2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary

KanCare Program

Chapter 7: Quality Management

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UnitedHealthcare® Community Plan

Welcome to UnitedHealthcare Community Plan

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic tools on our website at **UHCprovider.com**.

Click the Following Links to Access Different Manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to **UHCprovider.com**. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

You May Easily Search for a Specific Topic or Word in the Manual Using the Following Steps:

- CNTRL+F
- Type in the key word
- Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members. If you have questions about the information or material in this manual, or about our policies, please call **Provider Services**.

Important Information Regarding the Use of This Manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/ or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Participation Agreement

In this manual, we refer to your Participation Agreement as “Agreement”.

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Chapter 7: Quality Management

7.1 Care Provider Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets quarterly at a minimum and has oversight responsibility for issues affecting health services delivery. It is the decision-making body ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QMC is composed of UnitedHealthcare Community Plan management staff and reports its recommendations and actions to the UnitedHealthcare Board of Directors. The QMC has three standing committees:

- **Care Provider Advisory Committee** reviews and recommends action on topics concerning credentialing and recredentialing of care providers and facilities, peer review activities, and performance of all participating care providers. Participating care providers give UnitedHealthcare advice and expert counsel in medical policy, quality management, and quality improvement.
- **Health Care Quality and Utilization Management Committee** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical care.
- **Service Quality Improvement Committee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This committee oversees member and care provider intervention for quality improvement activities as needed.

Cooperation with quality improvement activities

All participating care providers must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax.

7.2 Quality Improvement Program

The Quality Improvement program at UnitedHealthcare Community Plan is a comprehensive program under the leadership of the Chief Executive Officer and the Chief Medical Officer. A copy of our Quality Improvement program is available upon request. The Quality Improvement program consists of the following components:

- Quality improvement measures and studies
- Clinical practice guidelines
- Health promotion activities
- Service measures and monitoring
- Ongoing monitoring of key indicators (e.g., over and under utilization, continuity of care)
- Health Plan performance information analysis and auditing (e.g.,HEDIS®)
- Health Services
- Educating members and physicians
- Risk management
- Compliance with all external regulatory agencies

Your participation is an integral component of UnitedHealthcare's Quality Improvement program.

As a participating physician, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback via your Network Account Manager. We require your cooperation and compliance to:

- Participate in quality assessment and improvement activities.
- Provide feedback on our clinical practice guidelines guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
- Advise us of any concerns or issues related to patient safety.
- Protect the confidentiality of patient information.
- Share information and follow-up on other care providers of care and UnitedHealthcare Community Plan to provide seamless, cohesive care to patients.
- Use the Physician Data Sharing information we provide you to help improve delivery of services to your patients.
- It is required that care providers allow the plan to use performance data.
- The care provider will offer Medicaid members the same number of office hours as they do to commercial members and they will not restrict the number of office hours that they offer Medicaid members.
- UnitedHealthcare Community Plan does not prohibit or discourage you from advocating on behalf of a member for appropriate medical treatment options. We do not prohibit you from discussing healthcare treatments and services, regardless of coverage limitations, and quality assurance programs with a member. We do not prohibit a health professional from discussing financial arrangements between you and UnitedHealthcare Community Plan with a member.

7.3 Care Provider Satisfaction

On an annual basis, UnitedHealthcare conducts ongoing assessments of care provider satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of care provider satisfaction include:

- Annual Provider Satisfaction Surveys and Targeted Improvement Plans
- Regular visits to care providers

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare Community Plan works with Market Strategies International and the Center for Study Services (CSS) to conduct our annual care provider satisfaction survey(s). CSS draws the survey samples of eligible physicians working within UnitedHealthcare Community Plan's networks.

Survey results are reported to our Quality Management Committee. The results are compared by the Health Plan year over year and also in comparison to other UnitedHealthcare plans across the country. The survey results include key strengths and key improvement targets.

7.4 Credentialing Standards

UnitedHealthcare will credential and re-credential you according to the regulations mandated by the accrediting body, the National Committee of Quality Assurance (NCQA) and Kansas state regulatory and contractual credentialing standards. The following key elements are required to begin the credentialing process:

- A completed Credentialing Application including Attestation Statement;
- Current Medical License;
- Current DEA Certificate;
- Current Professional Liability Insurance;
- Medicaid ID number (when applicable).

Information from primary sources regarding licensure, education and training, board certification, and malpractice claims history will be verified as part of the credentialing process.

7.5 Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process is to determine your competence and suitability for initial and continued inclusion in UnitedHealthcare Community Plan's provider network. You are subject to the credentialing and recredentialing process before you can evaluate and treat UnitedHealthcare Community Plan members.

