2025 IHCP Works Annual Seminar: UnitedHealthcare Informational Session on Nursing Facility Services

UnitedHealthcare Community Plan of Indiana

Kelsie Buckley, Provider Engagement Representative-Presenter

United Healthcare® Community Plan

Agenda

- About us
- UnitedHealthcare Community Plan
- Eligibility
- Claims, coding, and reimbursement
- Patient liability
- Claim reconsiderations, appeals, and grievances
- Doing business with us
- Resources

About Us

Mission and Vision

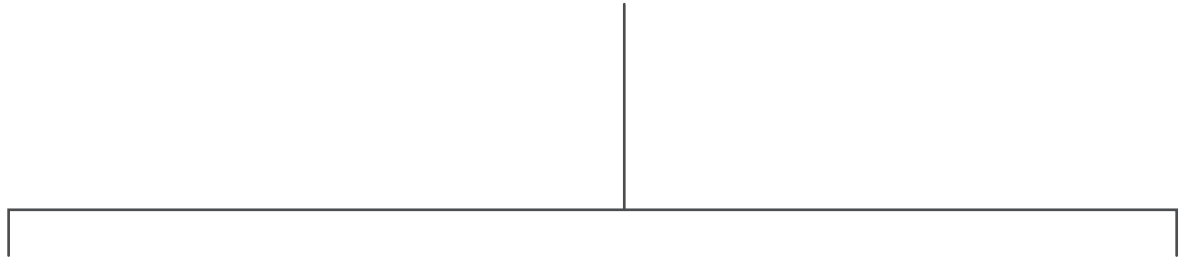
Our Mission

Delivering the most affordable coverage, simplest experience and highest quality supported care.

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicaid members as well as our members in other government-sponsored health care programs, and to be effective partners with physicians, hospitals and other health care professionals in serving their patients.

UNITEDHEALTH GROUP®



United Healthcare

Health care coverage and benefits

- Employer & Individual
- Medicare & Retirement
- Community & State
- Global

Optum

Health services and care delivery

- Optum Health
- Optum Insight
- Optum Rx

Optum Senior Community Care (SCC) is a business under OptumHealth Complex Population Management specializing in network and clinical services for some of the most complex patient populations in the health care space, primarily patients in skilled nursing facilities

Contracting and provider service for UnitedHealthcare's free-standing skilled nursing facility (SNF) network

Provider Engagement Service Model

Optum nursing facility provider engagement representatives support providers for LTSS services in a nursing facility with every engagement

- Acts as nursing facility direct point of contact
- Offers expertise, knowledge, and problem resolution
- Provides helpful resources and education
- Three dedicated Provider Engagement Representative (PERs)

