health, reduce care cost, increase health care provider satisfaction and advance health equity.

The Quality Program is a testament to this commitment through professional excellence, continuous learning, teamwork and collaboration. It was designed to meet or exceed the quality-related standards set by various regulatory bodies, including 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 clinical components of our Quality Program are firmly grounded in evidence-based guidelines and encompass the entirety of care provided by participating and contracted providers. This includes a broad spectrum of services, including medical, mental health to substance use disorder, dental, specialty care and pharmacy services. These services are delivered in diverse settings, from ambulatory and hospital settings to emergency departments and skilled nursing facilities. Moreover, UCare actively collaborates with its provider partners, to foster a culture of information sharing, practice guideline dissemination and implementing strategies to elevate the quality of care and service experience.

Our dedication extends to our members, as we consistently seek their feedback regarding their health care experiences and interactions with our plan. We assess various aspects of service quality, including accessibility, availability, accommodation of linguistic and cultural preferences, and the administrative functions that impact care delivery. This collaborative approach ensures that UCare remains a responsive health plan that consistently delivers on its promises.

To cater to the diverse needs of our membership, including those with limited English proficiency and varying cultural backgrounds, UCare conducts rigorous analysis, monitoring and evaluation of its processes. This allows us to gain deeper insights into the demographics of our served populations, covering age groups, disease categories, social factors and risk levels. Our Quality Program devises targeted interventions to address health care disparities and social risk factors, all with the ultimate goal of assisting our members in achieving optimal health. The systematic monitoring, evaluation of services and proactive pursuit of improvement opportunities, underline our commitment to optimizing care and services while efficiently utilizing health care resources.

In support of this ongoing process, UCare identifies and implements various initiatives and projects to enhance our members' health outcomes and experiences. Any concerning trends identified during our monitoring activities may evolve into performance improvement projects, focus or outcome studies. These initiatives may encompass 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. UCare then develops an action plan and seeks physician input through our Quality Committee structure. Subsequently, we collect outcome data and conduct rigorous analyses to gauge the effectiveness of our actions.

Through UCare's Quality Program, we are dedicated to delivering exceptional health care services, improving the lives of our members and positively impacting the communities we serve. Review UCare’s current, ongoing 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 the results of these audits with providers if specific deficiencies are found.

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	The 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 or absence of allergies or 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 or counseling of smoking habits and/or exposure.
10	Documentation exists related to the inquiry or counseling of alcohol or other substance habits and/or exposure.
11	Abnormal lab or 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 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 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 the day of admission or within two days or evidence of a pre-admission exam completed about a planned admission.
- Receipt of discharge information on the day of discharge or within two days. 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 that members receive a complete medication reconciliation within 30 days of discharge. Medication reconciliations help reduce the likelihood of readmission and can be part of a follow-up visit or 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 the 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 the 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, rehabilitation and long-term acute care hospitals.

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 the audit results with providers if specific deficiencies are found.

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
- UCare Medicare Plans Members

Compliance and fraud, waste and abuse

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, three 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 member safety at risk.

What is UCare doing about it?

UCare takes a proactive approach to detect and investigate potential health care fraud, waste and abuse (FWA). UCare has a Special Investigations Unit (SIU) to detect and investigate FWA allegations. The SIU detects potential FWA through ongoing audits and analysis of billing patterns. The SIU also receives reports or complaints of suspected FWA. 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 FWA.

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 FWA. 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 FWA, which providers must follow and UCare helps enforce. In addition, UCare's provider contracts have important terms addressing FWA.

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 Medical Assistance (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 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 results in unnecessary costs to UCare, or that fails 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 costs 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.
- The supervisor's countersignature and documentation (if applicable).
- Report of the member's progress or response to treatment, and changes in the treatment or diagnosis.
- 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 FWA 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, financial records, 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 service area.
- 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 chapter).
- Most importantly, report any suspected fraud, waste or abuse to UCare (see the Contacting UCare section below).

Obligations for providers who serve Medicare and/or Medical Assistance enrollees

Providers of administrative or health care services to Medicare and/or Medical Assistance-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 Medicare Managed Care Manuals Chapters 9 and 21 requirements.
- 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 Medical Assistance-eligible individuals under the Medical Assistance, 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 Medical Assistance program violations and/or FWA concerns to UCare, and the 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 Medical Assistance program violations and/or FWA 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 to monitor any of their downstream entities' compliance with Medicare and/or Medical Assistance 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 Medical Assistance requirements, UCare may:
    - Audit the provider;
    - Require self-monitoring reporting, such as training completion evidence, of the provider; and
    - Require the provider to 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 eight for provider-specific expectations related to UCare's Code of Conduct.

Contacting UCare

If you suspect any of the above situations or have questions, contact UCare's 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 in the following ways:

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

  UCare Special Investigations Unit
  PO 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 or gender) and health status (diagnostic data). Based on these predictions, a health plan receives monthly capitated payments 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 government agencies with valid and accurate encounter data for calculating risk adjustment payments. The primary source of encounter data submitted for this calculation is extracted from claims with additional health conditions 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 the medical record documentation from a face-to-face encounter between the patient and the provider supports reported diagnosis codes.
- Document all conditions being assessed during the encounter, including those 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 no longer present conditions. Do not use "history of" to report a condition that is present and actively being treated or monitored.
- Document an evaluation or assessment and plan for all active conditions. Diagnoses listed solely in a problem list are not acceptable for risk adjustment.

    - Assessment language examples: stable, improved, tolerating treatment, unstable, etc.
    - Plan examples: 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 can "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.

Providers are expected to have quality assurance processes in place to validate the diagnosis codes submitted on claims (encounter data) and to immediately report any corrections or issues with respect to previously submitted codes to UCare. UCare expects providers to 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 states it will validate encounter data by performing annual risk adjustment data validation (RADV) audits on a selection of Medicare Advantage plans. The U.S. Department of Health and Human Services (HHS) requires all Affordable Care Act (ACA) exchange plans to participate in an annual data validation audit. 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

UCare actively supports and promotes behaviors, attitudes and policies that enable providers to deliver services 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 and 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 potentially be cost-efficient.

Culturally congruent care:

- Allows the provider to obtain complete information to diagnose appropriately.
- Facilitates the development of treatment plans that the patient follows.
- Reduces delays in seeking care.
- Enhances overall communication between provider and patient.
- Enhances the compatibility between Western and traditional cultural health practices.

The culturally congruent provider:

- Has the knowledge to make an accurate health assessment that considers a patient's background and culture.
- Has the ability to convey that assessment to the patient, recognize culture-based beliefs about health and devise treatment plans that respect those beliefs.
- Is willing to incorporate health and health care delivery models from various 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.

The following chart illustrates the diverse membership enrolled in the Minnesota Health Care Programs UCare offers as of April 2024, as a percentage of enrollment:

Self-identified race	Asian	Black or African American	Hispanic	Native American (American Indian or Alaskan Native)	Native Hawaiian or other Pacific Islander	Unknown	White or Caucasian (Not of Hispanic Origin)
Prepaid Medical Assistance Program (PMAP)	12%	33%	14%	2%	0%	5%	42%
Minnesota Senior Care Plus (MSC+)	18%	32%	4%	2%	0%	1%	46%
MinnesotaCare	14%	24%	13%	1%	0%	8%	50%
Minnesota Senior Health Options (MSHO)	15%	21%	3%	1%	0%	0%	61%
UCare Connect + Medicare	6%	13%	3%	3%	0%	0%	76%
UCare Connect	7%	24%	4%	4%	0%	0%	62%
EssentiaCare	1%	0%	1%	1%	0%	3%	95%
Medicare Advantage	1%	1%	1%	1%	0%	1%	95%
UCare Individual & Family Plans	2%	2%	2%	0%	0%	11%	84%
UCare M Health Fairview IFP	8%	5%	3%	1%	0%	12%	75%
UCare Medicare Institutional Special Needs Plans (I-SNP)			71%	3%		9%	89%
UCare Your Choice	1%	1%	1%	1%	0%	12%	85%

UCare seeks to ensure members receive the care they need to maintain or improve their health. Several cross-departmental committees analyze various data sources by race or ethnicity and 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 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) that supports health care providers, staff and administrators in providing 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 maintained by the Minnesota Department of Health. In addition, there are a variety of training resources for health care professionals on providing language services and culturally congruent care.

Violet Health

UCare works with Violet Health, a pioneering cultural congruence insights and training platform, to educate providers on health disparities and clinical quality best practices. The platform offers educational resources and training modules focused on health disparities and best practices for inclusive delivery to equip providers with the knowledge and tools to foster a more inclusive and responsive health care environment.

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

UCare innovations in Culturally and Linguistically Appropriate Services (CLAS)

- 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 conduct periodic focus groups to receive input from a diverse range of community representatives.
- UCare is recognized nationally by health professionals. For example, America's Health Insurance Plans awarded UCare 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 workforce reflects the community we serve. Thirty percent of UCare employees are persons of color or American Indian. All new employees are required to attend the "Valuing and Managing Diversity" training.
- UCare integrates the cultural needs of our members into our daily activities. 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).
- 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 improve infrastructure 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 ensure continued interpreter service improvement. 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/UCKPjzRExkIqYtnbTPomxqIw/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:

- The "Language Poster" is available to post public areas. It is available on 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

UCare offers disease management programs to members living with asthma, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), diabetes, hypertension, heart failure and 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 the member's enrollment into certain disease management programs. Review UCare's 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 by learning to manage their chronic condition.

Members can learn more about program offerings by visiting the Managing health conditions page.

Asthma

Interactive voice response (IVR) or texting program

Pediatric and adult members in our IVR or texting program receive regularly scheduled education phone calls and text messages with chronic condition education and condition-related questions to respond to. An asthma educator reviews the answers and triages follow-up support for further education, referral to PCP or enrollment in the asthma education program.

Asthma Education Program

Our asthma program's pediatric and adult members (under 65) 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, and informative materials, may be available to participating members when working with a UCare Asthma Educator. This program is offered through UCare Health Educators and our partnership with Cecelia Health.

COPD

UCare partners with Cecelia Health to provide members with a virtual COPD support program. The program is designed to help members better manage their health. Members partner with a registered respiratory therapist to develop a plan to better understand their health needs and help manage their COPD. Find more information at ucare.org/COPDprogram.

CKD

UCare partners with Cecelia Health to provide members with a virtual CKD support program. The program is designed to help members better manage their health. Members partner with a registered dietician to develop a plan to better understand their health needs and help manage their CKD. Find more information at ucare.org/ckdprogram.

Diabetes

Interactive voice response (IVR) or texting program

Adult members in our IVR or texting program receive regularly scheduled education phone calls or texts providing chronic condition education and condition-related questions to respond to. A health coach reviews the answers and triages follow-up support for further education, referral to PCP or enrollment into the health coaching program.

Health coaching

Adult members in our diabetes program receive regularly scheduled health coaching calls with a UCare health coach. Our 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 them. 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 when working with a UCare health coach. UCare offers this program with our health coaches and our partnership with Cecelia Health.

Type 2 diabetes reversal program

UCare partners with Virta to bring eligible members their virtual nutrition therapy clinic program. The program helps members lower their blood sugar, lose weight and rely less on prescription drugs. Programs are tailored to the member and offer support from medical providers, coaches and digital health tools. To learn more, visit ucare.org/virta.

Chronic Condition Management

Brook Health Companion

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 smartphones. Members can chat with dieticians to help turn health goals into sustainable habits. Features include in-app chats, meal planning and scheduled reminders. Find more information at ucare.org/brook.

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 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 them. 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.

Remote patient monitoring

UCare partners with 100Plus, a Connect America company, to provide remote patient monitoring for members with a heart failure diagnosis. The program helps members manage their health at home and take proactive, preventive steps to stay healthy. Members partner with a 100Plus registered nurse to manage their heart failure at home. Members may receive a blood pressure cuff, blood glucose meter, weight scale or pulse oximeter to help with self-management of their chronic conditions. Members take readings with their device(s) and if their measurements fall outside of the normal range, the team is alerted, and they follow up with the member and their primary care provider. The devices are ready to use out of the box no smartphone, app, Bluetooth or WiFi is required. Batteries and test strip refills are provided at no additional cost.

Migraine management program

Adult members in our migraine management program receive regularly scheduled health coaching calls with a UCare health coach. Our 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 them. Health coaches use active listening, motivational interviewing and behavior change techniques. Migraine management tools are provided to participating members, including a headache management book, migraine diary and action plan.

Weight management program

UCare partners with Cecelia Health to support members through their weight management program. Eligible members receive virtual support from a Cecelia Health registered dietician (RD). The weight management program offers members support with managing weight loss, with or without medication; a personalized nutrition plan; real-time feedback and chat with their clinical team; and the ability to connect smart devices to share results with their clinical team. To learn more, visit ucare.org/wmprogram.

Medication Therapy Management program and pharmacist-provided services

The Medication Therapy Management (MTM) program is a free service for eligible UCare members to optimize their medication therapy and experience. UCare regards MTM services and comprehensive medication management (CMM) services provided by pharmacists as equivalent.

Eligibility

Member plan type	MTM eligible	Eligibility and requirements
Medical Assistance (Medicaid) Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Care Plus (MSC+) and UCare Connect (SNBC)		• UCare follows Minnesota Department of Human Services (DHS) guidance (Medication Therapy Management Services {MTMS}). • MTMS must be completed by an in-network pharmacist. • MTMS may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist. Pharmacists must meet state and federal requirements when providing and billing services via Telehealth (including audio-only).
Dual-eligible Medical Assistance MSC+ Duals, PMAP Duals and UCare Connect Duals		• Members receive Medical Assistance benefits through UCare and Medicare benefits, including MTM services, through an outside payer. Patients should be directed to their primary Medicare payer to determine eligibility for MTM.
Medicare UCare Medicare Plans, UCare Medicare PPO, UCare Medicare Group Plans and EssentiaCare		• All members with Part D benefits are eligible for MTM. • 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. • Not all members will receive active outreach or enrollment letters, but they can opt in or request services at any point. • Some members will receive active outreach for MTM if they meet specific Centers for Medicare and Medicaid Services (CMS) criteria. • MTM services may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist.
Dual-eligible Medicare UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare		• All members with Part D benefits are eligible for MTM. • 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. • Not all members will receive active outreach or enrollment letters, but they can opt in or request services at any point.