Types of Care Providers Subject to Credentialing and Recredentialing

UnitedHealthcare credentials and recredentials the following types of practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians including Psychiatrists, Advanced Practice Nurses, LCACs, LCPs, LCPCs, LPs, LSCSWs and LCMF Ts

Excluded from the credentialing and recredentialing process are practitioners who:

- Practice exclusively within an inpatient setting
- Hospitalists who are employed solely by the facility; and/or
- Nurse Practitioners and Physician Assistants who practice under the auspices and supervision of a credentialed UnitedHealthcare care provider

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

Credentialing and Recredentialing activities are completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website. First time applicants will need to contact the National Credentialing Center (VETTS line) at 877-842-3210 to obtain a CAQH number in order to complete the application on line. The following supporting documents must be submitted to CAQH upon completion of the application:

- Curriculum Vitae
- Medical license
- DEA certificate
- Malpractice Insurance Coverage
- IRS Form W-9

7.6 Peer Review

Credentialing Process

All applicants are reviewed by the Provider Advisory Committee (PAC).

Recredentialing Process

UnitedHealthcare recredentials practitioners every three years to assure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with UnitedHealthcare Community Plan's guidelines, processes, and care provider performance standards. Practitioners are notified prior to their next credentialing cycle to complete their application on the CAQH website. Failure to respond to UnitedHealthcare Community Plan's request for recredentialing information will result in administrative termination of your privileges as a UnitedHealthcare Community Plan participating care provider. You will be afforded three opportunities to respond to UnitedHealthcare Community Plan's request for recredentialing information before action is taken to terminate participation privileges.

Care Provider Performance Review

As part of the recredentialing process, UnitedHealthcare Community Plan queries its Quality Management database for information regarding your performance. This includes, but is not limited to:

- Member complaints
- Quality of care issues

Applicant Rights and Notification

Practitioners have the right to review the information in support of their credentialing/recredentialing applications and to request the status of their application. This review is at the practitioner's request and is facilitated by the credentialing staff. The credentialing staff notifies practitioners of any information obtained during the credentialing or recredentialing process that varies significantly from the information given to UnitedHealthcare Community Plan by the practitioner. Practitioners have the right to correct erroneous information of the request for clarification by the credentialing staff.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

7.7 Resolving Disputes

Contract concern or complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to: UnitedHealthcare Community Plan, P.O. Box 31364, Salt Lake City, UT 84131. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your applicable Provider Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, please follow the dispute resolution provisions of your applicable Provider Agreement.

If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, please follow the dispute resolution provisions of your applicable Provider Agreement.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the Member Handbook, and this Provider Administrative Guide.

7.8 HIPAA Compliance – Care Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare is a "covered entity" under the regulations as are all health care providers who conduct business electronically.

1. Transactions and Code sets

These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. All care providers who conduct business electronically are required to do so using the standard formats adopted under HIPAA or use a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare.

2. Unique Identifiers

HIPAA also requires the development of unique identifiers for employers, health care providers, Health Plans and individuals for use in standard transactions. (See National Provider Identifier section.)

3. Privacy of Individually Identifiable Health Information

The privacy regulations help ensure a national floor of privacy protections for patients by limiting the ways that Health Plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; also, to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

4. Security

The Security Regulations require covered entities to meet basic security objectives.

1. Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates, receives, maintains and transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Help ensure compliance with the Security Regulations by the covered entity's workforce.

UnitedHealthcare Community Plan expects you to be in compliance with the HIPAA regulations that apply to your practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at **cms.hhs.gov**.

7.9 Member Rights and Responsibilities

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.

Access to Protected Health Information

- UnitedHealthcare Community Plan members have the right to access health information maintained in a designated record set held at your office or at the Health Plan. Members may make a request to see and obtain a copy of certain health information UnitedHealthcare Community Plan maintains electronically, such as medical records and billing records. They may also make a request to obtain copies of their health information maintained electronically. If members health information is maintained electronically, members can request the Health Plan or you send a copy of their electronic health information in an electronic format. They can also request that a copy of their health information be provided to a third party they identify.

Amendment of PHI

- UnitedHealthcare Community Plan members have the right to request information held by you or Health Plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be in writing and provide reasons for the requested amendment. The request must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member. If the request is denied, members may have a statement of disagreement added to members health information.

Accounting of Disclosures

- UnitedHealthcare Community Plan members have the right to request an accounting of certain Disclosures of his or her PHI made by you or the Health Plan during six years prior to the request. This accounting must include disclosures by business associates. The accounting will not include disclosures of information made: (i) for treatment, payment and health care operations purposes; (ii) to members or pursuant to members authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require UnitedHeathcare Community Plan to provide an accounting.