Direct Point of Contact

Assigned geographically

Liaison between organizations

Education and Training

Optum Provider Engagement Representative Team

REGION 1
Missy Bateman
Email: melissa_bateman@optum.com
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REGION 3
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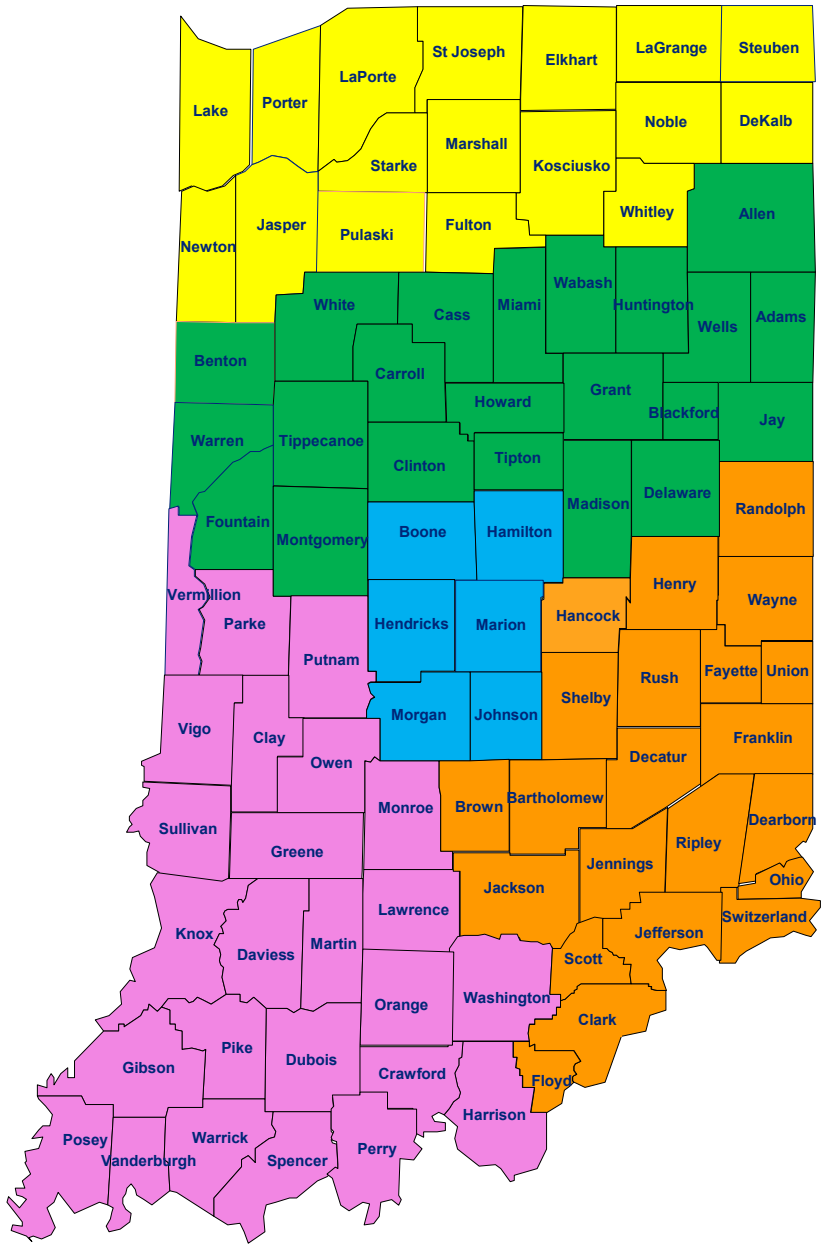

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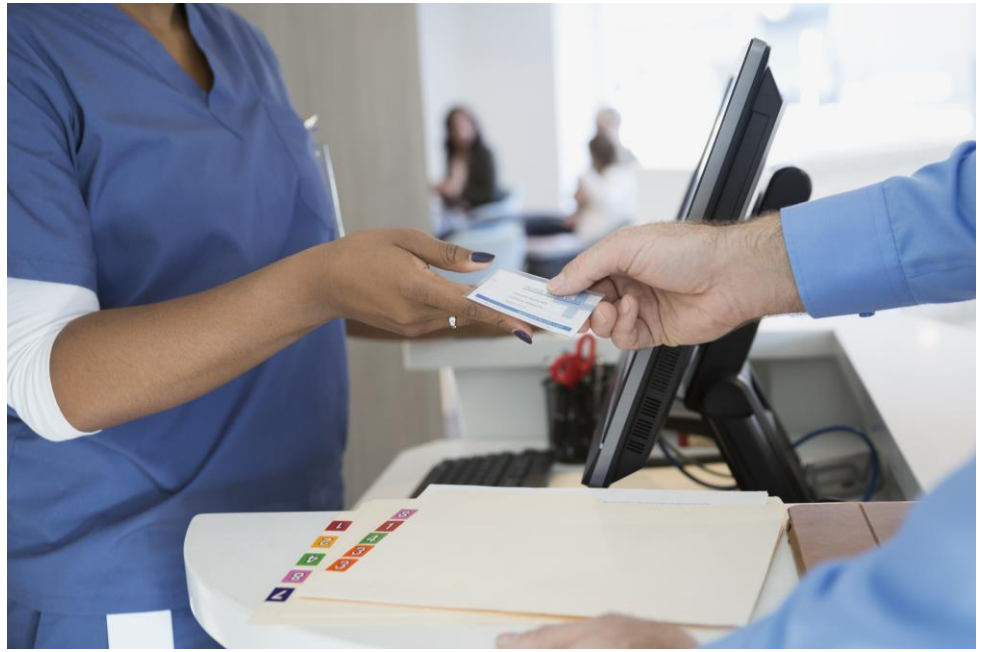
UnitedHealthcare Community Plan

Nursing facilities: Role in the Indiana PathWays for Aging plan

- The Indiana Health Coverage Programs (IHCP) covers long-term care (LTC) in a nursing facility (NF) for members who meet NF level-of-care (LOC) criteria and who are enrolled in the Traditional Medicaid fee-for-service (FFS) program or the Indiana PathWays for Aging (PathWays) managed care program.
- As the residence of plan members, the nursing facility is involved in many aspects of the resident's life, including providing financial services and guidance on health plan decisions.
- Nursing facilities may submit claims as frequently as weekly though most bill monthly or twice per month.