Member plan type	MTM eligible	Eligibility and requirements
		• Some members will receive active outreach for MTM if they meet specific CMS criteria. • MTM services may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist.
Medicare Value UCare Value and UCare Value Plus		• Not MTM eligible without Part D benefits.
Individual & Family Plans UCare Individual & Family Plans, UCare Individual & Family Plans with M Health Fairview		• All rendered services (MTM and pharmacist-provided services) must be completed by an in-network pharmacist. • MTM services may be completed in person, telephonically or virtually through interactive video (ITV) with a pharmacist. Pharmacists must meet state and federal requirements when providing and billing services via Telehealth (including audio-only). • Effective January 1, 2025, UCare has updated coverage for pharmacist-provided services per Minnesota Statute 62A.15.

Enrollment expectations

Pharmacists must be enrolled with Minnesota Health Care Programs (MHCP) as an MTM provider prior to UCare enrollment and reimbursement for any billable service (including non-MTM services). Please see details here: DHS MTM website. Pharmacists must be enrolled and participating in UCare's Medication Therapy Management (MTM) network (in-network) and meet all provisions outlined in the UCare Provider Manual.

Provider expectations

UCare expects providers to follow the 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 their medication regimen (including prescription, over-the-counter medications and/or herbal supplements) to help resolve 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 reach out to and provide MTM services to eligible members.

Documentation expectations

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

- Patient demographics*
- Date of encounter
- Chief complaint or reason for the 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)

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

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

****Medical Assistance members must have the patient's location documented if using telehealth.*

*****Medicare members must be provided with CMS standardized format materials (including a 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 pharmacist providers for supporting documentation, which may include, but is not limited to, medical and/or administrative records. The provider is responsible for submitting the requested information within seven calendar days of the request. Pharmacist 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 claims 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, CPT codes applicable to the service provided. Rates are based on individual provider service agreements.

MTM Specific Billing Processes: CPT codes include 99605, 99606 and 99607. MTM services are provided at no cost to members. Members who reside in an inpatient setting are not eligible for MTM services. Contracted pharmacists may submit one CPT 99605 per provider per member in a calendar year. Pharmacists should utilize clinical judgment to determine reasonable cadences for follow-up visits (CPT 99606). 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 used 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	One medical condition	At least one medication	No drug therapy problems	99605 or 99606	One unit
2	One medical condition	At least two medications	At least one drug therapy problem	99605 or 99606 and	One unit
				99607	One unit
3	At least two medical conditions	At least three to five medications	At least two drug therapy problems	99605 or 99606 and	One unit
				99607	Two units

4	At least three medical conditions	At least six to eight medications	At least three drug therapy problems	99605 or 99606 and	One unit
				99607	Three units
5	At least four medical conditions	More than nine medications	At least four drug therapy problems	99605 or 99606 and	One unit
				99607	Four units

Example one: 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 one: 99605 - one unit
- Claim line two: 99607 - two units

Example two: A pharmacist has a follow-up encounter with an existing patient with four medical conditions, 10 medications and three drug-therapy problems. Pharmacist should bill a level 4 service:

- Claim line one: 99606 - one unit
- Claim line two: 99607 - three 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. Information about the CCD can be found on the Pharmacy webpage in the Medication Therapy Management Program accordion. 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 or recoupment 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 an authorized representative (only if the member is cognitively impaired). 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 within Exhibit A of the UCare Continuity of Care Document located on the Pharmacy webpage in the Medication Therapy Management Program accordion.

Contact information

Contact pharmacyliaison@ucare.org, 612-676-6536 (option 2) or 1-855-931-5272 toll-free with questions regarding UCare's MTM program.

Health and wellness programs

UCare is committed to keeping members healthy and safe. The following health and wellness programs and resources are available to eligible UCare members. Visit UCare's Health and Wellness webpage to learn more.

Dental

Mobile Dental Clinic (MDC)

Available for any UCare member with a UCare dental benefit.

The MDC offers dental check-ups, cleanings and simple restorative care to members with 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, a UCare 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.

Direct members to call 1-866-451-1555 toll-free Monday through Friday from 8 am - 4:30 pm to schedule.

Visit the Mobile Dental Clinic page for the MDC schedule.

Adult Dental Kit

Reference the Adult Dental Kit information within the Kits section of this chapter.

Fitness and wellness

Activity tracker plus personal emergency response system (PERS) device

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

This easy-to-use, out of the box, activity tracker, plus PERS device features:

- 24/7 emergency call-for-help to a support agent directly through the device
- Step and heart rate tracking to help members reach their health goals
- Built-in GPS to support members both inside and outside their home
- Members with hypertension who use this smartwatch are eligible for a blood pressure monitor too

Members do not need to pair the PERS device with a cell phone or connect it to Wi-Fi.

Members can contact their care coordinator or UCare Customer Service at the number on the back of their member ID card to see if they are eligible.

Fitness programs

Health Club Savings
Available to UCare Individual & Family Plans and UCare Individual & Family Plans (IFP) with M Health Fairview, Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members 18 years or older.

UCare Medicare Plans (excluding UCare Advocate Choice and UCare Advocate Plus), UCare Medicare Group Plans and EssentiaCare members can choose from either the One Pass or Health Club Savings program.

UCare members who belong to a participating health club receive a monthly reimbursement that cannot be used in conjunction with One Pass. See the Health Club Savings page for monthly visit requirements, monthly reimbursement rates, participating club locations and additional details. To sign up, members must show their UCare member ID card at a participating location.

One Pass
Available to MSHO, UCare Connect + Medicare and UCare Medicare Supplement members. UCare Medicare Plans (excluding UCare Advocate Choice and UCare Advocate Plus), UCare Medicare Group Plans, UCare Your Choice and EssentiaCare members can choose from either the One Pass or Health Club Savings program.

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 24,000 participating fitness locations nationwide, plus:

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

Members can find participating locations and additional information at ucare.org/onepass or by calling 1-877-504-6830 (TTY 711), from 8 am - 9 pm, Monday through Friday.

Juniper®

Available for MSHO members.

Juniper's health management and wellness classes are designed for older adults and are led by certified instructors or coaches. Classes provide education, skills and strategies to prevent falls and promote self-management of chronic conditions like diabetes and chronic pain.

These group-based classes are available through a statewide network of participating facilities, including customized living facilities, churches, fitness, community and senior centers.

For more information, advise members to visit yourjuniper.org or talk to their care coordinator.

Kits

Numerous kits are available at no cost to eligible UCare members. Eligible members have access to the following kits but are typically limited to one order of each individual kit per year. The following kit contents are subject to change; it could take up to four to six weeks for members to receive their kits.

Members have three ways to order their kits; direct them to do so through:

- Their online member account.
- Their care coordinator or case manager (if applicable).
- UCare's Customer Service at the number provided on the back of their member ID card.

Adult Dental Kit
Available to MSHO, UCare Connect + Medicare, UCare Advocate Choice and UCare Advocate Plus members.

Eligible members can receive this kit once every three years. In the years they do 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 includes:

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

The Adult Dental Refill Kit includes:

- Replacement brush heads
- Toothpaste
- Dental floss

Connect to Wellness Kit
Available for UCare Connect and UCare Connect + Medicare members.

Members may choose one of the following kit options:

- Fitness Kit
- Sleep Aid Kit
- Stress Relief Kit
- Dental Kit
- ADHD and Autism Support Kit
- Smart Home Device Kit (available to UCare Connect + Medicare members only)
- Weighted Blanket Kit (available to UCare Connect + Medicare members only)

Visit the Connect to Wellness Kit page for more information.

LivingWell Kids Kits
Available for PMAP and MinnesotaCare members age 17 or younger.

UCare offers fitness and wellness Kids Kits to help kids feel 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:

- Fitness Fun Kit
- Youth De-stress Kit
- Child Dental Kit
- Teen or Tween Dental Kit

Visit the LivingWell Kid Kit page for more information.

Medication Toolkit
Available for MSHO, UCare Connect + Medicare and UCare Medicare (excluding UCare Advocate Choice, UCare Advocate Plus, UCare Your Choice and UCare Your Choice Plus) members.

The Medication Toolkit helps members manage their medications; it includes:

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

Visit the Medication Toolkit page for more information.

Memory Support Kit
Available for MSHO members, UCare Advocate Choice and UCare Advocate Plus members with a dementia diagnosis

The Memory Support Kit includes tools and activities to help members with memory loss, dementia or Alzheimer's. The kit includes:

- Photo album
- Memory training game
- Motion sensor light (batteries included)
- Voice-controlled alarm clock
- Brain books
- One of the following items:
    - Animatronic cat, dog, baby boy or baby girl
    - One-button radio
    - Twiddle Muff
    - Five-pound weighted blanket

Visit the Memory Support Kit page for more information.

Stress and Anxiety Kits
Available for MSHO members.

Each kit includes engaging tools to help members with stress and/or anxiety. Members may choose one of the following kit options:

- Sleep Aid Kit
- Stress Relief Kit
- Smart Home Device

Visit the Stress and Anxiety Kit page for more information.

Strong and Stable Kit
Available for MSHO, MSC+ and UCare Medicare (excluding UCare Your Choice and UCare Your Choice Plus), UCare Advocate Choice and UCare Advocate Plus members.

The Strong and Stable Kit provides tools to help members stay strong and prevent falls. The kit includes:

- Resistance band strength kit
- Tip sheets with helpful fall 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

Visit the Strong and Stable Kit page for more information.

Food access

Available for MinnesotaCare, PMAP, UCare Connect + Medicare, UCare Connect, MSHO and Minnesota Senior Care Plus (MSC+) members.

UCare connects members with local food resources through Second Harvest Heartland, helps members apply for SNAP benefits and finds food resources (food shelves, etc.) for members in their community.

Advise members to contact Second Harvest Heartland at 651-401-1411, 1-866-844-FOOD toll-free or email SHHCareCenter@2harvest.org.

Garmin discount

Members receive a 20% discount on select Garmin wearable products, like fitness trackers and running watches. The discount is available on up to two Garmin wearables and two Garmin accessories (like a watch or strap) per calendar year.

Members can purchase Garmin wearable products through their member portal, the discount is only available online.

Grandpad

Available for MSHO members, UCare Advocate Choice and UCare Advocate Plus members with a depression or anxiety diagnosis on file with UCare.

Grandpad is an electronic tablet designed to help members feel less isolated and stay connected with caregivers and family. It allows members to:

- Keep in touch through voice or video calls without the need for Wi-Fi
- Tune in to their favorite AM or FM station or search for their favorite songs
- Send text or voice recorded messages to loved ones
- Connect with their care providers and care coordinator
- Connect with a Grandpad customer service specialist to answer questions

For more information, advise members to contact their care coordinator or UCare Customer Service at the number on the back of their member ID card.

Healthy Benefits+ Visa card

Allowances, discounts and rewards

Combined flexible benefit allowance
Available for UCare Your Choice, UCare Your Choice Plus and EssentiaCare Access members.

Depending on the member plan, allowances range from $600 to $1,600. Allowances can be used for prescription eyewear, dental services and/or hearing aids. The annual amount is loaded to the member's UCare Healthy Benefits+ Visa® card, members can use their card to pay.

The allowance expires at the end of the year or upon plan termination.

More information is available at healthybenefitsplus.com/ucare, healthybenefitsplus.com/essentiacare or by calling the number on the back of the member's UCare Healthy Benefits+ Visa® card.

Healthy food allowance
Available for all MSHO and for eligible UCare Connect + Medicare members with a qualifying chronic condition.

Eligible members can use the allowance to buy healthy foods and produce. Approved items include fruit, vegetables, healthy grains, dairy, beans and more, and can be purchased at retailers including Cub, Hy-Vee and Walmart. Members scan their UCare Healthy Benefits+ Visa® card at checkout.

Monthly allowances are preloaded to the card and available to members on the first day of each month. Unused dollars do not roll over to the next month, unused money expires at the month's end.

- MSHO members receive a $75 monthly healthy food allowance.
- UCare Connect + Medicare members diagnosed with diabetes, hypertension or lipid disorders receive a $75 monthly healthy food allowance.

Visit healthybenefitsplus.com/ucare, or have members call the number on the back of their UCare Healthy Benefits+ Visa® card for more information.

Over-the-counter (OTC) allowance
Available for UCare Medicare Plans, UCare Your Choice Plans, UCare Medicare Group Plans, EssentiaCare, UCare Connect + Medicare and MSHO members.

Members can use their OTC allowance to purchase eligible health items like cough drops, first aid supplies, pain relievers, sinus medication and toothpaste at participating retailers. OTC allowance values and expiration dates vary by plan type. The card won't work if the patient is no longer a UCare member.

Visit healthybenefitsplus.com/ucare, healthybenefitsplus.com/essentiacare or call the number on the back of the UCare Healthy Benefits+ Visa® card for more information.

Prescription eyewear allowance
Available for UCare Medicare Plans (excluding UCare Your Choice Plans) and EssentiaCare (excluding Access) members.

The annual prescription eyewear allowances range from $100 to $225, depending on plan. Allowances are loaded to the member's UCare Healthy Benefits+ Visa® card, then they pay for eyewear with this card. The allowance expires at the end of the year or upon plan termination.

Visit healthybenefitsplus.com/ucare, healthybenefitsplus.com/essentiacare or call the number on the back of the member's UCare Healthy Benefits+ Visa® card for more information.

Transportation allowance
Available for UCare Advocate Choice and UCare Advocate Plus members.

Eligible members receive an annual transportation allowance on their UCare Healthy Benefits+ Visa® card to pay for transportation to and from eligible medical appointments. Members receive funds once per year and can pay for transportation directly with the card. The allowance expires at the end of the year or upon plan termination.

Members can call the number on the back of their UCare Healthy Benefits+ Visa® card or visit healthybenefitsplus.com/ucare to check their card balance.

