2019
Care Provider Manual

Care Provider, Health Care Professional, Facility and Ancillary

Massachusetts Senior Care Options 2019

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UnitedHealthcare®
Community Plan

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Chapter 1: Introduction

Welcome

Welcome to the Senior Care Options Community Plan care 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 prior authorization. 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.

Easily find information in this manual using the following steps:

1. CTRL+F.
2. Type in the key word.
3. 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 about 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”.

Background

UnitedHealthcare Senior Care Options (SCO) is a fully integrated Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare SCO service area. Members of UnitedHealthcare SCO must be 65 years of age or older, eligible for MassHealth Standard, and if eligible enrolled in Medicare Part A/Medicare Part B. Certain individuals who are Medicaid-eligible but not eligible for Medicare may also be enrolled in this Medicare Advantage Plan, receiving the same benefits and services as dually-eligible individuals. UnitedHealthcare SCO is currently available in the following counties: Bristol, Essex, Hampden*, Middlesex, Norfolk, Plymouth*, Suffolk and Worcester* counties.
(* indicates partial county).

Contacting UnitedHealthcare SCO

UnitedHealthcare SCO manages a comprehensive provider network of independent care providers and facilities. The network includes health care professionals such as primary care providers, specialist care providers, medical facilities, allied health professionals and ancillary service providers.

UnitedHealthcare SCO offers several options to support care providers who require assistance.

Provider Service Center

This is the primary point of contact for care providers who require assistance. The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare SCO. The Provider Service Center can assist you with questions on benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc.

They may be reached at 888-867-5511 from 8 a.m. – 8 p.m. (Eastern time) Monday through Friday to meet your needs. If you are hearing impaired, you may call the Provider Service Center at 888-685-8480 (TDD). The Provider Service Center works closely with all UnitedHealthcare SCO departments.

Provider Services: **888-867-5511**
Admission Notification: **866-604-3267**
Admission Notification Fax: **888-840-6450**

UnitedHealthcare Community Plan of Massachusetts Website

UHCprovider.com/MACommunityPlan offers the convenience of online support 24 hours a day, seven days a week. This site was developed specifically with you in mind, allowing for personal support. You may verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, and submit prior authorization requests at **UHCprovider.com**.

The UnitedHealthcare SCO Network

UnitedHealthcare SCO maintains and monitors a network of participating care providers, including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers to obtain covered services.

Members using UnitedHealthcare SCO must choose a primary care provider (PCP) to coordinate their care. PCPs are the basis for the managed care philosophy. UnitedHealthcare SCO works with contracted PCPs who manage the health care needs of members and arrange for medically necessary covered medical services. To help ensure coordination of care, members are encouraged to coordinate with their PCP before seeking care from a specialist.

Contracted health care professionals are required to coordinate member care within the UnitedHealthcare SCO care provider network. Where possible, members should be directed to UnitedHealthcare SCO contracted care providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare SCO.

The out-of-network referral and prior authorization procedures explained in this manual are particularly important to the UnitedHealthcare SCO program. Understanding and adhering to these procedures are essential for successful participation as a UnitedHealthcare SCO care provider.

Occasionally, UnitedHealthcare SCO distributes communication documents on administrative issues and general information of interest regarding UnitedHealthcare SCO to you and your office staff. It is very important you and/or your office staff read the newsletters and other special communications and you retain them with this manual, so you may incorporate the changes into your practice. All policy and procedure information, including changes to existing policies and procedures, found in our newsletters and other communications are incorporated into this manual.

Participating Care Providers

Primary Care Providers

With the exception of member self-referral covered services, the PCP is responsible for providing or authorizing covered services for members of UnitedHealthcare SCO. PCPs are generally physicians of internal medicine, family practice or geriatricians. These care providers must have a minimum of two years geriatric experience. Members must select a PCP when they enroll in UnitedHealthcare SCO and may change their designated PCP at any time.

Specialists

A specialist is any licensed participating care provider (as defined by Medicare and/or MassHealth) who provides specialty medical services to members. A PCP may refer a member to a specialist as medically necessary.