Right to Request Restrictions

- Members have the right to request restrictions to you or Health Plan's uses and disclosures of the individual's PHI for treatment payment and healthcare operations. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented. You and Health Plan must agree to individual's request to restrict disclosure. Members have the right to request restriction on uses or disclosures of their information for treatment, payment, or health care operations. In addition, members may request to restrict disclosures to family members or to others who are involved in their healthcare or payment for their healthcare.

Right to Request Confidential Communications

- Members have the right to request communications from you or the Health Plan be received at an alternative location or by alternative means. You will accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A Health Plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

1. A responsibility to supply information (to the extent possible) that the organization and you need in order to provide care
2. A responsibility to follow plans and instructions for care that they have agreed to with you
3. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Member rights can be found at UHCCommunityPlan.com, and are listed below for your reference.

Member Rights

UnitedHealthcare Community Plan will follow any federal and state laws regarding member rights. We will make sure we and you respect those rights. UnitedHealthcare Community Plan members have a right to:

- Be cared for with respect and dignity, no matter what their health status, sex, race, color, religion, national origin, age,marital status or sexual orientation.
- Be told where, when and how to get the services they need from UnitedHealthcare Community Plan.
- Be told by their primary care provider what is wrong, what can be done for them, and what is likely to happen, in a language they understand.
- Participate in decisions involving their health care and make decision to accept or refuse medical treatment.
- Learn about all treatment choices, in a way appropriate to their condition and ability to understand.
- Get a second opinion about their care by a care provider in or out of the UnitedHealthcare Community Plan network, at no cost.
- Give their OK to any treatment or plan for your care after that plan has been fully explained to them.
- Refuse care and be told what they may risk if they do.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Choose a primary care provider from the UnitedHealthcare Community Plan network, including the right to refuse care from specific providers.
- Get a copy of their medical record, and talk about it with their primary care provider.
- Ask, if needed, that their medical record be corrected.
- Be sure their medical record is private and that it will not be shared with anyone except as required by law, contract, or with their approval.
- Use the UnitedHealthcare Community Plan grievance system to settle any grievances. Or, submit any grievances to the state of Kansas if they feel they were not fairly treated.
- Exercise their rights, as long as it does not cause a problem with the way UnitedHealthcare Community Plan and you or the state agency treats them.
- Use the Administrative Hearing System.
- Allow someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
- Receive kind and respectful care in a clean and safe place free of unnecessary restraints.
- Ask for and get information about physician incentives.
- Ask for and get information about UnitedHealthcare Community Plan, its services, you and members' rights and responsibilities.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To write advance directives.
- Have services provided in a culturally competent manner, with consideration for limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate.

- Have the right to see an out-of-network care provider, if no participating network care provider is available, at no additional cost beyond what they would pay if services were furnished within the network.

7.10 National Provider Identifier

NPI is the standard unique identifier (a 10 character number with no imbedded intelligence) for health care providers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which covered entities must accept and use in standard transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared by you with all impacted trading partners such as care providers to whom you refer patients, billing companies, and Health Plans.

The NPPES assists you with application, processes the application and returns the NPI to you.

There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care provider and a Type 2 entity is an organizational provider, such as a hospital system, clinic, or DME providers with multiple locations. Type 2 care providers may enumerate based on location, taxonomy or department.

Only care providers who are direct providers of health care services are eligible to apply for an NPI. This creates a subset of care providers who provide non-medical services who will not have an NPI.

Taxonomy

Taxonomy codes are 10-character federally established alpha numeric codes which health care professionals use to identify their unique specialty areas. They are a combination of Provider Type and Provider Specialty self-declared by health care providers during the National Provider Identifier (NPI) enumeration process. The Health Care Provider Taxonomy code set is developed by the Centers for Medicare & Medicaid Services (CMS) and is published twice a year in July and January.

NPI Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who conduct business electronically. **Additionally, most state agencies are requiring the use of the NPI on paper claims – UnitedHealthcare Community Plan will require NPI on paper claims also in anticipation of encounter submissions to the state agency.**

NPI will be the only health care provider identifier used for identification purposes in standard transactions for covered health care providers.

How to get an NPI

You may apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online at **https://nppes.cms.hhs.gov/NPPES**.

- You may agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- You may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND. NPI Enumerator staff will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. You may obtain a copy of this form by contacting the NPI Enumerator in any of these ways:
  - Phone: 800-465-3203 or
    TTY: 800-692-2326
  - Mail: NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059
  - Email: customerservice@npienumerator.com

How to share your NPI with us

Once you have NPI, it is imperative you communicate it to UnitedHealthcare Community Plan immediately by visiting UHCprovider.com. There you will find downloadable forms to fill in the appropriate information.

Fax NPI information to 855-773-3156, Attn: Provider Demographics. To assist us in expediting this process, please also include your provider name, address, and TIN.