Utilities allowance
Available for MSHO members.

Members receive a $55 monthly utility allowance to pay for monthly household utility bills or rent by using the Healthy Benefits+ card.

This monthly allowance is available to members on the first day of each month. Unused dollars do not roll over to the next month, unused money expires at month end or upon plan termination.

Visit healthybenefitsplus.com/ucare or call the number on the back of the UCare Healthy Benefits+ Visa® card for more information.

Community education class allowance
Available for UCare Medicare Plans (excluding UCare Your Choice and Advocate plans), UCare Medicare Group Plans, EssentiaCare, UCare IFP, UCare IFP with M Health Fairview, UCare Connect, UCare Connect + Medicare, PMAP, MinnesotaCare, MSHO and MSC+ members.

Eligible members receive an allowance to use toward most community education classes nationwide. Members can find a class by checking a local community education catalog or contacting a local school district for times and locations. When they enroll in the class, they can use their Healthy Benefits+ card when they check out in-person, over the phone or online.

Plan	Amount
UCare Medicare (excluding Your Choice Plans and Advocate Plans)	$45 Annually
UCare Medicare Group Plans	$45 Annually
EssentiaCare	$45 Annually
UCare IFP Plans/UCare IFP with M Health Fairview	$45 Annually
UCare Connect	$100 Quarterly
UCare Connect + Medicare	$100 Quarterly
MSHO	$100 Quarterly
MSC+	$100 Quarterly
PMAP	$100 Quarterly
MinnesotaCare	$100 Quarterly

Allowance amounts and expiration dates vary by plan type. The card won't work for inactive members. UCare can't reimburse for classes that are paid for without the Healthy Benefits+ card.

Members can learn more, check their card balance or request a replacement card at healthybenefitsplus.com/ucare or they can call 1-833-862-8276 (TTY users call 711).

Grocery discounts

Available for UCare Medicare Plans, UCare Medicare Group Plans, EssentiaCare, UCare IFP, UCare IFP with M Health Fairview, UCare Connect, UCare Connect + Medicare, PMAP, MinnesotaCare, MSHO and MSC+ members.

Members receive discounts on healthy food like milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more at participating grocery stores. Weekly discounts are pre-loaded onto the UCare Healthy Benefits+ Visa® card. To access the discount, members can scan their Healthy Benefits+ card at check-out.

Visit healthybenefitsplus.com/ucare or call 1-833-862-8276 (TTY 711) for more information.

Rewards

Members can earn rewards for completing certain preventive screenings, tests or exams. Earned reward dollars will be loaded onto the Healthy Benefits+ Visa card. Advise members to log in or create an online member account at member.ucare.org to see if they are eligible.

Healthy transitions

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

This program provides individualized support, education and resources for eligible members during the critical first 30 days after a hospital or short-term rehabilitation center stay. When members return home, they are paired with a trained and certified community health worker. The community health worker provides two in-home and two phone visits during those 30 days.

These visits cover:

- Discharge documentation
- Home safety and fall risks
- Nutrition
- Medications
- Socialization
- Appointment setting and transportation
- Short-term goal setting
- Resources and referrals to other providers

Community health workers collaborate with the member and their care coordinator to ensure the member's needs are met.

Members can contact their care coordinator to see if they're eligible and to learn more.

Member perks

Programs and services to help support healthy living, plus extra discounts. Refer to the UCare Member Perks page for current perk listings.

Caregiver Assurance

Available for UCare's MSHO and UCare Connect + Medicare members, UCare Advocate Choice and UCare Advocate Plus members.

Eligible members and their designated caregivers get up to 12 visits with a caregiver advisor within the plan year, resources and service referrals. Caregiver advisors are licensed professionals who help with care coordination, service advice and referrals, stress reduction tips and more.

Members can call 612-672-7996 (TTY users call 711) for more information or visit https://wellbeingadvisor.org/ucare/caregiverassurance-cga/.

Pregnancy, children and teens

Management of maternity services (MOMS) program

The MOMS program provides pregnant members with information to help them stay healthy during and after pregnancy. As a reward, eligible members can earn $75 when they attend early prenatal and timely postpartum visits. UCare offers pregnancy education to members through our Pregnancy Advisor Nurse Line and our telephonic case management program, members can call 612-676-3326 or 1-855-260-9708 toll-free.

Once the baby is born, lactation services are available for breastfeeding members. Members can request a breast pump at no charge to assist in breastfeeding when the member must be separated from their babies due to work or illness (a medical order is required), and limits apply. Advise members to call UCare Customer Service at the number listed on the back of their member ID card.

Childbirth and pregnancy education classes
Available for PMAP, MinnesotaCare, UCare Connect and UCare Connect + Medicare members.

UCare members can learn about the stages of labor, care options, life with a newborn, breastfeeding, childbirth and pregnancy to prepare them for parenthood. Classes are at no charge, offered through clinics, hospitals and other health agencies, and no referrals are needed.

Members can contact UCare Customer Service to find out more about classes.

Available for UCare IFP and UCare IFP with M Health Fairview members.

Members who complete in-person or virtual, eligible courses through a hospital, freestanding birth center and/or any course offered by an individual or organization with approved certificates or credentials may be reimbursed for up to $200 worth of childbirth education classes per member, per birth. To receive the benefit, members will be required to complete a reimbursement request. Lactation classes and breastfeeding supplies recommended by the Health Resources & Services Administration (HRSA) are a covered preventive benefit.

Quit Smoking and Vaping Program
Available for members in any UCare plan.

UCare offers the Quit Smoking and Vaping Program, a tobacco and nicotine quit line program with special-trained coaches. Members who are planning a pregnancy, who are currently pregnant or are postpartum receive access to additional outbound calls from a quit coach throughout their pregnancy and into postpartum. Pregnant smokers who complete an assessment through the Quit For Life portal or call the UCare Tobacco and Nicotine Quit Line at 1-855-260-9713 during their pregnancy or within one year after delivery are also eligible for a $25 reward.

Seats, Education and Travel Safety (SEATS) program

Available for PMAP, MinnesotaCare, UCare Connect, UCare Connect + Medicare, UCare IFP or UCare IFP with M Health Fairview members.

Through UCare's SEATS program, car seats and safety education are available at no charge to eligible UCare members who are pregnant or have children under age 9. Members are required to attend an education session to learn proper installation and use before they receive their car seat. Typically, there is a two to three week waiting period, and limits apply. Pregnant members are eligible for one car seat per year and children are eligible for one car seat every three years.

Members can contact 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.

Quit Smoking and Vaping Program

Members can learn to stop smoking, vaping or chewing tobacco through the tobacco and nicotine quit line. Nicotine patches, gum or lozenges are available to eligible members.

Reference the Quit for Life information within this chapter if you know a member who is planning a pregnancy, is pregnant or postpartum.

Members can receive help through the following methods, advise them to:

- Call the tobacco and nicotine quit line at 1-855-260-9713 (TTY 711) toll-free, available 24 hours a day, seven days a week.
- Visit myquitforlife.com/ucare or myquitforlife.com/essentiacare.
- Download the Rally Coach Quit For Life mobile app.

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 serves as a provider resource; coverage and benefits vary among UCare plans. For more details, refer to the Member enrollment and eligibility chapter of the provider manual, member handbook or member contracts specific to the member's UCare plan.

See the Authorization and notification standards chapter of the provider manual to review authorization requirements for MHSUD services.

For payment and billing questions, reference UCare's MHSUD payment policies.

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 is a set of services developed to bring restorative, recovery-oriented interventions directly to individuals who can benefit from them, whether in their homes or elsewhere in the community.
- For additional information on notification and concurrent review requirements for ARMHS, see the Authorizations and notification standards page of the provider website.

Behavioral Health Homes (BHH)

- To be eligible for BHH 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 or therapies.

Diagnostic assessment, psychotherapy, psychological and neurological testing

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

Early Intensive Developmental and Behavioral Intervention (EIDBI)

- Members must be under age 21 with an autism spectrum disorder or 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. Send the form to UCare via email at MHSUDservices@ucare.org or by fax at 612-884-2033 or 1-855-260-9710 toll-free.

Intensive Outpatient Dialectical Behavioral Therapy (IOP DBT)

- Includes group and individual IOP DBT.

Partial hospitalization program

- A minimum of 20 hours per week is 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 to use 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 and individual risk, create an appropriate treatment plan and/or access SUD-MOUD services.
- Medicare practitioner and place of service rules must be followed to use Medicare benefits.

Outpatient substance use disorder treatment

- Medicare practitioner and place of service rules must be followed to use 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 245G.11 Subdivision 1 and 4.
- 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. The rate enhancement for treatment services provided to Medical Assistance (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, subd. 5, paragraph c, clause (1).
    - Are culturally specific or culturally responsive programs as defined in section 254B.01, subd. 4a.
    - Are disability responsive programs as defined in section 254B.01, subd. 4b.

Institutions for Mental Disease (IMD)

An 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

UCare may cover residential treatment services; DHS-approved rates may be used to determine payment. Room and board coverage may vary between UCare plans and require the county of residence or DHS approval.

Residential services include:

- Adult Residential Crisis Stabilization Services
- Children's Mental Health Residential Treatment
- 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 via email to rateletters@ucare.org. Include NPI or TIN when submitting letters. Allow 30 days for rates to be loaded into our system.

Inpatient hospital mental health and substance use disorder (admissions)

See the Hospital services chapter 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 (MHSUD) case management

The goal of MHSUD 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.

MHSUD case managers work with members who are transitioning from an inpatient or residential setting and ensure the member has the appropriate follow-up, medication, transportation to appointments, understanding of discharge needs and more.

Mental Health Targeted Case Management (MH-TCM)

UCare does not require a referral, notification or prior authorization for MH-TCM. Services can begin once a member is assessed and determined to meet the MH-TCM criteria in the Minnesota administrative rule. 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 unfamiliar with MH-TCM agencies, call the 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 enrolled with Minnesota Health Care Programs (MHCP) with a provider type of Targeted Case Management to render services to UCare members.
- UCare's MH-TCM reimbursement rate is 100% of the Minnesota Medical Assistance posted rate. 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 are billing appropriate charge amounts to UCare. UCare reserves the right to collect any overpayments.

Manage your provider file

MHSUD providers must be set-up in the UCare system for electronic claim submission. Learn more about updating your information on the Manage Your Information page.

MHSUD providers not currently in the UCare network can enroll in UCare's payment system by submitting a Facility Location Add form (found within the How to Submit Claims for Payment accordion on the Non-Contracted Provider Resources page). These providers can also submit a request to join the UCare network.

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.

Integrated care management

The Integrated Care Management (ICM) department and its programs assist members in an integrated way with their medical needs, behavioral health needs and social drivers of health. This model combines evidence-based, whole-person care in one department. Therefore, medical conditions, mental health and substance use and social needs can be more effectively addressed throughout a member's life.

The ICM team brings experiences from nursing, social work, mental health, substance use disorders and community needs. These programs are available to UCare members at no cost.

Triage and access

The triage and access teams:

- Find in-network mental health and substance use disorder providers, clinics or facilities for in-person or telehealth care and schedule appointments
- Connect providers or external care managers with ICM Care Managers for consultation
- Ensure cultural and socioeconomic needs and preferences are taken into consideration
- Confirm appointments
- Assist with the intake process
- Follow up with members after an appointment
- If applicable, connect members to alternate or additional resources when more needs are identified
- Educate about mental health and substance use disorder services

Advise members to contact these teams at 612-676-6533, Monday through Friday from 8 am – 5 pm.

Adult Complex Care Management

The Adult Complex Care Management (CCM) program is a telephonic program designed to improve the health of the highest-risk members with complex health and social needs. This program assists members and their caregivers in navigating the healthcare system, coordinating care and accessing necessary services and resources to improve health outcomes and quality of life. Complex care management is provided by registered nurse care managers trained to conduct thorough, NCQA-approved assessments that capture all aspects of a member's complex and chronic health needs.

To refer a member to the Adult CCM program, call 612-676-6538, Monday through Friday from 8 am – 5 pm, or email them at ccmteam@ucare.org.

Adult Care Management

The Adult Care Management (CM) program is a telephonic program designed to improve the health of UCare members with medical, mental health and substance use disorders (MHSUD) and social needs. The program focuses on members who are undergoing transitions of care, have frequent hospitalizations, have residential treatment stays and have emergency department use to provide them support to avoid needing use of these high acuity services. It assists members and their caregivers in navigating the health care system, coordinating care and accessing necessary services and resources to improve health outcomes and quality of life. This program

To refer a member to the Adult CM program, call 612-676-6512, Monday through Friday from 8 am – 5 pm or email them at cmteam@ucare.org.

Social determinants of health

The Social Determinants of Health (SDOH) team's focus is to improve access to essential resources for members' wellbeing, including access to food, housing and transportation. The team consists of Housing Specialists, a Community Liaison and a Community Health Worker. The SDOH team:

- Refers members to community-based partners
- Participates in community or regional collaboratives, stakeholder groups or workgroups

- Facilitates communication and relationships between community partners and UCare
- Shares information amongst partner organizations

Contact the SDOH team at 612-676-6533, Monday through Friday from 8 am – 5 pm or via email at SDOHteam@ucare.org.

UCare's Maternal Child Health Program

This program was 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
- Mental Health and Substance Use Disorder screening
- Access to UCare-provided benefits and resources
- Ongoing telephonic support to monitor high-risk indicators throughout pregnancy and the postpartum period

Prenatal care management

UCare registered nurses provide telephonic, holistic support to high-risk pregnant members to help promote healthy, full-term pregnancies and positive birth outcomes. The program includes:

- **Pregnancy education and resources:** Members receive education on pregnancy, information about community resources and incentives to support their prenatal care.
- **Health monitoring:** Prenatal and postpartum warning signs are reviewed with members, along with guidance on where to seek care.
- **Individualized care planning:** Care Managers collaborate closely with members to assess physical health, mental health, psychosocial needs and substance use concerns. An individualized care plan is then developed to address needs and improve clinical outcomes.
- **Ongoing support:** Care Managers maintain regular contact, following up at least monthly throughout the pregnancy, to ensure continued support and care.
- **Public health prenatal home visits:** These visits are offered to all pregnant members.