Eligibility

Member Eligibility



Who is eligible?

- PathWays members are:
- 60 years of age and older
- Are eligible for a full-coverage aged, blind or disabled Medicaid category (with or without Medicare)
- Members can be receiving long-term support services including:
    - Residing in a nursing or long-term care facility.
    - Members must be able to be safely served in the community with waiver services.
- Members can also be on the Behavioral and Primary Health Coordination program.

Verifying Member Eligibility and Benefits

Before providing services, please verify member eligibility and benefits.

- Always check the IHCP portal for Medicaid eligibility. The IHCP portal will be updated prior to the MCE portal. Always check benefits before providing services to a PathWays for Aging member
- To register to use our online portal, you will need a One Healthcare ID. Go to **UHCprovider.com** and select “New User” on the top right-hand corner
- Once registered, visit **UHCprovider.com** > Sign in > Eligibility and Benefits
- Call Provider Services at **877-610-9785** Monday through Friday from 8am to 8pm ET or call the number on the back of the member’s ID card

Member ID Cards

- UnitedHealthcare Community Plan - Indiana PathWays for Aging members receive an ID card with information to help you submit claims accurately and completely
- Be sure to check the member's ID card at each visit and copy both sides of the ID card for your files
- Member ID cards can also be viewed online using the Eligibility & Benefits tool on UHCprovider.com

Sample member ID cards for illustration only; actual information varies depending on payer and other requirements

Claims, Coding, and Reimbursement

Claim Submission

Submit nursing facility claims using CMS Form UB-04 in one of the following ways:

Electronic Claims Submission

- Use the Claims Submission Tool on **UHCprovider.com**
- Use **Payer ID 87726**
- For electronic submission, Payer ID may be located on the Member ID card. Learn more at **UHCprovider.com/edi**