7.11 Fraud and Abuse

Fraud and abuse by you, members, Health Plans, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to him/her self or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: Care provider practices inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the KanCare program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the KanCare Program.

Examples of fraud and abuse include:

Misrepresenting Services Provided

- Billing for services or supplies not rendered

- Misrepresentation of services/supplies
- Billing for higher level of service than performed

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Administrative or Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent third party liability reporting

Member Fraud or Abuse Issues

- Fraudulent/Altered prescriptions
- Card loaning/selling
- Eligibility fraud
- Failure to report third party liability/other insurance

Reporting Fraud and Abuse

If you suspect another care provider or a member has committed fraud or abuse, you have a responsibility and a right to report it.

Reports of suspected fraud or abuse can be made by calling:

- Call UnitedHealthcare Community Plan at 866-242-7727 or
- Contacting the State of Kansas Attorney General's Medicaid Fraud Control Unit at 866-551-6328 or 785-368-6220

For care provider-related matters (e.g. doctor, dentist, hospital, etc.), please furnish the following:

- Name, address and phone number of care provider
- Care provider number
- Type of care provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of others who can aid in the investigation
- Dates of events
- Specific details about the suspected fraud or abuse

For member-related matters (beneficiary/recipient), please furnish the following:

- The person's name, date of birth, Social Security number, ID number
- The person's address
- Specific details about the suspected fraud or abuse

7.12 Ethics & Integrity

Introduction

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with members, care providers, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators and others has never been greater. It's not only the right thing to do, it is necessary for our continued success and that of our business associates.

Compliance Program

As a business segment of UnitedHealth Group, UnitedHealthcare is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Compliance program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealthcare Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program;
- Development and implementation of ethical standards and business conduct policies;
- Creating awareness of the standards and policies by education of employees;
- Assessing compliance by monitoring and auditing;
- Responding to allegations or information regarding violations;
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for employees, managers and others to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare has Compliance Officers located in each Health Plan. In addition, each Health Plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the Health Plan.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare employee which comes to your attention should be reported to a UnitedHealthcare senior manager in the Health Plan or directly to the Compliance Officer.

UnitedHealthcare's Special Investigations Unit (SIU) is an important component of the Compliance program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities. To facilitate the reporting process of any questionable incidents involving plan members or care providers, call 866-242-7727. Please refer to the Fraud and Abuse section of this Manual for additional details about the UnitedHealthcare Fraud and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare operations and implementing reviews and audits to help ensure compliance with law, regulations, and policies/contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our care providers, UnitedHealthcare will conduct an appropriate investigation. You are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by your applicable Provider Agreement and this Manual) and access to your office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If you become the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to your operations (other than a routine request for documentation from a regulatory agency), you must advise the UnitedHealthcare plan of the details of this and of the factual situation which gave rise to the inquiry.

Extrapolation Audits of Corporate-wide Care Provider Billing

UnitedHealthcare Community Plan will work with the State of Kansas to perform "individual and corporate extrapolation audits" and this may affect all programs supported by dual funds (state and federal funding), as well as state-funded programs, as requested by the Kansas Department of Health and Environment and/or the Kansas Department of Aging and Disability Services.

Record Retention, Reviews and Audits

You must agree to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Records must be maintained for a period of not less than six years from the close of the KanCare program agreement between the state and UnitedHealthcare, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. United Healthcare and its affiliated entities (including OptumHealth) will request and obtain prior approval from each care provider for the disposition of records under review or inspection.

To help ensure that members receive quality services, you must agree to cooperate and comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet KanCare program standards.

You must cooperate with the state or any of its duly authorized representatives, the Kansas Department of Health and Environment, the Kansas Department of Aging and Disability Services, the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency prior-approved by the state, at any time during the term of your applicable Provider Agreement.

These entities shall, at all reasonable times, have the right to enter onto your premises. You agree to allow access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, and records and/or to otherwise evaluate (including periodic information systems testing) your performance and charges.

All reviews and audits shall be performed in such a manner that will not unduly delay your work. If you refuse to allow access to all documents, papers, letters, or other materials, this will constitute a breach of your applicable Provider Agreement.

You must keep records for a for period of not less than six years from the date of termination of the contract, unless the state authorizes in writing their earlier disposition. You agree to refund to the state any overpayment disclosed by any such audit.

However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 6-year period, you agree to retain the records until completion of the action and resolution of all issues which arise from it and for one year thereafter. The state shall also retain the right to perform financial, performance, and other special audits on such records maintained by you during regular business hours throughout the term of your applicable Provider Agreement.

Delegating and Subcontracting

If you delegate or subcontract any function, the subcontract or delegation must include all requirements of your applicable Provider Agreement and this Guide.