Postpartum care management

UCare's Maternal & Child Health (MCH) Postpartum Care Management Team offers telephonic support for families and their newborns after birth. Key elements of the program include:

- **Automatic enrollment:** After delivery, participants in the prenatal care management program are automatically transitioned into the postpartum care management program.
- **High-risk outreach:** Members identified as high-risk postpartum receive a call from an engagement specialist. If ongoing needs are identified, members are referred to RN Care Managers for further support.
- **Mental health support:** Nurses assess the member's mental health, provide education on postpartum depression and guide them on how to seek appropriate care.
- **Social determinants screening:** Members are assessed for social determinants of health; a PHQ-2 screening is completed to identify any mental health concerns.
- **Resource and education support:** Appropriate resources are provided, along with education on the importance of well-child visits and assistance in selecting a pediatrician.
- **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.
- **Public health postpartum home visits:** These visits are offered to all newly delivered members within several weeks of delivery.

Neonatal Intensive Care Unit (NICU) care management

UCare's NICU care management is an extension of the Maternal and Child Health (MCH) program, designed to support both parents and babies during and after a NICU stay. Key components of NICU care management include:

- **Comprehensive support:** Specialty NICU Care Managers provide individualized care management, addressing the family's medical and emotional needs.
- **Collaboration:** Care Managers work closely with health care providers and community resources to coordinate care and ensure families have the support they need.
- **Family engagement:** NICU Care Managers engage with parents to meet postpartum needs and offer education, encouragement and emotional support throughout the baby's hospitalization.
- **Transition planning:** Families are supported during the transition home, and the program helps ensure safe and timely follow-up care at the appropriate level.

Advise members to contact the Maternal and Child Health Program Line, Monday through Friday from 9 am - 5 pm at 1-855-260-9708 toll-free.

Child and adolescent care management

UCare's Children and Adolescent Care Management (CACM) program supports children and adolescents diagnosed with autism spectrum disorder, mental health or substance use conditions, or who have complex medical needs. The program offers individualized assistance to both the member and their family through a dedicated team of care managers who specialize in pediatric care. These care managers work closely with families to ensure children receive the right services and support.

Key supports provided by the CACM program include:

- **Education and resource navigation:** Helps families understand the member's diagnosis, treatment options and how to access appropriate services.
- **Connection to care providers:** Coordination with specialists, therapists and primary care to ensure a comprehensive care plan is in place.
- **Support for social needs:** Addresses non-medical barriers such as housing instability, food insecurity or transportation challenges.
- **Family and caregiver support:** Offers guidance, emotional support and linkage to resources that benefit the entire caregiving network.

To effectively support members, CACM care managers conduct regular assessments that focus on:

- **Social determinants of health (SDOH):** Identifying external factors that may affect the child's health and well-being.
- **Care team involvement:** Ensuring collaboration and communication among all providers involved in the member's care.
- **Services in place:** Evaluating current services to identify gaps or opportunities for enhancement.
- **Home and community safety:** Assessing for any risks to ensure a secure environment.
- **Preventative care:** Promoting routine check-ups, screenings and immunizations to support overall health.

Based on these assessments, care managers make appropriate referrals and coordinate care to close gaps, promote stability and improve outcomes. The CACM program continues to provide support as long as the child or adolescent and their family need it.

To refer a member to the CACM team, email their name, UCare ID, date of birth, contact information and the reason for referral to familyhealthcasemanagement@ucare.org.

Child and teen checkups

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in Minnesota as the Child and Teen Checkup (C&TC) program, is a required Medical Assistance (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.

For C&TC questions, call the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free.

Providers 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.

Every visit is an opportunity

Every visit a child makes to a clinic offers the opportunity to complete a C&TC screen, including:

- 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 OBGYN, which must include documentation of the date the visit occurred and evidence of all:

- 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 EPSDT should always include one of the following codes to ensure visits count toward national and state quality benchmarks.

CPT	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0610, S0612, S0613, S0302
ICD 10	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, 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-ups with the patient regarding these referrals to ensure they receive the needed services. 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:

HIPAA compliant referral condition code	Use this referral condition code for billing when a C&TC screening results in one of the following:
NU (no referral - not used)	• No referral(s) given ("NU"). • If only a verbal dental referral was made for preventive dental health care.
ST (new diagnosis or treatment service requested)	• One or more referrals were made ("ST"). • 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). • Patient is scheduled for another appointment with the screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).
AV - declined referral (referral recommended, but was declined)	• One or more referrals were made and the patient declined one or more of the referrals (AV).
S2 (continue current services or treatment)	• The patient is currently under treatment for a diagnostic or corrective health problem(s).

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. Review the section of the MHCP Provider Manual for correct billing for C&TC. Refer 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 the 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 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

As of 2025, telehealth services are no longer eligible for well child care visits.

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. 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 and immunizations.
- Resources on health plan programs and contacts, as well as contacts for county public health departments created by the C&TC Metro Action Group are available on the Dakota County Public Health website.
- Bright Futures presented by the American Academy of Pediatrics
- A reminder from your healthcare provider: come back to get caught up is a patient resource from the Minnesota Council of Health Plans that explains the importance of childhood immunizations. Translated and audio recorded in English, Somali and Hmong.

UCare C&TC clinic tools

- C&TC information for providers
- UCare Member C&TC Schedule
- UCare Rewards and Incentives
- UCare Provider Manual: Interpreters chapter and Transportation chapter

Comprehensive outpatient rehabilitation facility services

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 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 Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

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 Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-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 service provider 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 unavailable immediately. The authorized representatives may be notified by telephone if personal delivery is unavailable immediately. The authorized representative must be informed of the contents of the notice. The call's date, time and phone number must be documented. The notice must be mailed to the representative on the same day as the telephone notification. 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 BFCC-QIO no later than noon the day before services end (as indicated in the NOMNC) to request a review. The BFCC-QIO will inform UCare and the provider of the request for review.
    - The provider is responsible for providing the BFCC-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 end of business day, the BFCC-QIO must decide when the coverage will end. The provider and UCare must cooperate with the BFCC-QIO to provide information for the review. The provider must obtain appropriate signatures from the member and/or the member's representative. The BFCC-QIO for Minnesota and Wisconsin members is Livanta, call their helpline at 1-888-524-9900 or 1-888-985-8775 TTY.
    - Protected Health Information provided to the BFCC-QIO must be handled in accordance with the Health Insurance Portability and Accountability Act (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 Institutional Special Needs Plans, EssentiaCare, UCare's Minnesota Senior Health Options and UCare Connect + Medicare Plans

Denial forms are located on the Denial Notice Forms page on the UCare website.

UCare's Federally Qualified Health Center - Rural Health Clinic payment carve-out process

On July 1, 2019, the process outlined in Section 256B.0625 of Minnesota Statute for Medical Assistance Covered Services, Subdivision (subd.) 30 (i) that required the Minnesota Department of Human Services (DHS) to change claims processing between Federally Qualified Health Center (FQHC) and Rural Health Clinic (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 charts below show the type of service, program and provider type.

Professional services billed by FQHCs:

Carve-out type	Claim path	Notes
Full Carve-out • Prepaid Medical Assistance Program (PMAP) • Minnesota Senior Care Plus (MSC+) Non-duals • UCare Connect Non-duals	Provider to DHS	• Provider bills DHS directly. • DHS determines and pays provider encounter rate. • **Note:** if the provider sends the claim to UCare, then the claim will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare • MSC+ Duals • UCare Connect (SNBC) Duals • Minnesota Senior Health Options (MSHO) • UCare Connect + Medicare	Provider to UCare	• Provider bills UCare directly. • UCare determines and pays the provider reimbursement according to the UCare provider contract.

Dental services billed by FQHCs:

Note: DentaQuest is UCare's dental administrator for all dental claims.

Carve-out type	Claim path	Notes
Full Carve-out • PMAP • MSC+ Non-duals • MSC+ Duals • UCare Connect Non-duals • UCare Connect Duals • UCare Connect + Medicare • MSHO	Provider to DHS	• Provider bills DHS directly. • DHS determines and pays the provider encounter rate. • **Note:** if the provider sends the claim to UCare or DentaQuest, the claim will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare	Provider to DentaQuest	• Provider bills DentaQuest directly. • DentaQuest determines and pays the provider reimbursement according to the DentaQuest contract. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."

Medical Assistance (Medicaid)-covered pharmacy services billed by FQHCs:

Note: three FQHCs have pharmacies.

Carve-out type	Claim path	Notes
Full Carve-out • PMAP • MSC+ Non-duals • UCare Connect Non-duals For Medical Assistance-covered drugs • MSC+ Duals • UCare Connect Duals • MSHO • UCare Connect + Medicare	Provider to DHS	• Provider bills DHS directly. • DHS determines and pays provider encounter rate. • **Note:** if the provider sends the claim to UCare, then the claim will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare	Provider to UCare	• Provider bills UCare directly. • UCare determines and pays the provider reimbursement according to the UCare provider contract.

Medical Assistance-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 • PMAP • MSC+ Non-duals • UCare Connect Non-duals For Medical Assistance-covered Service • MSC+ Duals • UCare Connect Duals • MSHO • UCare Connect + Medicare	Provider to Fulcrum Health Fulcrum Health to DHS	• Provider bills Fulcrum Health directly. • Fulcrum Health will send the claim to DHS for processing. • DHS determines and pays the provider encounter rate. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare	Provider to Fulcrum Health	• Provider bills Fulcrum Health directly. • Fulcrum Health determines and pays the provider reimbursement according to the Fulcrum provider contract. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."

Professional services billed by RHCs:

Carve-out type	Claim path	Notes
Partial Carve-out • PMAP Non-duals • MSC+ Non-duals • UCare Connect (SNBC) Non-duals	Provider to UCare UCare to DHS	• Provider bills UCare directly. • In most cases, UCare "pays" $0 and sends the claim to DHS for processing. • DHS determines and pays the provider encounter rate.
No Carve-out • PMAP Duals • MinnesotaCare • MSC+ Duals • UCare Connect (SNBC) Duals • MSHO • UCare Connect + Medicare	Provider to UCare	• Provider bills UCare directly. • UCare determines and pays the provider reimbursement according to the UCare provider contract.

Dental services billed by RHCs:

Note: DentaQuest is UCare's dental administrator for all dental claims.

Carve-out type	Claim path	Notes
Partial Carve-out • PMAP • MSC+ Non-duals • MSC+ Duals • UCare Connect Non-duals • UCare Connect Duals • UCare Connect + Medicare • MSHO	Provider to DentaQuest DentaQuest to DHS	• Provider bills DentaQuest directly. • DentaQuest "pays" $0 and sends the claim to DHS for processing. • DHS determines and pays the provider encounter rate. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare	Provider to DentaQuest	• Provider bills DentaQuest directly. • DentaQuest determines and pays the provider reimbursement according to the DentaQuest contract. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."

Medical Assistance-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 • PMAP • MSC+ Non-duals • UCare Connect Non-duals For Medical Assistance-covered Service • MSC+ Duals • UCare Connect Duals • MSHO • UCare Connect + Medicare	Provider to Fulcrum Health Fulcrum Health to DHS	• Provider bills Fulcrum Health directly. • Fulcrum Health will send the claim to DHS for processing. • DHS determines and pays the provider encounter rate. • **Note:** if the provider sends the claim to UCare, UCare will be denied with instructions to "bill other payer."
No Carve-out • MinnesotaCare	Provider to Fulcrum Health	• Provider bills Fulcrum Health directly. • Fulcrum Health determines and pays the provider reimbursement according to the Fulcrum provider contract. • **Note:** if the provider sends the claim to UCare, the claim will be denied with instructions to "bill other payer."

American National Standards Institute (ANSI) codes on remittance advice or 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 them to DHS for encounter payment.	256 - Service not payable per managed care contract. 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" the replacement claim at $0 and forwarded it 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.
The provider initiated the void claim, and UCare processed and forwarded it to DHS to void the 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 or waiver services

Home and community-based services (HCBS) or waiver services allow individuals who meet specific criteria to receive services in their home or community rather than in facilities or institutions. HCBS waiver services promote community living and independence. Members choose services based on their individual needs. 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 goods and services not typically covered by Medical Assistance. There are services covered through HCBS waivers that are also covered under Medical Assistance, as they may exceed the amount, scope and duration of Medical Assistance state plan services, such as extended home health and extended skilled nursing services.

HCBS service providers must enroll with the Minnesota Department of Human Services (DHS), unless they are direct delivery or receipt service providers. However, direct delivery and receipt service providers are also encouraged to enroll with DHS.

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

Providers must only offer waiver services that they are qualified and registered with DHS to provide. This includes all elderly waiver and housing stabilization service providers. A UCare contract does not supersede the DHS enrollment requirement.

A complete list of enrolled providers is available on DHS's MnHelp website. Provider lists are also available via the DHS licensing look-up website or the MHCP Provider Directory.

Housing stabilization services (HSS)

Housing stabilization is a HCBS, and providers of housing stabilization must abide by the HCBS requirements. Information about being a HCBS provider can be found on the DHS website. HSS is a Minnesota Medical Assistance benefit to help people with disabilities (including mental illness and substance use disorder) and seniors find and keep housing.

Providers are to follow Minnesota Administrative Rule 9505.0225 regarding requesting recipients to pay for services.

UCare plans that include coverage under the Elderly Waiver

- UCare's Minnesota Senior Health Options (MSHO)
- Minnesota Senior Care Plus (MSC+)

Note: UCare Connect, UCare Connect + Medicare and a small number of Prepaid Medical Assistance Program (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 waiver programs 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) program provides home and community-based services (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 EW services require authorization from the UCare Care Coordinator before services begin.

Elderly Waiver service requests

EW service requests should be directed to the member's care coordinator. These services may be requested by the member, a member's representative or the member's primary care physician. Members must meet financial eligibility criteria to qualify for EW services. Financial eligibility must be verified by the county financial worker prior to the start of waiver services.