How to Contact Us

RESOURCES	USES	CONTACT INFORMATION
UnitedHealthcare Community Plan Website	Verify member eligibility, check claim status, submit claims, request adjustment, review remits, and submit requests for prior authorizations.	UHCprovider.com/MACommunityPlan
Provider Service Center	Provider Service Center	8 a.m. – 8 p.m. Eastern time, Monday – Friday 888-867-5511
Member Services	Verify network primary care providers and pharmacies and receive information about drug formulary matters.	888-867-5511, TDD 711
Admission Notification	Notify us of a hospital admission.	Admission notification: 866-604-3267 Admission fax number: 888-840-6450
Prior Authorization – Medical	Notify us of medical services including elective admissions, e.g. knee/hip replacement, that need prior authorization.	Prior authorization: 877-651-6677 Prior authorization fax number: 888-840-6450
Prior Authorization – Pharmacy	Notify us of pharmacy services that need prior authorization.	800-711-4555 OptumRx.com
Prior Authorization – Behavioral Health	Notify us of behavioral health services that need prior authorization.	888-556-4059
Dental Benefits Provider (DBP)	Provider Services (including prior authorization)	855-812-9210 dbp.com

Chapter 2: Prior Authorization

Covered Benefits

The evidence of coverage included below lists services covered by UnitedHealthcare SCO.

Coverage includes Medicare Part A and Part B, MassHealth, and some additional benefits that are offered as part of the UnitedHealthcare SCO plan. Some services may require prior authorization by UnitedHealthcare SCO. For the list of covered services please refer to the current year's evidence of coverage found on **UHCCommunityPlan.com/MA** > Senior Care Options > **Evidence of Coverage**.

Prior Authorization

The presence or absence of a procedure or service on the list does not define whether or not coverage or benefits exist for that procedure or service, or whether such service may be considered medically necessary for a specific individual. A facility or care provider must contact UnitedHealthcare SCO for prior authorization and some services requiring prior authorization may also require a medical necessity review. For the appropriate contact information, please refer to the list of contacts in Chapter 1. Our prior authorization form is located at **UHCprovider.com/MACommunityPlan** > **Prior Authorization and Notification Resources**.

Link: Use the Prior Authorization and Notification app on Link. Go to **UHCprovider.com** and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification app tile on your Link dashboard.

Emergency and Urgent Care

Definitions

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a care provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Members with an emergency medical condition should be instructed to go to the nearest emergency care provider.

Members who need urgent (but not emergency) care are advised to call their primary care provider, if possible, prior to obtaining urgently-needed services. However, prior authorization is not required.

Urgently-needed services are covered services that are not emergency services when:

- The member is temporarily absent from the UnitedHealthcare SCO service area; and/or
- When such services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition; and/or
- It is not reasonable given the circumstances of required immediate care to obtain the services through a UnitedHealthcare SCO network care provider.

In certain instances, services may be considered urgently-needed services when the member is in the service area, but the UnitedHealthcare SCO care provider network is temporarily unavailable or inaccessible such as after-hours or emergent care.

Direct Access Services

Females have direct access (without a referral or authorization) to OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services are ordered by a PCP.

Members may access behavioral health services without a referral from their primary care provider as long as the member

obtains these services from a participating care provider. Those services are discussed later in this section. Members requiring behavioral health services may call United Behavioral Health at 888-556-4059. Telephone access is available anytime. Behavioral health inpatient services and detoxification programs are available after coordination for emergency admissions or a mental health care provider's evaluation has taken place.

Hospital Services

Acute Inpatient Admissions

All elective inpatient admissions require prior authorization from the UnitedHealthcare SCO prior authorization service center. UnitedHealthcare SCO nurses and staff, in coordination with admitting care providers and hospital-based care providers (hospitalists), are in charge of coordinating and conducting continued stay reviews, providing appropriate authorizations for extended care facilities and coordinating services required for adequate discharge.

UnitedHealthcare SCO case managers assist in coordinating services identified as necessary in the discharge planning process and coordinating the required follow-up by the corresponding primary care providers.

Chapter 3: Care Provider Responsibilities

Non-Covered Services

Some medical care and services are not covered or are limited by UnitedHealthcare SCO regardless of whether such care and services might otherwise be medically necessary. The following list talks about these exclusions and limitations. The list describes services not covered under any circumstances, and some services covered only under specific circumstances.

This list may not be comprehensive, so it is best to contact us directly to help ensure a specific service is covered, and if so, whether notification or prior authorization is necessary. You and members may always review the evidence of coverage (EOC).

Information in this section relates to the MassHealth benefit chart. Find the MassHealth benefit chart in the member's EOC for UnitedHealthcare SCO at **UHCCommunityPlan.com/MA**.

If members receive non-covered services, they must pay for the services themselves.

UnitedHealthcare SCO does not pay for the exclusions listed in this section and neither does Original Medicare or MassHealth, unless they are found upon appeal to be services we should have otherwise paid or covered. Please see the EOC for the current year's list of services not covered by UnitedHealthcare SCO.