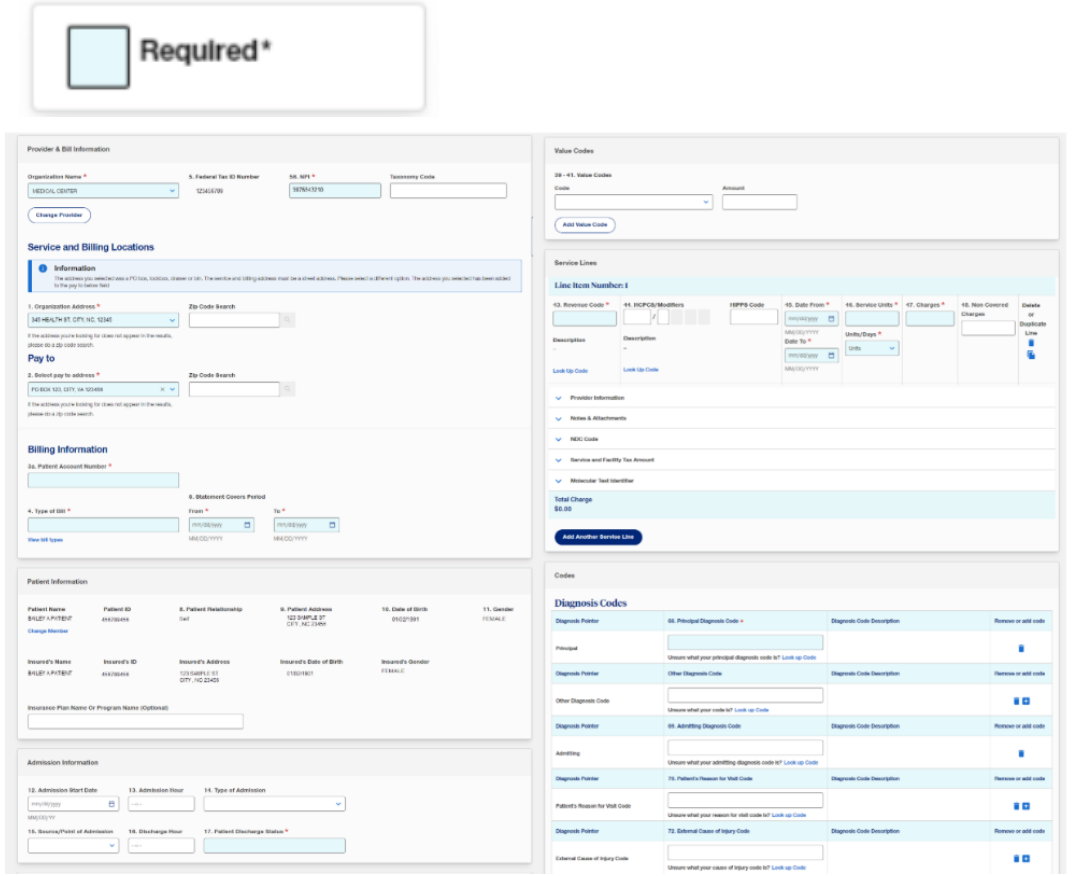
Paper Claim Submission

UnitedHealthcare Community Plan of Indiana PathWays for Aging
P.O. Box 5270
Kingston, NY 12402

Facility Claim Form

- Make note that all red * and blue boxes must be filled in. (there are some boxes that are required but not highlighted in blue or with a *).
- You will start with the Provider & Bill Information.
- If the address you're looking for does not appear in one of the dropdown results, you may do a ZIP code search. Under Billing Information, you can click the link to **View bill types,** if needed.
- Patient information is next this should prepopulate for the member you chose.
- Admission information is the next section this is a must complete section 12-17 must be filled out.
- Condition codes and value codes are optional.
- Service Lines – Modifiers are a must but not highlighted in this section.
- Codes – principal is the only one needed.
- Additional claim information all needs to be completed.
- Submit

- Example of a UB-O4 claim within the UHC Portal



Claim Processing and Payment

- **Claim Processing:**
  - We will pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt.
  - We will pay or deny clean paper claims within thirty (30) calendar days of receipt.
- **Standard Timely Filing:**
  - 90 days from the date of service for in-network and out-of-network services

Definition of a Clean Claim for Nursing Facilities

- A clean claim is one that includes all required data elements, such as:
  - Type of bill
  - Coverage dates
  - Bill status
  - Revenue codes
  - Rate of payment
  - Service units
  - Total charges
  - Provider number
  - Third-party prior payments
  - Estimated amount due
  - Recipient number
  - Provider signature and name
  - Number of covered days
  - Date of admission
  - Condition, occurrence, and value codes
  - Third-party liability payor name
  - Recipient name
  - Admitting Diagnosis
  - Attending physician ID number

- Has correct and valid information for each required field.
- The recipient is Medicaid-eligible on the date of service.
- The level of care is approved for both the recipient and the facility for the billed dates.
- The provider is eligible to render services on the billed date.
- The claim is not a duplicate of one already paid.

- Exclusions:
- A claim is not considered clean if:
- The provider is under investigation for fraud or abuse.
- The claim is under medical necessity review.
- Claims with errors originating in the state's claims processing system may still be considered clean if no additional provider input is needed.

Nursing Facility Reimbursement: Skilled Care and Transition to Custodial Care

The per diem payment includes but is not limited to the following services:

- Laundry services
- Nutritional services
- Personal care services
- Personal care supplies
- Incontinence supplies
- Stock medical supplies
- Wound care supplies
- Analgesics
- Antacids
- Laxatives
- Vitamins

Nursing Facility Reimbursement: Leave of Absence

- The IHCP does not reimburse nursing facilities for bed-hold days unless the member is receiving hospice care.
- Members should speak directly with their facility about any bed-hold or leave-day policies.
- Facilities must clearly communicate these policies and cannot charge members for services they did not request.
- Medicaid does not require facilities to hold beds, and any bed-hold during a member's absence is considered a noncovered service unless related to hospice.
- If a facility offers this option, it must be documented in its written policy and shared with the resident before any hospital transfer or therapeutic leave.