The role of the care coordinator for EW services is to:

- Conduct a MnCHOICES assessment to determine member eligibility.
- Develop a support plan inclusive of waiver services.
- Assist with accessing waiver services.
- Approve and 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 waiver type.

Services not covered by 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 related to 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 the care coordinator has not approved.

Waiver services are limited to the member's individual case mix classification budget set by DHS.

UCare covers the cost of eligible and authorized EW services for UCare's MSHO and MSC+ members. UCare does not cover the following:

- Services or items purchased prior to the 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 or outside of service authorization dates and/or limits.
- Essential Community Support (ECS) services. The care coordinator assesses the need and then authorizes and monitors services, but the provider bills DHS for payment of ECS services.

Review of requests for waiver services

Requests for waiver services are not categorized as medical necessity reviews; however, the care coordinator completes assessments to determine eligibility within 20 business days of the member's 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. The member and provider will be issued a DTR written notification.

- When an EW member is admitted to a skilled nursing facility (SNF) for 30 days, on day 31 the care coordinator is required to complete a DTR for the member's services. If the member returns to the community, a new service authorization is needed for the remainder of the waiver span.
- If a member becomes ineligible for waiver services for any reason, 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 enrolled in hospice.
- Services related to the terminal condition are paid by Medicare when enrolled in 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 authorization requests.

Providers should contact Customer Service for assistance in determining the care coordinator assigned to the member.

- Minnesota Senior Health Options (MSHO): 612-676-6868 or 1-866-280-7202
- Minnesota Senior Care Plus (MSC+): 612-676-3200, 1-800-203-7225
- UCare Connect + Medicare: 612-676-3310, 1-855-260-9707
- UCare Connect: 612-676-3395, 1-877-903-0061

Members approved for HCBS waiver services receive service coordination from their assigned care coordinator. The care coordinator monitors and updates the member's support plan as needed. Providers are reimbursed according to guidelines established by Minnesota DHS. Care coordinators may negotiate provider payment rates if no specified rate is 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.

Coding information for waiver service providers

Coding examples for waiver providers include:

- John Doe attended adult day services all day for six hours on April 11.
    - Submit claim using S5100 with 24 units as the code, which is defined as adult day services; per 15 minutes.
- A homemaker is at Jane Doe's home for one hour on April 14.
    - Submit the 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 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 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 EW services for eligible UCare MSHO and MSC+ members are submitted directly to UCare for claim adjudication rather than the state's system, Medicaid Management Information System (MMIS).

As a reminder, all claims must be submitted electronically. To submit a claim attachment, 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 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 an 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 SA 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 through Sunday when an authorization lists the number of Units of Service (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 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 process claims correctly.

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

Providers do not need to be contracted with UCare for EW services; they need only be 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 to bill for EW services UCare receives 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. Providers are to follow Minnesota Administrative Rule 9505.0225 regarding requesting recipients to pay for services.

Additional information regarding waiver services

See the MHCP Provider Manual. Select a chapter, such as Home care services.

Home care services

Home care providers are not allowed to subcontract to another entity to provide covered services for UCare members unless they obtain prior written approval from UCare. The approval is at UCare's sole discretion. If requested by UCare, the provider must provide copies of the subcontracts.

Home care services criteria

UCare Medicare Plans, EssentiaCare and UCare Advocate Plans (HMO 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 Medical Assistance (Medicaid) benefits; therefore, UCare follows both Medicare and Medical Assistance criteria for coverage.

Medicare standards are reviewed first. If a request for home care does not meet Medicare criteria, it is reviewed using Medical Assistance criteria.

For Medical Assistance 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 Medical Assistance 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 through the UCare Provider Portal, the Provider Assistance Center (PAC) at 612-676-3300 or 1-888-531-1493 toll-free or the Minnesota Department of Human Services MN-ITS system.

Medical Assistance 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. Services include skilled nurse visits, home health aide visits and home health therapies (occupational, physical, respiratory and speech language 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.

- The 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, terminal 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 Medical Assistance 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 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).
- Refer to the Medicare Claims Processing Manual (cms.gov) for more information.

For MSHO and UCare Connect + Medicare:
- For Members who meet Medicare coverage criteria, 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.
- Refer to the Medicare Claims Processing Manual (cms.gov) for more information.
- If MSHO and UCare Connect + Medicare members do not meet Medicare criteria, they must meet Medical Assistance criteria. Providers must bill the specific Medical Assistance rates.
- Providers must bill specific T-codes along with revenue codes for Medical Assistance reimbursement.
- Must be billed on the 837I form.
- Refer to Home Care Services (state.mn.us) for more information.

For PMAP, MSC+, UCare Connect and MinnesotaCare:
- Members must meet Medical Assistance home health criteria.
- Providers must bill the Medical Assistance rates.
- Providers must bill the appropriate T-code along with the revenue code.
- Must be billed on the UB-04 form or 837I claim.
- Refer to Home Care Services (state.mn.us) for more information.

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.
- Refer to the Medicare Claims Processing Manual (cms.gov) for more information.

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 the appropriate modifier to indicate a separate service or the second visit will be denied as a duplicate claim.

Enrollee rights and provider responsibilities

UCare Medicare Plans, EssentiaCare, MSHO and UCare Connect + Medicare members have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their plan's decision that Medicare coverage of home health services should end.

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 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 Advocate Plans (HMO I-SNP), EssentiaCare, UCare's Minnesota Senior Health Options (MSHO) and UCare Connect + Medicare members no later than two days before coverage of their services will end. If the member does not agree that covered services should end, the member may request an expedited review by the QIO in that state. The provider must furnish a detailed notice explaining why services are no longer necessary or covered. The review process will be completed within 48 hours of the member's request for a review.

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, 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 Assistance (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 Medical Assistance 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 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 Minnesota Statute 256B.0659 subdivision (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.
- At all times, follow all requirements listed under Minnesota Statute 256B.0659.
- 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 2010 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 can print a certificate. Individual PCAs are responsible for keeping a copy of the certificate for their 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 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 subd. 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 must use the PCA Time and Activity Documentation, DHS-4691 document.

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 or 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 subd. 6 and 256B.0659. PCA provider agencies must follow the specified authorization procedures and cooperate with all phases of the authorization process.

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 Statute, section 148.171, subd. 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

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 county waiver case manager to request the assessment.

Initial assessment

- Role of the UCare care coordinator.
    - State statute requires the 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 subd. 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, the following:**
        - 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 subd. 9). The agency nurse, independently enrolled private duty nurse or county public health nurse must:

- Request authorization from the UCare care coordinator or county waiver case manager.
- Provide documentation to support the immediate need for the service.

Upon care coordinator/county waiver case manager 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 an 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 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 on UCare's Medical Services Authorization page under "Forms and Information."

Transition of care or 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 or DHS-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.
- Please refer to MN–ITS User Manual for a full list of requirements.

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 Minnesota Statute §148.171 to 148.285.
- Licensed social worker, as defined in Minnesota Statute §148E.010 and Minnesota Statute §148E.055.
- Mental health professional, as defined in Minnesota Statute §245.462, subd. 18 or Minnesota Statute §245.4871, subd. 27.
- Qualified designated coordinator, as defined in Minnesota Statute §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 their hire date.
- 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.19a and 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 their 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.

Community First Services and Supports (CFSS)

CFSS is a Minnesota Health Care Program (MHCP) that offers flexible options to meet people's unique needs. The program allows members greater independence in their homes and communities. CFSS covers similar services to Personal Care Assistance (PCA) services.

For additional information regarding transition and implementation, refer to the Transition from PCA to CFSS and the Community First Services and Supports pages.

Authorization is required for payment of all CFSS services as outlined in Minnesota Statute §256B.85, subd. 5, Minnesota Statute §256B.0659. CFSS providers must follow the specified authorization procedures and cooperate with all phases of the authorization process.

CFSS standards for providers and agencies working with UCare

CFSS providers are required to follow DHS standards and responsibilities in accordance with Minnesota Statute 256B.85 and the CFSS Policy Manual.

CFSS training and supervision

Minnesota Statue 256B.85 subd. 11b and 18a

UCare is the authorizing entity for CFSS worker training and development. CFSS providers are required to follow the MCHP DHS provider requirements for CFSS worker training and supervision.

CFSS authorization process

Authorization is required for payment of all CFSS services as outlined in Minnesota Statute 256B.085. CFSS providers must follow the specified authorization procedures and cooperate with all phases of the authorization process.

Member eligibility

Member eligibility should be verified monthly via MN-ITS or the UCare Provider Portal. **Participant's representative is** an individual age 18 or older and capable of directing care on behalf of a person receiving CFSS services when the person is assessed as unable to direct their own care. To receive PCA or CFSS services, a person must not live in any of the following settings:

- Hospital
- Nursing facility
- Intermediate care facility for persons with developmental disabilities (ICF or DD)
- Foster care setting licensed for more than six people
- Housing owned or controlled by their PCA or CFSS provider agency

Member programs with CFSS benefits

UCare covers CFSS 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

For UCare Connect, UCare Connect + Medicare, Prepaid Medical Assistance Program (PMAP) and MinnesotaCare Expanded Benefit set (pregnant women and children under 21), contact the county of the member's residency or Minnesota DHS. This group may be eligible for CFSS services; however, UCare and its delegates are not the approval authorities for these services.

Starting CFSS services

Ref: Minnesota Statute 256B.85 subd. 5, Minnesota Statute 256B.0659

A MnCHOICES assessment is required to evaluate eligible UCare member's need for CFSS services.

The member, member's family, member's representative, primary care clinic or physician must contact the member's UCare care coordinator or county waiver case manager to request the assessment.

Initial assessment

- Role of the UCare care coordinator or case manager.
    - State statute requires the use of the MnCHOICES assessment for CFSS. Ref: Minnesota Statute 256B.85
    - The assessment must be performed by the UCare care coordinator or county waiver case manager.
    - Upon completion of the assessment and approval of the service delivery plan (see consultation services section), the care coordinator/county waiver case manager will submit one copy of the service delivery plan to UCare and provide another copy to the member.
- Role of the CFSS provider.
    - Contact the UCare care coordinator or county case manager for approval **before providing service**.
- Role of UCare.
    - Upon receipt of the completed assessment, UCare reviews and provides a written response within 14 calendar days or 10 business days.
    - UCare then sends a copy of the service plan to the CFSS agency or fiscal management services (FMS) provider.
- The CFSS authorization includes worker training and development services.
    - To request additional funds for the person's worker training and development budget, the CFSS provider agency (agency model) or FMS provider (budget model) must request an increase from the member's UCare care coordinator or county case manager.

Consultation services

Ref: Minnesota Statue 256B.85 subd. 17

Consultation service providers are MHCP providers who support people receiving CFSS, they:

- Educate members to make informed decisions about how to meet their needs using CFSS.
- Help members write their service delivery plans if desired.
- Review members' service delivery plans.
- Provide members with ongoing support as needed.

All members who use CFSS must select a consultation service provider. All consultation service providers must have a contract with the state to provide consultation services and be enrolled with UCare.

Authorization is required for consultation services and approved by a UCare care coordinator or county case manager.

- At the time of the member's assessment, the UCare care coordinator or county case manager provides the member with a list of consultation service providers.
- When the member or their representative selects a consultation services provider, UCare will authorize and issue a service approval letter.
- Requests for an additional consultation services session must be approved by the member's care coordinator or county case manager.

45-day temporary start of CFSS services

Ref: Minnesota Statute 256B.0652 subd. 9 and 14, Minnesota Statute 256B.85, subd. 5

The 45-day temporary start of CFSS services allows a member not currently receiving services to begin CFSS services temporarily until the lead agency assessor can schedule and complete an in-person assessment.

A temporary start of CFSS services:

- Requires authorization prior to, or at the start of, service (Minnesota Statutes 256B. 0652 subd. 9 and 14, Minnesota Statute 256B.85 subd. 5).
- Must be approved by the member's UCare care coordinator or county case manager.

Upon care coordinator or case manager approval, UCare will:

- Issue an approval for up to 45 days.
    - The amount of time authorized for the temporary start of service does not affect the amount of time for future authorizations.
    - The 45-day temporary start of CFSS is only available under the CFSS agency model.

Request for 45-day temporary increase in CFSS services

Ref: Minnesota Statute 256B.0652 subd. 9. and 14.

The process to increase PCA or CFSS services for up to 45 days is allowed when the person has had either of the following:

- Significant change in condition.
- Change in their need for services and support.

A temporary increase of CFSS services must be approved by the member's UCare care coordinator or county case manager.

Upon care coordinator or case manager approval, UCare will:

- Issue an approval for up to 45 days.
    - The increase cannot exceed 45 days.
    - If the member requires an increase of CFSS services for more than 45 days, the UCare care coordinator or county case manager must complete a reassessment.

Change request of CFSS provider agency or FMS notification

Ref: Minnesota Statute 256B.85 subd. 8a and 12b subd. 14. Minnesota Bill of Rights for Clients of Home Care Providers exempt from Licensure.

A change of CFSS provider request must be received via fax at UCare and must include:

- Member demographics, including member UCare ID.
- Name of current CFSS agency or FMS.
- Member or member representative signature.
    - Complete the CFSS Provider Change Request Form found on UCare's Medical Services Authorization page under "Forms and Information."

Note: To change Consultation Services, providers must contact the member's UCare care coordinator or county case manager.

Transition of care or services

Ref: Minnesota Statute 256B.0652 subd. 14(5)

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

- Fax a copy of the previous health plan or DHS service agreement.
- Provide a copy of the member's current PCA MnCHOICES Assessment.
    - Complete the PCA or CFSS Authorization Transfer form found on the UCare's Medical Services Authorization page under "Forms and Information."

Flexible use of CFSS services

Ref: Minnesota Statute 256B.85 subd.11

In CFSS, members can use the units or dollars flexibly throughout the entire service plan year, unless any of the following is true:

- Member is on the Minnesota Restricted Recipient Program (MRRP) for PCA or CFSS.
- Members on MRRP are not eligible for CFSS budget model.
- UCare denies flexible use.
- DHS revokes or denies flexible use.