Services Not Covered by UnitedHealthcare SCO

The following items and services are not covered under Medicare or MassHealth, or by our plan:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are otherwise listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan (see Chapter 3, Section 5 in the member EOC for more information on clinical research studies). Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private hospital room, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a member's room at a hospital or a skilled nursing facility, such as a telephone or a television, that would not otherwise be present without a charge by the care provider for such item(s).
- Fees charged by a member's immediate relative or members of their household, except as may be described in the MassHealth benefit chart.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when otherwise covered and medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, including the unaffected breast to produce a symmetrical appearance.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, except as described in the MassHealth benefit chart.

Covered Benefits

For a complete listing please review benefit chart in the member EOC or visit **UHCCommunityPlan.com/MA**. The following are covered benefits by UnitedHealthcare SCO:

- Routine foot care, except for the limited coverage provided according to Medicare guidelines, except as described in the MassHealth benefit chart.
- Hearing aids or exams to fit hearing aids, except as described in the MassHealth benefit chart.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids,

except as described in the MassHealth benefit chart. Eyeglasses are covered after cataract surgery.

- Acupuncture.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease, except as described in the MassHealth benefit chart.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease, except as described in the MassHealth benefit chart.

General Care Provider Responsibilities

UnitedHealthcare SCO contracted care providers are responsible for:

A. Verifying member enrollment through **UHCprovider.com/eligibility**, or contacting the Provider Service Center prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.

B. Rendering covered services to UnitedHealthcare SCO members in an appropriate, timely, and cost-effective manner and in accordance with their specific contract, the Centers for Medicare and Medicaid Services (CMS) and state of Massachusetts requirements.

C. Maintaining all licenses, certifications, permits, or other prerequisites required by law, regulation and policy to provide covered services, and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare SCO.

D. Rendering services to members who are diagnosed as being infected with the human immunodeficiency virus (HIV) or having acquired immune deficiency syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract.

E. Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility.

F. Making a concerted effort to educate and instruct members about the proper use of the care provider's office in lieu of hospital emergency rooms. Do not refer or direct members to hospital emergency rooms for non-emergent medical services at any time.

G. Abiding by the UnitedHealthcare SCO referral and prior authorization guidelines.

H. Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to another facility has been obtained from UnitedHealthcare SCO; or, (2) the member's condition is emergent and use of a contracted hospital is not feasible for medical reasons. You agree to provide covered services to members while in a hospital as determined medically necessary by the care provider or a medical director.

I. Using contracted hospitals, specialists, and ancillary providers. A member may be referred to a non-contracted care provider only if the medical services required are not available through a contracted care provider and if prior authorization is obtained.

J. Obtaining prior authorization from UnitedHealthcare SCO for all hospital admissions.

K. Providing culturally competent care and services.

L. Compliance with Health Insurance Portability and Accountability Act (HIPAA) provisions.

M. Adhering to member advance directives (Patient Self Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member's choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. You are required to maintain policies and procedures regarding advance directives and document in individual medical records whether or not a member executed an advanced directive. Information about advance directives is included in the UnitedHealthcare SCO Member Handbook.

N. Establishing standards for timeliness and in-office waiting times that consider the immediacy of member needs and common waiting times for comparable services in the community.

O. You must confirm your provider data every quarter. You may do this through LINK or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access Link's My Practice Profile App to make many of the updates required in this section.

Member Eligibility and Enrollment

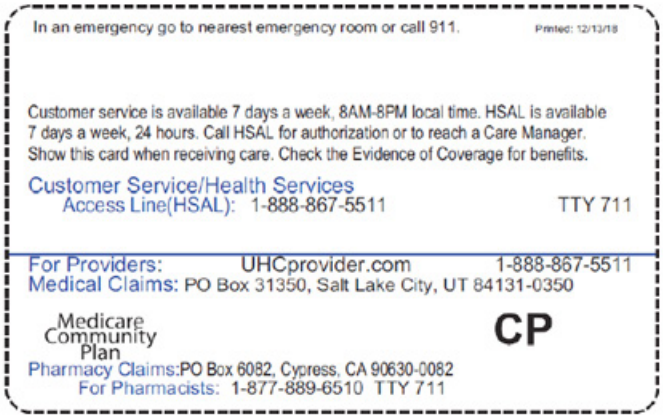
Medicare and Medicaid beneficiaries who elect to become members of UnitedHealthcare SCO must meet the following qualifications:

1. Members must be entitled to Medicare Part A and be enrolled in Medicare Part B.
2. Members must be entitled and enrolled in Medicaid Title XIX benefits, specifically MassHealth Standard.
3. Members must reside in the UnitedHealthcare SCO service areas: Worcester County (partial), Suffolk County, Norfolk County, Middlesex County, Plymouth County (partial), Bristol County, Hampden County (partial) Essex County. A member must maintain a permanent residence within the service area, and must not reside outside the service area for more than six months.
4. Members who do not have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) at the time of application.