Steps To Obtain Authorization For Special Care Unit & Ventilator Add-On

- Obtaining Special Facility Qualification status To be reimbursed at the rates effective for DOS on or after July 1, 2023, NF providers will use the Nursing Facility Schedule of Special Facility Qualifications (Schedule Z) to obtain qualification as a facility providing these specialized services. The Schedule Z form and instructions are available on the *Long Term Care* of the Myers and Stauffer website, under Nursing Facility > Forms > Schedule of Special Facility Qualifications (Schedule Z).
  - **SCU Requirements (Effective July 1, 2023):**
    NF providers billing Medicaid for SCU reimbursement no longer need to include room numbers. However, they must complete and submit the *Special Care Unit Qualifications* section of Schedule Z by the deadline for OMPP review.
  - **Ventilator Program:**
    NF providers seeking ventilator program reimbursement must complete and submit the *Ventilator Program Qualifications* section of Schedule Z by the due date for OMPP determination.
  - **Certification Statement:**
    An authorized representative (e.g., board member or owner) must sign and date the certification statement after reviewing Schedule Z. Handwritten signatures are required—PDFs or copies are acceptable, but electronic signatures are not.
  - **Program Changes:**
    NF providers must promptly notify OMPP of any changes that affect their specialized service program qualifications.

Nursing Facility Reimbursement: Special Care Unit & Ventilator Add-On Billing

- Qualifying nursing facilities are eligible to receive additional reimbursement for members who are in an **Alzheimer's and dementia care in a special care unit** (SCU) and **ventilator-dependent services**. Additional reimbursement per Medicaid resident day is in the form of an add-on.
  - Revenue code 0199 – Ventilator-dependent residents
  - Revenue code 0193 – Special Care Unit residents with Alzheimer's or dementia
- Revenue codes must be billed as an additional detail line in addition to the applicable room and board revenue code.
- Claims billed with revenue codes 0193 or 0199 must be submitted for the DOS being billed for the accommodation days.
- SCU and Vent approved provider listing can be viewed at **myersandstauffer.com/client-portal/indiana/indiana-long-term-care/.** Additional information can be found here **Indiana Medicaid: Providers: IHCP Quick Hits**

Rate Cap

Rate Changes

- The FSSA contracts with Myers and Stauffer to complete periodic minimum data set (MDS) reviews for all residents of Medicaid-certified nursing facilities in Indiana, regardless of payer source.
- Every Medicaid-certified nursing facility in Indiana is reviewed a minimum of once every 3 years. (Year is defined as the State fiscal year – July 1 through June 30.)
- We will proactively reprocess any claims paid incorrectly due to delays in system updates or retroactive rate change by the state; providers do not need to submit claim reconsiderations or corrected claims for these scenarios.

Hospice in a Nursing Facility

- Hospice Provider are responsible for billing for room and board while the member is receiving hospice care
- These claims should be paid within 21 days for clean electronic claims allowing for the payment to pass through to the NF in the agreed time with the hospice agency
- If a member discharges from hospice care, the NF can bill for room and board claims. Depending on that notification and claim discharge submission, UHC can override any potential NF timely filing issues. Please work with your advocate on these scenarios.
- **Reminder** If the member is in a Special Care Unit and the hospice provider is not made aware of that then the hospice room and board claim could deny due to timely filing when adding the SCU add-on code to the claim

Nursing Facility Reimbursement Summary for Indiana PathWays for Aging Medicaid

Service description	Revenue code	Type of bill	Payment rate	Authorization required?
Nursing facility custodial care (30, 60, 90, 120 day NFLOC)	0110, 0120, 0130	065x	100% of Medicaid daily rate for both PAR and NON-PAR	No
Nursing facility skilled care	0110, 0120, 0130	021x	100% of Medicaid daily rate for both PAR and NON-PAR	No
Out of state	Non-covered	N/A	N/A	N/A
Ventilator Unit Add-On	199	065xx	$80 per diem	No
Alzheimer's and Dementia care in a special care unit (SCU) (state approved facilities only)	193	065xx	$12 per diem	No
Bed hold days	Non-covered	N/A	N/A	N/A
Medicare crossover Part B claims	042x, 043x and 044x	023x	Only payable if Medicaid rate is greater than the Medicare rate (QMB only)	No
Medicare crossover Part A claims	0110, 0119, 0120, 0129, 0130, 0139 and 0022	021x	Only payable if Medicaid rate is greater than the Medicare rate (QMB only)	No

Medicare Crossover

- Medicare crossover claims billed with TOB 022x and 023x are only payable if Medicaid rate is greater than the Medicare rate
  - Nursing facilities should submit claims for Medicare deductible to the Medicaid plan
  - Information entered from the Medicare EOB should always match the claim submitted to the Medicaid plan to avoid denials
- **For aligned dual members** (members who have UHC D-SNP and UnitedHealthcare PathWays):
  - Nursing facility will send one claim to UnitedHealthcare
  - UnitedHealthcare processes it against the Medicare benefits first and then processes the Medicaid benefits to pay any leftover deductibles
- **For dual members, whose Medicare benefits are not UnitedHealthcare D-SNP**:
  - **First --** Nursing facilities will need to submit the claim to Medicare
  - **Second --** Nursing facilities submit the claim with an EOB to UnitedHealthcare PathWays Medicaid

Patient Liability

Member Patient Liability

- Patient liability is the term applied to the monetary amount that IHCP residents must contribute toward their monthly care in the facility. The terms client obligation, member liability and personal resource contribution also indicate patient liability.