When using CFSS units or dollars in a flexible manner, a member cannot:

- Transfer units or dollars from one service plan year to another.
- Add additional units or dollars unless they experience a change in condition.

CFSS goods and services

Ref: Minnesota Statute 256B.85 subd. 6, subd. 9. and subd.17

Goods and services are items or services purchased through CFSS that either:

- Increase the member's independence.
- Decrease the member's need for assistance from another person.

When a member identifies good(s) and/or service(s) to purchase using CFSS funds, the consultation services provider:

- Reviews the member's service delivery plan.
- Offers guidance on whether the goods and services meet the requirements in the covered items section on this page.
- Submits the service delivery plan to the UCare care coordinator or county case manager for authorization.

The UCare care coordinator or county case managers:

- Review and approve the member's service delivery plan.
- UCare issues a service authorization.

CFSS personal emergency response system (PERS)

Ref: Minnesota Statute 256B.85 subd. 7

In CFSS, members can use some of their units or dollars to purchase a personal emergency response system (PERS) as an electronic back-up system. PERS is a CFSS service that covers:

- An electronic device typically worn as a pendant or bracelet that includes an alert or panic button that the member can press in the event of a fall or other emergency.
- Installation and monitoring of the device.

To purchase PERS:

- The consultation services provider reviews the member's service delivery plan.
- The UCare care coordinator approves the member's service delivery plan.
- UCare authorizes units or dollars to the selected provider.

Making changes to individual PCA and CFSS UMPI numbers (additions, changes or deletions)

PCA and CFSS provider numbers are not automatically updated in UCare systems for individual PCAs and CFSS Individual Support Workers. If you have a new PCA or CFSS worker with a new UMPI number, it is your responsibility to provide that information to UCare.

When there are additions, changes or deletions to a PCA or CFSS 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

For CFSS providers:

- Add a non-credentialed practitioner for additions
- Change a non-credentialed practitioner for changes
- Term a non-credentialed practitioner for deletions

Once submitted, you will receive a confirmation number. To check the status of the request, contact the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free and provider your confirmation number from your submitted form. Allow 30 days for your request to be reviewed and completed.

When sending updated or new UMPI numbers to UCare, do not send your entire PCA or CFSS UMPI roster or listing. Send only the information for new or updated PCAs.

Electronic visit verification (EVV)

Ref: Public Law 114-255

EVV is required for all Medical Assistance personal care services (PCA and CFSS), including some waiver services and home health services. CFSS providers must be compliant with this direction provided by DHS.

Providers who serve UCare members who require EVV and have not enrolled with HHAeXchange (HHAX), must enroll even if they use a third-party EVV system. For more information, visit the electronic visit verification or the electronic visit verification compliance policy webpage.

Contact HHAX through their Client Support Portal for questions about enrolling or connecting third-party EVV systems.

Utilization compliance

UCare monitors compliance with these requirements. The CFSS provider is required to:

- Enforce compliance;
- Implement a corrective action plan if deficiencies occur;
- Take immediate disciplinary action if directed by UCare to do so.

Hospital services

This section provides information regarding the hospital admission process for all UCare health plans. See the Nursing facility services chapter for information regarding the Swing Bed admission notification process. For 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 chapter also includes information regarding the Important Message from Medicare and the Detailed Notice of Discharge (DND) for UCare Medicare Plans, 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's Mental Health and Substance Use Disorder (MHSUD) department at 612-884-2033 or 1-855-260-9710 toll-free or sent via a secure email to MHSUDservices@ucare.org. Refer to the authorization requirements grid on the 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 Integrated Care Management (ICM) 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. Refer to the authorization requirements grid on the Authorization page of the UCare provider website 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 or newborn admissions

Complete the Birth Notification Form to report the delivery date, delivery type, birth weight and level of care required. The Birth Notification Form is on the Policies & Resources page 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 authorization for Acute Inpatient Rehab and LTAC hospital admissions for all lines of business. Notification is required within 24 hours of admission and UCare reserves the right to complete concurrent review.

UCare uses utilization triggers for utilization 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 case management or discharge planning support needs are identified.

Note: All admissions for Acute Inpatient Rehab or LTAC are processed by UCare Health 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.

Encounter Alert System and Daily Admission Report

On June 1, 2025, UCare transitioned to the Department of Human Services Minnesota Encounter Alert System (EAS) vendor PointClickCare (PCC). The Encounter Alert Service helps interoperability of care across Minnesota.

- **Facilities enrolled** with Minnesota EAS are no longer required to manually report **most** inpatient notifications of admission to UCare via fax, email or phone. Additionally, UCare will not send the Daily Admission Report to facilities and providers.
- **Facilities not enrolled** with Minnesota EAS should notify UCare of all Hospital Inpatient Level of Care Admissions within 24 hours of admission. Via the Inpatient Notification form located on the UCare's Medical Services or Mental Health and Substance Use Disorder Services Authorizations pages.
- A notification number is not required for claims payment for acute inpatient hospitalization. All providers should follow the guidance listed here and in the authorization grids.

EAS notifications are not currently in place for the following services:

- Substance Use Disorder Inpatient
- Substance Use Disorder Residential Stay
- Detox Admission
- Mental Health Residential Stay
- Skilled Nursing Facility Admission
- Swing Bed Admission
- Long Term Acute Care Admission
- Acute Inpatient Rehabilitation
- Neonatal Intensive Care Unit Admissions

The facility or admission types listed above should continue to be reported as listed in the UCare authorization grids. Organizations not enrolled in the EAS are required to notify UCare of all Hospital Inpatient Level of Care Admissions within 24 hours of admission.

For scenarios where EAS reporting is not available, UCare produces and shares Daily Admission Reports regarding the admission notifications UCare receives for a facility. New reports are created seven days per week, 365 days a year and are available for retrieval by hospitals and delegated care coordination and case management agencies via the secure file transfer protocol (SFTP) site.

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.

For additional information see the UCare transitions to Encounter Alert System - FAQs.

Notice of discharge and Medicare appeal rights

When a UCare Medicare Plans, UCare Institutional Special Needs Plans (I-SNP), EssentiaCare, Minnesota Senior Health Options (MSHO) and 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 expiring 12/31/2025. They may not deviate from the form's content 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 in an outpatient or observation setting on the chance that the patient may receive 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 disagrees 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 Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO). If UCare or the hospital determines inpatient care is no longer medically necessary and the member files an appeal, the BFCC-QIO will contact UCare and request that the DND 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 BFCC-QIO notification. Hospital staff must keep documentation of the DND delivery time.

Use of standardized notice

Hospitals must use the Detailed Notice of Discharge (CMS-10066) expiring 12/31/2025. The Centers for Medicare & Medicaid Services will accept this form until a new one is introduced.

In-person delivery

The IM must be delivered to enrollees in person. However, if enrollees are not able to comprehend the notice, it must be delivered to and signed by their representative.

Notice delivery to representatives

When enrollees are not competent or able to receive or comprehend the information, CMS requires that enrollees Medicare appeal rights are notified to their 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 enrollees have indicated may act for them but who has not been named in any legally binding document may be a representative to

receive the notices described in this section. This representative 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 enrollee's competency, if the hospital is unable to personally deliver a notice to a representative, then the hospital should call and advise the representative 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 the Health Insurance Portability and Accountability Act (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 enrollees comprehend the contents of the notice before obtaining their signature. This includes explaining the notice to enrollees if necessary and providing an opportunity for them to ask questions. The hospital should answer all the questions orally to the best of its ability. Enrollees should be able to understand that they may appeal a discharge decision without financial risk but may have to pay for any services received after the discharge date if they stay in the hospital and do not appeal.

These instructions do not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Thus, if enrollees can comprehend the notice but either are physically unable to sign it or need 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 or representative to demonstrate that the enrollee or representative received the notice and understands its contents.

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. 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 patients a copy of the signed or annotated notice and retain a copy of the signed notice for their records. The hospital may determine whether to retain the original notice or give it to enrollees. 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, see Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance of the Medicare Managed Care Manual.

Care transitions

All members of UCare's Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), UCare Connect, UCare Connect + Medicare and Institutional Special Needs Plans (I-SNP) products are assigned a care coordinator. Members enrolled in Prepaid Medical Assistance Program (PMAP), MinnesotaCare, UCare Medicare Plans, EssentiaCare, UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview are assigned a case manager based on specific criteria including acute complex health care need and identified diagnoses. 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. In some cases, members may also need assistance after an outpatient procedure.

While care coordinators or case managers are ultimately responsible for ensuring that care transition tasks are completed, UCare requires providers and facilities to work collaboratively with care coordinators or case managers and members and their family. This ensures that care is coordinated as members transition from one setting to another, such as when discharged from an acute 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.
- 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, rehabilitation facilities or customized living centers communicate with the member's primary care provider regarding planned and unplanned transitions.

Care transition protocols for 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. The delegate care coordinator is responsible for timely involvement and will review the transition need and the associated action steps required. The delegate care coordinator, with input from other members of the Interdisciplinary Care Team 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. 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

This section explains how to access interpreter services, professional standards for interpreters and how to work with interpreters. It also provides guidance on claims and reporting for UCare's contract interpreter service agencies.

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 Network Management (PNM) department continually evaluates its interpretation network to ensure appropriate geographic, language and culturally congruent coverage. PNM consults with UCare Customer Service, the Health Equity Committee, primary care providers and the Minnesota Department of Human Services to ensure members have access to high-quality interpreters.

Arranging interpreter services at your clinic

We aspire 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:

- **Call a UCare contracted interpreter agency.** Providers can call the agencies listed in this chapter to schedule interpreter services. Members can also call UCare Customer Service to obtain the names and phone numbers of UCare contracted agencies. 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 contracted 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 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 of minutes before the interview to explain the situation and any background needed to understand 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, work with the same interpreter over time to 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 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 you don't want the other party to hear. Expect everything you say and everything the patient says to be translated. 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 hear 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 they 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 fit with what you said), 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 and to see if the interpreter is satisfied or has questions or comments about the communication process.

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 their understanding of what you said if this would not unduly embarrass the patient.

When an interpreter is used, you will communicate **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

Following is a list of interpreter agencies contracted with UCare 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 (by MN counties)
ASL Interpreting Services 5801 Duluth Street, Suite 106 Golden Valley, MN 55422 763-478-8963 www.aslis.com	American Sign Language (ASL)	All counties in Minnesota
Claro Interpreting Services 3355 Hiawatha Ave - Ste 115 Minneapolis, MN 55406 651-705-8890	Amharic, Arabic, Armenian, Burmese, French, Karen, Kiswahili, Oromo, Romanian Russian, Somali, Spanish,	Anoka, Benton, Blue Earth, Carver, Dakota, Hennepin, Kandiyohi, Le Sueur, Morrison,

Agency	Languages	Service area (by MN counties)
	Swahili, Thai, Ukrainian, Vietnamese	Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright
CareInt 4645 Park Commons Dr. Minneapolis, MN 55416 612-922-0587	Russian	Hennepin, Ramsey
Global Language Connections 3618 East Lake Street Minneapolis, MN 55406 612-249-6100 https://globallanguageconnections.com/	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 or Kosrean, Mien, Moldovian, Mongolian, Nepali, Nepalese, Nigerian Pidgin English, Norwegian, Nuer (Sudanese), Oromo, Pashto, Persian, Pidgin English, Polish, Portuguese, Punjabi, Romanian, Russian, Samoan, Senegalese, Serbian, Somali, Spanish, Swahili, Swedish, Tagalog, Taiwanese, Tamil, Telugu, Thai, Tibetan, Tigrinya, Turkish, Twi, Ukrainian, Urdu, Vietnamese, Yoruba	All counties in Minnesota
Intelligere 10000 Highway 55, Suite 400 Plymouth, MN 55441 952-920-6160 1-877-859-8800 toll-free	Albanian, Amharic, Arabic, Armenian, Ashanti, Azeri, Bassa, Belarusian, Bengali, Bosnian, Bulgarian, Burmese, Cambodian or Khmer, Cantonese, Creole, Croatian, Czech, Dan, Dari, Dinka, Dutch, Estonian, Ewe, Farsi, Filipino, French, Fulani, Georgian, German, Ghana, Grebo, Greek, Gujarati, Haitian Creole, Hausa, Hebrew, Hindi, Hmong, Hungarian, Indonesian, Italian, Japanese, Karen, Khmer, Kisii, Kpelle,	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

Agency	Languages	Service area (by MN counties)
	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	
Intercultural Mutual Assistance Association (IMAA) 2500 Valleyhigh Drive Northwest Rochester, MN 55901 507-289-5960 www.imaa.net	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, Quechua, Russian, Somali, Spanish, Swahili, Tagalog, Tamil, Telugu, Thai, Turkish, Vietnamese	Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca, Winona
Itasca Interpretation Services 475 Etna Street, Suite 1 Saint Paul, MN 55106 651-457-7400 www.itascacorp.biz	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 2994 Rice Street Little Canada, MN 55113 651-252-3200 1-877-408-2431 toll-free www.kttsmn.com	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
Vadmin Genov DBA Health Management Services 700 Washington Ave N. Suite 504 Minneapolis, MN 55401 612-670-2147 Fax: 612- 489-6056	Arabic, Russian, Turkish, Ukrainian	Hennepin
Project FINE 202 West 3rd Street	Arabic, Bosnian, Bulgarian, Cambodian, Chinese, Czech,	Minnesota counties: Filmore, Goodhue,