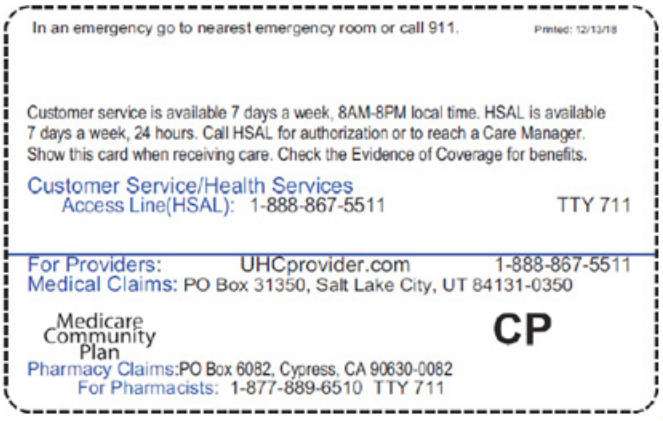
Each UnitedHealthcare SCO member receives a UnitedHealthcare SCO identification (ID) card containing the member's name, member number, primary care provider name, and information about their benefits. The UnitedHealthcare Community Plan SCO ID membership card does not guarantee eligibility. It is for identification purposes only.

Some members may be eligible for UnitedHealthcare SCO if they are not eligible for Medicare Parts A or B. Please check the UnitedHealthcare SCO website to ensure that an individual is in fact our member.

SCO Member ID card – Medicaid only members



SCO Member ID card – Dual members



Chapter 4: Claims Process/Coordination of Benefits/Claims

Primary Care Provider Member Assignment

UnitedHealthcare SCO is responsible for managing the member's care on the date the member is enrolled with the plan and until the member is disenrolled from UnitedHealthcare SCO.

Each enrolled UnitedHealthcare SCO member must choose a primary care provider (PCP) within the UnitedHealthcare SCO Provider Directory. Members receive a letter notifying them of the name of their PCP, office location, telephone number, and the opportunity to select a different PCP. If the member doesn't choose a PCP, we will assign them to one. They may request a change at any time should they prefer someone other than the PCP assigned. If the member elects to change the initial PCP assignment, the effective date is the day the member requested the change. If a member asks UnitedHealthcare SCO to change their PCP at any other time, the change is made effective on the request date.

Verifying Member Enrollment

As a PCP, you should verify member eligibility either by going to **UHCprovider.com/eligibility** or by calling Provider Services at 888-867-5511. At each office visit, your office staff should:

- Ask for the member's ID cards and have a copy of both sides in the member's office file.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- Refer to the member's ID card for the appropriate telephone number to verify eligibility in UnitedHealthcare SCO options, deductibles, coinsurance amounts, copayments, and other benefit information.

You should verify member eligibility prior to providing services.

Coordinating 24-Hour Coverage

PCPs are expected to provide coverage for UnitedHealthcare SCO members 24 hours a day, seven days a week. When they are unavailable to provide services, they must arrange coverage from another participating care provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating care providers. Participating care providers may consult their UnitedHealthcare Senior SCO Provider Directory, or contact UnitedHealthcare SCO Member Services with questions regarding which care providers participate in the UnitedHealthcare SCO network.

Claims Submission Requirements

UnitedHealthcare SCO requires you initially submit your claim within your contracted deadline. Please consult your contract to determine your initial filing requirement.

The timely filing limit is set at 90 days after the date of service.

UnitedHealthcare SCO contracted care providers, serving members enrolled with UnitedHealthcare SCO, are able to take advantage of single claim submission. Claims submitted to UnitedHealthcare SCO for members process first against Medicare benefits under UnitedHealthcare SCO, where applicable, and then automatically processes against Medicaid benefits. You do not need to submit separate claims for the same member.

A clean claim is defined as:

- Has all information necessary to adjudicate the claim, and
- All supporting documentation (if applicable), and
- Is processed without obtaining additional information from the servicing care provider or from a third party.

Additional information, which may be necessary to deem a claim complete, could include medical records. Medical records may include, but are not limited to: admitting, operative, anesthesia and/or care provider's notes. These records may be required in certain circumstances, or to determine whether a claim includes the appropriate diagnosis and procedure codes for accurate payment pursuant to contractual and/or state guidelines. If you are under investigation for fraud, waste or abuse, or if a claim is selected for medical review by UnitedHealthcare SCO, this claim may not be treated as a clean claim.