- The local county office of the DFR calculates and assigns the patient liability amount. Member information, including patient liability/client obligation reflected in IHCP Provider Healthcare Portal, is updated daily from the information relayed by the Indiana Eligibility Determination and Services System (IEDSS) at the county offices. Providers are not required to send the C-519 form.

- The full amount of patient liability is deducted from the claims starting with the first claim for a month until the claim amount satisfies the patient liability even if on subsequent claims.

Claim Reconsiderations, Appeals and Grievances

Claim Service Model

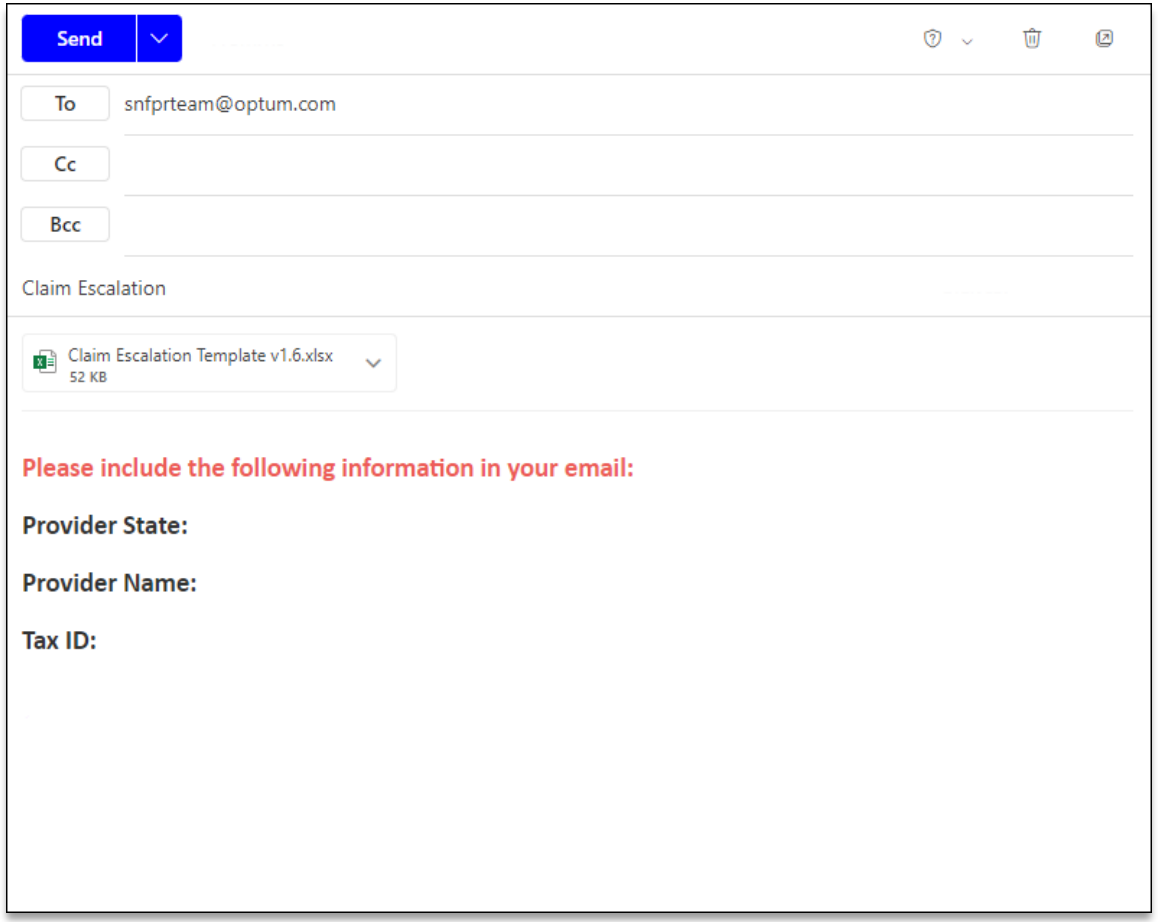
If you disagree with the processing of a claim, follow the 2-step claim service model for contracted skilled nursing facilities by completing the outlined steps in order below.