Agency	Languages	Service area (by MN counties)
Winona, MN 55987 507-452-4100 www.projectfine.org	Dari, French, German, Hmong, Italian, Japanese, Korean, Laotian, Nepali, Pashto, Portuguese, Romanian, Russian, Somali, Spanish, Thai	Houston, Olmsted, Wabasha, Winona Wisconsin counties: Buffalo, La Crosse, St. Croix, Trempealeau
Slavic Translation Services 6770 28th SE Buffalo, MN 55313 612-618-6642	Amharic, Anuak, Arabic, Armenian, Belarusian, Berber, French, Georgian, Khmer, Moldovan, Oromo, Romanian, Russian, Spanish, Somali, Sudanese, Swahili, Ukrainian	Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright
Surad Interpreting and Translation Co. 2025 Nicollet Avenue, Suite 101 Minneapolis, MN 55404 612-872-8059 612-424-6656 fax	Afar, Amharic, Arabic, Berber, Bosnian, Burmese, Cambodian, Chinese, Dari, Dinka, Farsi, French, Hindi, Hmong, Karen, Karenni, Khmer, Kiswahili, Korean, Laotian, Mandarin, Nuer, Oromo, Pashto, Russian, Somali, Spanish, Swahili, Thai, Tigrinya, Ukrainian, Urdu, Vietnamese	Anoka, Carver, Cass, Crow Wing, Dakota, Hennepin, Leech Lake Band of Ojibwe reservation, Morrison, Ramsey, Scott, Todd, Wadena, Wright
The Bridge World Language Center, Inc. 110 2nd Street South, Suite 213 Waite Park, MN 56387 320-259-9239 1-800-835-6870 toll-free www.bridgelanguage.com	Arabic, Badini, Belarusian, Bengali, Cambodian, Cantonese, Chinese, French, Gujarati, Hindi, Hmong, Korean, Kurdish, Laotian, Lithuanian, Pashto, Polish, Portuguese, Punjabi, Russian, Spanish, Somali, Swahili, Tagalog, Thai, Tigrinya, Ukrainian, Urdu, Vietnamese,	Anoka, Benton, Clay, Hennepin, Ramsey, Sherburne, Stearns
The Language Banc, Inc. 1625 Park Avenue Minneapolis, MN 55404 612-588-9410 1-888-588-1904 toll-free www.thelanguagebanc.com	Afar, Amharic, Anuak, Arabic, Armenian, American Sign Language (ASL), Bambara, Bassa, Bengali, Bosnian, Burmese, Cambodian, Cantonese, Cebuano, Creole, Croatian, Dari, Ewe, Fanti, Farsi, Filipino, French, Fulani, Fuzhou, Ga, German, Gio, Gola, Grebo, Gujarati, Hebrew, Hindi, Hmong, Ibo, Igbo, Italian, Japanese, Karen, Karenni, Khmer, Kissii, Kiswahili, Konyaka, Korean, Kpelleh, Krahn, Krio, Kru, Kru-Liberian, 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,	All counties in Minnesota

Agency	Languages	Service area (by MN counties)
	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 1327 County Road D, Circle E Saint Paul, MN 55109 651-644-7100 www.minnesotalanguageconnection.com	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 309 Litchfield Avenue Southwest Willmar, MN 56201 Phone: 612-254-8545 Fax: 952-487-4945 https://wcinterpreters.com/	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	All 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 Internet Explorer 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 listed on the OIG or SAM system is prohibited from providing 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 regarding 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 established standards 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 (subd.) 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 badges in a visible manner at all times while on health care facility premises and providing interpretation services to UCare members.
- The interpreter service agency must furnish UCare with training materials the agency uses 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 the assignment without the agreement or permission of staff.
    - Failure to wear a 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 and Resources webpage under the Interpreter Provider Resources drop-down. Click the link above, download the report and open the Excel document. A copy can be saved to a personal or 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 and 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 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-rays, labs and pharmacy.
- The interpreter service agency must respond to requests with one or more day's 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 arrival time 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 arrival time.
- 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 to 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, 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 Minnesota community coding practice or recommendation for interpreter services section.
- Claims must be submitted using the 837P format through a clearinghouse that works directly with UCare for electronic data interchange (EDI) claim transmission. See the Claims and payment 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 and 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 six months from the date of services.
- UCare's standard claim adjustment timeline is six months from the initial date of when the claim was processed (paid or denied).
- 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.

Direct claims questions 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: UCare does not cover drive time or wait time. 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 the following and other resources on the Policies and 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

This chapter describes UCare's authorization requirements, coverage details and denial notification requirements for skilled-level and custodial care provided in a nursing facility. UCare does not cover skilled nursing facilitites or swing bed stays for members of the 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 Institutional Special Needs Plans, EssentiaCare (Preferred Provider Organization), UCare's Minnesota Senior Health Options 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, speech-language pathologists and/or audiologists.
- Provided directly by, or under the general supervision of, 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 to assist 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 or non-skilled care is available for qualifying MSHO, UCare Connect + Medicare, Minnesota Senior Care Plus (MSC+) and UCare Connect members.

Skilled Nursing Facility (SNF): A facility certified by Medicare to provide inpatients with skilled nursing care, rehabilitation 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 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, hospice and 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 treating 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 ensure member safety and achieve the medically desired result.
- Services are provided under a plan of care established and periodically reviewed by a physician.
- Skilled services are necessary for treating an illness or injury with the expectation of improvement within a reasonable and generally predictable period of time. Alternatively, such services must be required to establish a safe and effective maintenance program. At least one of the following types of skilled services is needed:
    - 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 notification 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 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 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 Medicare Part A days available, the stay must meet Medicare skilled-level coverage criteria, and UCare or its approval authority must authorize the stay. 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 or eligibility criteria.
- Alternatively, a resident of a long-term care 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 by telephone or in-person is required at least every 24 hours thereafter.

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

- UCare Senior Select
- UCare Medicare Supplement

UCare Medicare Plans, 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. If the separation criteria are met, a member may have more than one benefit period.

Swing bed authorization requirements

Notification 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 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

The medical necessity for swing bed admission follows Medicare's 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 is not receiving the 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 resides 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
- Medical Assistance (Medicaid) custodial or long-term care NF days
    - These may include Medical Assistance bed hold days. The facility must meet Medical Assistance occupancy requirements for coverage of bed hold days. The number of days per current Medical Assistance 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 received skilled care in a skilled nursing facility.
- If the member is in a skilled nursing facility but is not receiving the 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

Notification for swing bed stays is required before admission or within one business day after admission. Approval for swing bed services is based on Medicare medical necessity criteria. These criteria are outlined in 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

The medical necessity for swing bed admission follows Medicare's 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 nursing facility days. Up to 100 of these days may be Medicare skilled-level care days. After UCare has paid claims for 180-days of skilled nursing facilities and/or nursing facilities, UCare notifies the Department of Human Services the health plan responsibility has been exhausted, and Medical Assistance will pay all further custodial days.

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).
- Medical Assistance custodial long-term care nursing facility days.
    - These may include Medical Assistance bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medical Assistance 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. After UCare has paid claims for 180-days of skilled nursing facilities and/or nursing facilities, UCare notifies the Department of Human Services the health plan responsibility has been exhausted, and Medical Assistance will pay all further custodial days.

UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview coverage details

UCare covers room and board, daily skilled nursing care and related ancillary services for post-acute treatment and rehabilitative care of illness and injury following 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 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 are paid for in full by original Medicare and other insurance (for example: Medicare Supplement), for which UCare paid nothing.
- Swing bed days (billed to Medicare).
- Medicaid custodial or long-term care nursing facility days.
    - These may include Medical Assistance bed hold days. The facility must meet Medical Assistance occupancy requirements for coverage of bed hold days. The number of days per current Medical Assistance 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 Medical Assistance will pay all further custodial days.

For additional information regarding Nursing Home Authorization, see the State Public Programs and 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.
- Medical Assistance custodial or long-term care nursing facility days.
    - These may include Medical Assistance bed hold days. The facility must meet Medicaid occupancy requirements for coverage of bed hold days. The number of days per current Medical Assistance standard is 36 therapeutic leave days and 18 hospital 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 is not receiving a 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

Notification 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

The medical necessity for swing bed admission follows Medicare's 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. After UCare has paid claims for 100-days of skilled nursing facilities and/or nursing facilities, UCare notifies the Department of Human Services the health plan responsibility has been exhausted, and Medical Assistance will pay all further custodial days. 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 Medical Assistance payment is evaluated in the claim's reimbursement process for the following products: MSC+, UCare Connect, MSHO and UCare Connect + Medicare.

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 and Billing webpage under "Forms and 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 Health Services fax: 612-884-2247
- UCare Health Services email: 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 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 Medical Assistance, 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 Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO).

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 call's date, time and phone number 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 members decide to appeal the end of coverage, they must contact the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) by noon of the day before services are to end (as indicated in the NOMNC) to request a review.

The BFCC-QIO will inform UCare and the provider of the request for a review.

- The BFCC-QIO for Minnesota and Wisconsin is Livanta.
    - This information is on the UCare-specific denial forms for UCare Medicare Plans, EssentiaCare, MSHO and UCare Connect + Medicare.
- The provider is responsible for providing the BFCC-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 BFCC-QIO must decide by close of business on the day coverage is to end.

- The provider and UCare must cooperate with the BFCC-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 BFCC-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, 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

Family planning services

UCare members have open access to family planning services. Members may obtain covered family planning services from any qualified provider, including those outside 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 at least 30 days, but not 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 delivery date.

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 cannot 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 (surgically 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.

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:

- 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 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, including preabortion and follow-up services.

UCare's Maternal Child Health Program

See the Integrated care management chapter for additional information.

Breast pump coverage

Breast pumps are covered for pregnant members prior to delivery or breastfeeding members post-delivery. 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.

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 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, UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview members are eligible for doula services. MHCP-enrolled doula providers are allowed to provide and bill

for doula services for MHCP and Individual & Family Plans members based on guidelines in the DHS MCHP Provider Manual. Limits apply.

Individual & Family Plan and Individual & Family Plan with M Health Fairview

- Bill all non-labor and non-delivery sessions with T1033 with no modifier (limited to six sessions).
- Bill all labor and delivery sessions with T1033 with U4 modifier (limited to one session).

Prepaid Medical Assistance Program, MinnesotaCare and UCare Connect

- Providers follow the DHS MHCP Provider Manual – Doula Services

Rewards, incentives and resources

MOMS handbook

This handbook includes facts, tips and resources to make pregnancy easier. Find information about breastfeeding, eating healthy during pregnancy and UCare's Seats, Education and Travel Safety (SEATS) Program. Members can call UCare to request a free handbook or download the Spanish version from the MOMS web page.

Rewards

Members can earn rewards for completing certain preventive screenings; those reward dollars are loaded onto the Healthy Benefits+ Visa card. Advise members to log in or create an online member account at member.ucare.org to see if they are eligible.

Public health

Local public health agencies provide various services for UCare members and the community. According to the American Public Health Association, "Public health promotes and protects the health of people and their communities."

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 below services. Providers should contact the local county public health agency to connect a member to public health services. Contact information is available on the Minnesota Department of Health (MDH) 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 families with social, emotional, physical and parenting support. 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 support for pregnant and parenting members.

Child and Teen Checkups

Child and Teen Checkups (C&TC) is Minnesota's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is a federal program required in every state to provide comprehensive health care and dental services for children who are eligible for Medical Assistance (Medicaid). The Minnesota Department of Human Services administers it with technical and clinical assistance from the MDH. (Source: Minnesota Department Health C&TC website). See the Child and teen checkups chapter for more information if you are a C&TC provider.

C&TC visits are covered 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 the Department of Human Services attributes to an Integrated Health Partnership (IHP) are assigned to the IHP for outreach. Agencies also conduct C&TC provider training 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 (MHCP) 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, such as furnace filters and mattress covers. See the Allergen-Reducing Products for Children website for more information. 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.

Children are 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 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 the member's local public health agency to make a referral for a home assessment.

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 operate under the direct authority of, a government unit.
- 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 government unit. Examples of a unit of government include county, city or school district. Services must be performed at a main clinic site, satellite clinic or mobile clinic open to the public or the recipient's home.

Services that county public health agencies may provide for members enrolled in UCare's MHCP 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 evaluates 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 needed to ensure that the recipient receives the necessary care.

UCare covers evidenced-based, evidence-informed and universal home visiting models 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 public health nurse clinics can provide include:

- Safety assessments
- Infectious disease assessment and/or follow-up
- Senior health classes
- Public health services as a 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 MHCP manual. See the Physician's Services section of the MHCP manual: Enhanced Asthma Care Services for more detail.

UCare MHCP members under the age of 21 for 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.

Children are 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 MDH.
- Registered Environmental Health Specialist as defined and credentialed by the MDH.

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 details about covered products.

Fluoride Varnish Application (FVA)

UCare reimburses county public health agencies, primary care and dental clinics for fluoride varnish.

Child and Teen Checkups (C&TC)

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. The Minnesota DHS administers it with technical and clinical assistance from the MDH. See the MDH C&TC website or the Child and teen checkups section for more C&TC provider information.

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 keeping members healthy and safe. Learn more about the health and wellness programs 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 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)

Public health agencies need to communicate with their patients' primary care clinics regarding services they provided to ensure this information is incorporated into the patients' medical records and plans of care. Please take the time to provide this information to the member's PCP.

Tips for public health providers

Conveniently view claims

Providers can review submitted claims information via the UCare Provider Portal. If you need 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 and Tribal Partners page for the latest news and updates from the UCare County and Tribal Relations Team.
    - Counties can contact the County and Tribal Relations Team Representative assigned to your county (see the County Team Coverage Map on the County Partners page), or email UCareCountyRelations@ucare.org.
- Community Relations: Contact communityoutreacheve@ucare.org to request UCare's involvement in your community event.
- UCare Quality Improvement Program: UCare is committed to delivering members optimal and cost-effective health care. We aim to continuously improve 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 Highlights webpage for more information.

Transportation

External resources and links

Minnesota Statutes, section 256B.0625, Subdivision (subd.) 17 and subd. 18h (Medical Assistance 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 referenced in this section and UCare's transportation provider agreements.

Assisted Transportation: Transportation is provided to ambulatory UCare members who require assistance, including escort to the medical service desk 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 or special transportation services. This form must be completed by the member's primary care provider and returned to UCare for processing before it is 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). CC 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 transportation service vehicles for modes 2-7.

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 section. 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 or Ramp Transportation: Transportation services provided to a UCare member who is dependent on special durable medical equipment that requires 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 provided by an Ambulance Transportation provider approved by UCare. Drivers must provide passenger assistance, including escort to the medical service desk and/or through the door of the member's destination.

Nonemergency Medical Transportation (NEMT): Minnesota Statutes § 256B.0625, subd. 17 defines "Nonemergency medical transportation service" as 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, subd. 3, to obtain covered medical services. Minnesota Statute § 256B.0625, subd. 17 requires that all NEMT providers 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: Intended to be used by a UCare member who received a transportation level of service assessment and whose assessment determined that 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 client's needs 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. This includes, but is not limited to, service provided by specially equipped buses, vans, sedans or taxis. STS drivers provide passenger assistance, including escorting to the medical service desk 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 requires a nonemergency medical transportation provider to use a vehicle that can transport a client in a prone or supine position. This is NEMT Mode 7.

Unassisted Transportation: Transportation services are 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**

**Also called "Common Carrier" or "Access Transportation."*

***Also called "Special Transportation Services."*

	Ambulance transportation	Unassisted transportation (Modes 1-3)	Assisted transportation (Modes 4-7)	Extended transportation (Waiver services)	Supplemental benefits transportation
Prepaid Medical Assistance Program (PMAP)	Covered	Covered	Covered	Not covered	Not covered
MinnesotaCare	Covered	Limited coverage[1]	Limited coverage[1]	Not covered	Not covered
Minnesota Senior Care Plus (MSC+)	Covered	Covered	Covered	Covered for members with EW	Not covered
UCare's Minnesota Senior Health Options (MSHO)	Covered	Covered	Covered	Covered for members with EW	Three rides per week to covered fitness, Juniper classes (all modes), one ride per week to participating Health Food Allowance grocery store sites (all modes), one ride per day to AA or NA meetings for members with SUD (all modes).[3]
UCare Connect (SNBC)	Covered	Covered	Covered	Covered by county for members with disability waiver[2]	

	Ambulance transportation	Unassisted transportation (Modes 1-3)	Assisted transportation (Modes 4-7)	Extended transportation (Waiver services)	Supplemental benefits transportation
UCare Connect + Medicare (HMO D-SNP)	Covered	Covered	Covered	Covered by county for members with disability waiver[2]	Three rides per week to covered fitness, Juniper classes (all modes), one ride per day to AA or NA meetings for members with SUD (all modes), one ride per week to participating Health Food Allowance grocery store sites for members with qualifying condition(s) (hypertension, diabetes or lipid disorders).[3]
UCare Medicare Plans	Covered	Not covered	Not covered	Not covered	Not covered
UCare Advocate Choice and UCare Advocate Plus (I-SNP)	Covered	Not covered	Not covered	Not covered	$500 annual transportation allowance. Allowance is loaded on member's UCare Healthy Benefits+ Visa card.
UCare Individual & Family Plans and UCare Individual & Family Plans with M Health Fairview	Covered	Not covered	Not covered	Not covered	Not covered

[1]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.

[2]Covered through the member's county of residence for members with a BI, DD, CAC or CADI waiver.

[3]Effective Jan. 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, use the Member Eligibility Lookup (log-in required) function in the UCare Provider Portal.

All MHCP plans: UCare covers rides to MNsure Navigator Organizations and county or tribal agencies within 90 days of the member's renewal date.

Rides cannot exceed 30 miles for primary care (PCC) or 60 miles for specialty including mental health.

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 QRyde to manage the assignment of rides to transportation providers.

- Transportation providers must login to UCare's HealthRide scheduling software, QRyde, to review, accept or decline rides daily.
- Contracted agency's designated QRyde administrator requiring access to QRyde must submit an access request form to UCare. To receive assistance in submitting this form, email the HealthRide department at health_ride@ucare.org.
- If a contracted agency's users experience issues with access or when using QRyde that cannot be resolved by reading the QRyde User Guide, they may contact the HealthRide department at 612-676-6878 or 1-833-276-1183 toll-free for assistance. If the issue is not urgent, they may email the HealthRide department at health_ride@ucare.org. Direct billing and claims questions to UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll-free.
- If a contracted agency needs to update its daily ride capacity, it must submit a capacity update form to UCare. To receive assistance in submitting this form, email the HealthRide department at 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 QRyde. 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's 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 Latitude (Lat.) and Longitude (Lon.)

- 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 at stscon@ucare.org, 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. The provider must include:
  - Transportation provider
  - Member's identification number
  - Member's 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, Care Coordinators or UCare Integrated Care Management staff. Providers **are still** required to obtain ride assignments and CON authorization numbers to receive payment from UCare for NEMT Modes 4-7. **UCare will allow a one-time exception for hospital or facility discharge if the member has a medical need and will not require a CON. The hospital or facility can upgrade a member's ride to a higher-level mode for a single-need ride.*
- 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. **UCare will allow a one-time exception for hospital or facility discharge if the member has a medical need and will not require a CON. The hospital or facility can upgrade a member's ride to a higher-level mode for a single-need ride.*
- Transportation providers must escort all members receiving an assisted mode of transportation into their destination and obtain a signature from the member attesting to receiving the ride as well as a signature of an office personnel attesting to the member being dropped off.
- Transportation companies providing NEMT Mode 6: Protected Transport will follow the ride assignment requirements outlined in this section, as well as provide UCare with the required Level of Service Assessment (LOS) required for all Protected Transportation.

- **Pre-Service (ride) Request Requirements**: Providers are required to obtain a copy of the LOS assessment completed by a qualifying treating healthcare provider and email the copy 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 that their ride request was denied.
- **Post-Service Ride Requirements**: Providers are required to obtain a copy of the LOS assessment completed by a qualifying treating healthcare provider and submit the copy to UCare for approval. When emailing UCare's HealthRide team for a booking ID post service, the provider must also send a copy of the LOS assessment with the booking ID 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 that their ride request was denied.

Providers should report emergency room, hospital discharge, skilled nursing facility (SNF) appointments and 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 at least 48 hours before the ride or within 72 hours after the provided ride, UCare will only allow five 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 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 legal requirements, 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 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 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.

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 them. 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, including 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 or SAM results)
  - Vehicle Management
    - Service records
    - Safety inspection and maintenance records
    - Retention policy
      - Standards for operation of vehicles

C. Documentation and Records

- Transportation providers must maintain documentation and records as specified under Minnesota Statutes § 256B.0625, subd. 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 Minnesota Statute § 256B.0625, subd. 17b)
- Complaint records
- Accident or 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 (front and back)
    - 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 contractors 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 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 passengers arrive at least 10 minutes before the appointment.
- Drivers must wait 10 minutes past their scheduled arrival time and 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 established by your 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 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.

  Note: County and volunteer providers are exempt from this specific requirement.

- 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://pqc.health.state.mn.us/hci/searchInterpreter.jsp
- A driver cannot be a family member of the UCare member being transported. A 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 members install the car seats 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 from 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 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 using a removable device if that device meets the identification and legibility requirements. The transportation provider must ensure that all vehicles have proper signage prior to providing transportation to any UCare member.*

  Note: 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.
- Service area updates are subject to review by UCare's Provider Network Management department. All requests to add new or discontinue existing transportation services within your UCare-approved service area can be emailed to trans-prov@ucare.org and will be reviewed by UCare's Provider Network Management department. 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 Network Management department. These documents may be submitted by email to 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.
- 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 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 performance issues or fraudulent activities are suspected or confirmed with specific drivers, this must be reported to UCare immediately. You are 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

- Unaccompanied minors must be between the age of 12-17 for any appointment type other than mental health appointments. For mental health appointments the minor must be 3 years and older.
- UCare must obtain written parental consent before allowing any minor under 18 years of age to be transported without being accompanied by a parent or legal guardian. In these cases, a CON number will be assigned to the member account to allow for NEMT mode 4 assisted. 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 providers must notify and coordinate with UCare prior to providing transportation services if any parental consent is received for an unaccompanied minor under 18 years old to determine the 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; the transportation provider must contact UCare with any questions on whether this exception applies prior to providing transportation services to the minor.
- 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 pickup points 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, billing must reflect the most direct mileage between members pickup and destination addresses.

Section three: fraud, waste and abuse requirements

Transportation providers are responsible for ensuring 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 point 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).
- Mileage submission that is more than the actual miles of 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 immediately contact UCare at 1-877-826-6847 toll-free** if they discover information regarding fraudulent, wasteful or abusive use of the transportation system by a UCare member or driver.

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 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 while the allegation is investigated.

Providers must fully cooperate with any UCare investigation.

Section four: billing and claim requirements

See the Claims and payment chapter 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, which results in the member missing their scheduled appointment.
- Passenger assistance includes escort to the destination's door and/or medical service desk.
- 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 information below is needed to properly bill UCare for transportation services.

- **Provider Identification:** All providers must bill using their NPI or UMPI. If your agency is contracted for both special transportation (NEMT Modes 4-7) and common carrier transportation services (NEMT Modes 2-3), you will need to include the appropriate billing taxonomy to ensure 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 expects (NPI or UMPI), contact the UCare Provider Assistance Center at 612-676-3300 or 1-888-531-1493.
-

Type of billing ID	Loop or segment	Place on claim image
If billing NPI	Loop 2010AA NM109	Box 33a
If billing UMPI	Loop 2010BB REF 01 - G2 REF 02 - UMPI	Box 33b
Taxonomy type	**837P loop professional**	**Place on claim image**
Billing Provider	2000A - Billing Provider Specialty Information PRV01 - BI for billing provider PRV02 - PXC (Health Care Provider Taxonomy) PRV03 - Taxonomy Number If CC - enter 344600000X If STS - enter 34390000X	CMS - 1500 Box 33b - with ZZ indicator Double entry in box 33b may not be allowed on electronic claim submissions. You will need to contact your clearinghouse to add the appropriate taxonomy to the loop. If CC - enter 344600000X If STS - enter 34390000X UB04 Box: 81CC, Box a First Box - Qualifier B3 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 loops and segments below are 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 or 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 or 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	A0100	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 or destination modifier	Description *(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 transportation claim

Ambulatory round trip

MM	DD	YY	MM	DD	YY	Place of service	CPT or 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 or 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 Three leg trip (pharmacy run)

MM	DD	YY	MM	DD	YY	Place of service	CPT or 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 Three leg trip (pharmacy run)

MM	DD	YY	MM	DD	YY	Place of service	CPT or 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	DD	YY	MM	DD	YY	Place of service	CPT or 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 servic	CPT or 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 2, 2025 update

Page	Chapter	Topic changes	Type of change(s)			
			Update	New	Deletion	Other
Throughout the provider manual		Changed Medicaid references to Medical Assistance.	X			
15	Working with UCare's delegated business services	Within the Pharmacy services section, revised the Formulary information, prior authorization and formulary exceptions section.	X			
27	Member enrollment and eligibility	Within the Medicare programs section, updated the Medical supplemental plans information.	X			
33	Provider credentialing	Updated the notes section within Practitioner license types that require credentialing.	X			
44	Claims and payment	Revised the Fee schedule updates and Claim adjustment and appeals sections. Removed the Timely filing deadline for reconsideration.	X		X	
106	Disease management programs	Added the Remote patient monitoring section.		X		
109	Medication Therapy Management program and pharmacist-provided services	Renamed the chapter and updated references to MTM to refer to pharmacist instead. Updated the Billing processes, Eligibility chart and Provider expectations sections. Added an Enrollment expectation section.	X	X		
139	Home and community based services or waiver services	Within the Elderly Waiver service requests section, clarified what EW services UCare does not cover.	X			

145	Home care services	Removed and revised information from the Care transitions section. Changed references of MHSUD to ICM. Revised the Encounter Alert System and Daily Admission report information section.	X		X	
162	Hospital services	Within the Hospital admission notification | all UCare members section, revised the Encounter Alert System and Daily Admission Report information. Added, removed and revised content within the Care	X	X	X	
169	Interpreter services	Updated the agency, languages and service areas within the UCare contracted interpreter service agencies list.	X			
189	Nursing facility services	Added information to the UCare Connect (SNBC) coverage details section regarding 100-day SNF and 180-day NF benefit periods		X		
204	Transportation	Within Section two: transportation provider requirements section, revised the I. Multiple Riders information. Within Section three: fraud, waste and abuse requirements section, removed the "Mileage for each rider when there are multiple riders on the trip" bullet. Within Section four: billing and claim requirements section, revised NEMT Mode 3 service code.	X		X	

August 22, 2025 update

Page	Chapter	Topic changes	Type of change(s)			
			Update	New	Deletion	Other
13	Provider support	Within the UCare Provider Portal section, renamed the Third-Party Agreement Notification form to the UCare Provider NDA Attestation form.	X			
16	Working with UCare's delegated business services	Revised the Physician administered drugs section and updated Eye-Kraft information.	X			
24	Provider responsibilities	Within the Notifying UCare of contracts with third-party billers section, renamed the Provider Notification/Change/Update/Termination Third-Party Agreement form to NDA Attestation form. Revised the Model of Care training section.	X			
28	Member enrollment and eligibility	Within the Verification of eligibility section, updated the requirements for claim status inquiries.	X			
33	Provider credentialing	Updated the Practitioner license type lists who do and do not require credentialing.	X			
56	Electronic data interchange	Within the EDI transactions or reports, updated the Eligibility and benefits (270/271) definition.	X			
66	Medical necessity criteria for services requiring authorization	Revised the guidance within the Medical, mental health and substance use disorder services requiring authorization section.	X			
91	Clinical practice guidelines – medical, mental health, and substance use disorders	Removed the Medical and Mental health and substance use disorders sections.			X	

107	Medication Therapy Management program and pharmacist-provided services	Updated the Eligibility chart.	X			
117	Health and wellness programs	Updated the rewards guidance.	X			
125	Mental health and substance use disorder services	Moved the Child and Adolescent Case Management (CACM) section to the Integrated Care Management chapter.	X			
123	Integrated care management	Added this chapter.		X		
137	Home and community based services or waiver services	Added the Housing stabilization services section. Revised the Elderly Waiver, Denial of waiver service requests and Waiver obligations – important notice for EW providers sections.	X	X		
142	Home care services	Revised the Personal Care Assistance (PCA) | standards for agencies in the UCare network section. Revised the Community First Services and Supports (CFSS) section.	X			
159	Hospital services	Revised the Encounter Alert System and Daily Admission Report section.	X			