Step 1 – Request a claim reconsideration online

- Sign in to the UnitedHealthcare Provider Portal at UHCprovider.com > Sign In > Claims & Payments > **Act on Claim**
- Attach relevant documents to reconsideration request

Step 2 – Request a claim escalation

- If you do not agree with our determination, you may email a claim escalation request to snfprteam@optum.com
  - Download the escalation template by clicking the download link at the top of the screen and complete the grey sections.
  - Include your Tax ID, Provider Name, and Provider State in the email.



Appeals

- Appeals are a formal review of a processed claim that was partially paid or denied
- Providers must submit a claim reconsideration before submitting an appeal
- The informal dispute process shall be commenced by a provider submitting a written objection to the MCE, within the following time limits:
  (1) If the provider disagrees with the MCE's determination regarding the provider's claim, the informal process must be commenced within sixty (60) days after the provider's receipt of written notification of the MCE's determination.
  (2) If the MCE fails to make a determination within thirty (30) days of the date the claim was submitted, the informal process must be commenced within ninety (90) days of the date the claim was submitted to the MCE.
- In the event the matter is not resolved to the provider's satisfaction within thirty (30) days after the provider commenced the informal process set out in section 2 of this rule, the provider shall have sixty (60) days after the end of the thirty (30) day period to submit a formal appeal notice to the MCE.
- View the **Reconsiderations and Appeals Interactive guide** to learn more.

Provider Grievance On Behalf of the Member

- Grievances are complaints expressing dissatisfaction with operations, activities, or behavior of a health plan or member
- Grievances can be filed online or by mail:
  - **Online**: **UnitedHealthcare Community Plan Medicaid Appeals & Grievances tool**
  - **Phone**: Call Provider Services at **844-284-0146**
  - **Mail: UnitedHealthcare Community Plan**
    Attn: Appeals and Grievances Unit
    P.O. Box 31364
    Salt, Lake City, UT 8413-0364
- Providers may only file a grievance on a member's behalf with the written consent of the member

Doing Business With Us

UnitedHealthcare Provider Portal

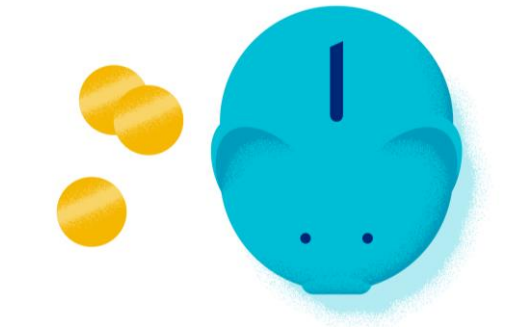
- Provider Portal Chat
- Member Eligibility Information and Member ID Cards
- Inpatient Prior Authorization and Notification
- Claim Submissions
- Claim Status and Reconsideration Requests
- Digital reference number
- Keep Track of UnitedHealthcare Tasks with TrackIt
- Electronic Payments and Statements
- Policies and Procedures

Bookmark UnitedHealthcare Community Plan Homepage

Choose a state from dropdown>View Plans> Select Community Plan

Electronic Payments

- Optum Pay® lets you receive electronic funds transfer (EFT) for claim payments and receive Explanation of Benefits (EOBs) online
- Fully integrated, full-service payment and remittance advice solution designed reduce administrative costs because mail time is eliminated
- Funds are available as soon as they are posted to your bank account
- To receive EFT and electronic EOBs through Optum Pay, visit **Optum.com/enroll**
- Here's what you'll need:
  - Bank account information for direct deposit
  - Either a voided check or a bank letter to verify bank account information
  - A copy of your practice's W-9 form



Fraud, Waste and Abuse

- When you report a situation that could be considered fraud, you're doing your part to help save money for the health care system and prevent personal loss for others
- If you suspect another provider or member has committed fraud, waste or abuse, you have a responsibility and a right to report it
- Taking action and making a report are important first steps
- After your report is made, we will work to detect, correct and prevent fraud, waste and abuse in the health care system
- To report health care fraud, waste, and abuse:
  - **Phone**: Health Care Fraud Tip Line at 844-359-7736 24 hours per day
  - **Online**: visit uhc.com/fraud

Resources

Support Contacts

Description	Contact Information
Provider Services	877-610-9785 24 hours a day
Optum Provider Advocate	**SNF_Medicaid_PER@optum.com**
UnitedHealthcare Provider Portal Support	866-842-3278 Option 1 Monday-Friday 7 AM – 9 PM CST
Optum Pharmacy	800-613-3591 Monday-Friday 8 AM – 5PM PST
Transportation	800-832-4643 Monday-Friday 8 AM – 8 PM ET
Join Our Network	**UHCprovider.com/join**
Website for UHC Community Plan	**UHCprovider.com/incommunityplan**

UnitedHealthcare Online resources

- UHCprovider.com
- Provider Administrative Manual
- Network News
- UHCprovider Training
- Community Plan Reimbursement Policies

Optum Provider Engagement Representative Team

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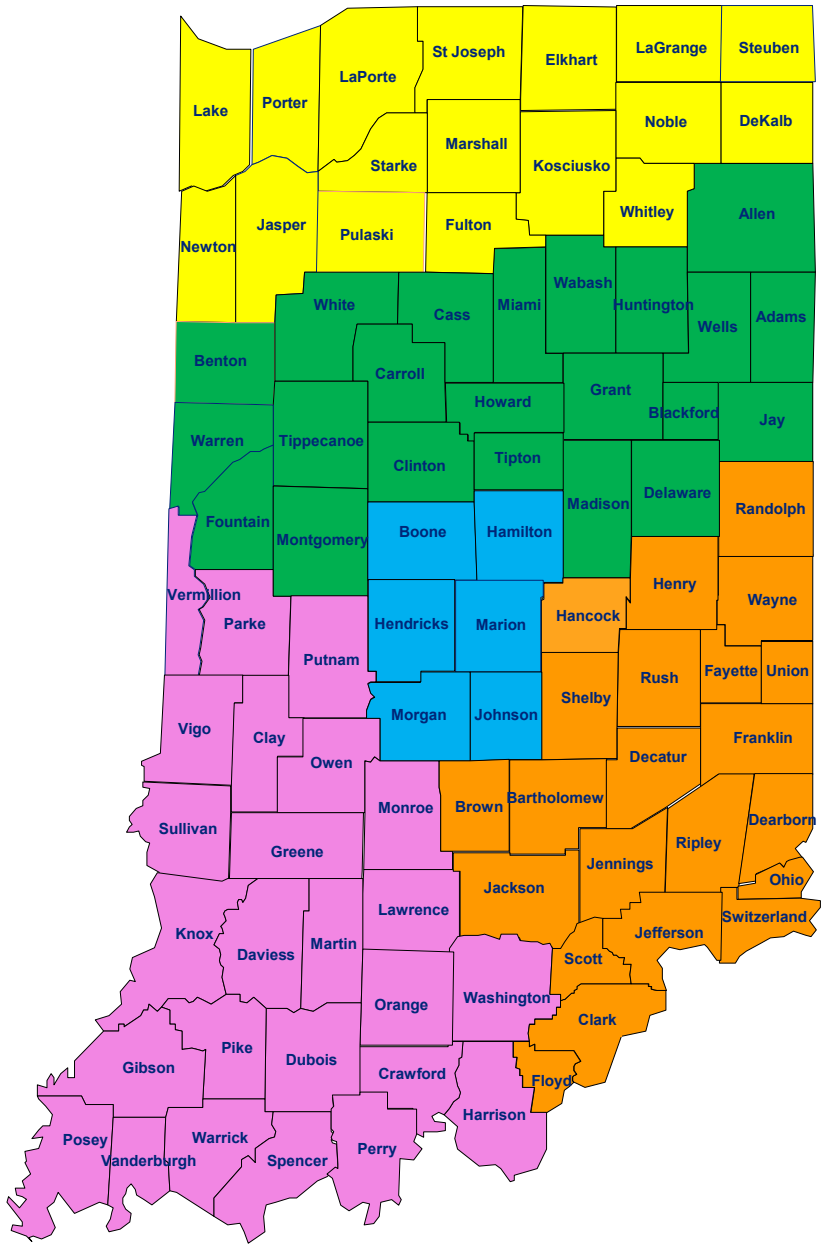

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Thank You.

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