Please mail your paper claims to:

UnitedHealthcare Community Plan
P.O. Box 31350
Salt Lake City, UT 84131-0350

For electronic claims submissions, go to **UHCprovider.com/claims** and sign up for electronic claims submission. If you have questions about gaining access to the UnitedHealthcare SCO website, choose the care provider website tab and follow the instructions to gain access.

Submission of CMS-1500 form Drug Codes

UnitedHealthcare SCO is now required to submit claims encounters to the state that contain national drug code (NDC) information related to drugs for outpatient services. To fulfill that requirement, claim submissions will be denied if this NDC outpatient services drug information is not included in the claim submission. Attach the current National Drug Code (NDC) 11-digit number for claims submitted with drug codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LINo3 segment of the HIPAA 837 electronic form.

Care Providers

Participating care providers should submit claims to UnitedHealthcare SCO as soon as possible after service is rendered, using the standard CMS claim form or electronically.

To expedite claims payment, identify the following items on your claims:

- Member's name, date of birth, address and UnitedHealthcare SCO ID number
- Name, signature, address and phone number of care provider or servicing care provider, as in your contract document
- National Provider Identifier (NPI) number
- Care provider tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-9 diagnostic codes
- Revenue codes (UB-04 only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Referring care provider's name (if applicable)
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach an anesthesia report for claims submitted with a QS modifier
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable)

UnitedHealthcare SCO will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare SCO should comply with the HIPAA requirements.

Hospitals

Hospitals should submit claims to the UnitedHealthcare SCO claims address as soon as possible after service is rendered, using the standard UB-04 form.

To expedite claims payment, identify the following items on your claims:

- Member name;
- Member's date of birth and sex;
- Member's UnitedHealthcare SCO ID number; indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details;
- Appropriate diagnosis, procedure and service codes;
- Service dates (including admission and discharge date);
- Charge for each service;
- Care provider's ID number and locator code, if applicable;
- Care provider's tax ID number;
- Name/address of participating care provider.

UnitedHealthcare SCO will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare SCO should comply with HIPAA requirements.

Balance Billing

The balance billing amount is the difference between Medicare and MassHealth's allowed charge and your actual charge to the member. You are prohibited from billing, charging or otherwise seeking payment from members for covered services.

You may not bill UnitedHealthcare SCO members for covered services. If a member requests a service not covered by UnitedHealthcare SCO, you should educate the member about how the service is not covered and they are financially responsible for all applicable charges.
You **may not** bill a member for a non-covered service unless:

1. You have informed the member in advance that the service is not covered, and the exact amount they will owe.
2. The member has agreed in writing to pay for the services if they are not covered.

Coordination of Benefits

If a member has coverage with another plan that is primary to Medicare and MassHealth, please submit a claim for payment to that plan first. The amount payable by UnitedHealthcare SCO will be governed by:

- The amount paid by the primary plan, and
- Medicare secondary payer law and policies.

Care Provider Claim Dispute and Appeal

Initial claims must be received within 90 days unless your agreement with us specifies differently. You may dispute a claims payment decision by requesting a claim review. Care providers must submit an adjustment request within 365 calendar days from the last timely processed claim, or within 365 calendar days of the most recent PRA or EOB (whichever is later).

Care Provider Claims Dispute

Stated as "Administrative Appeals by Practitioner" on care provider remittance.

If you are not able to resolve a claim denial through the Provider Service Center, you may challenge the claim denial or adjudication by filing a formal claim dispute.

UnitedHealthcare SCO policy requires the dispute, with required documentation, must be received within 90 days of the claim's denial date. Failure to meet this requirement is deemed a waiver of all rights to further administrative review.

A claim dispute must be in writing and state with particularity the factual and legal basis and relief requested, along with supporting documents (e.g., claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity means a chronology of pertinent events and a statement why you believe the action by UnitedHealthcare SCO was incorrect.

Chapter 5: Care Management and Quality of Care Oversight

UnitedHealthcare SCO seeks to improve the quality of care provided to its members. UnitedHealthcare SCO encourages your participation in health promotion and disease-prevention programs. You are encouraged to work with UnitedHealthcare SCO in its efforts to promote healthy lifestyles through member education and information sharing. UnitedHealthcare SCO seeks to accomplish the following objectives through its Quality Improvement and Medical Management programs.

Medical Policies and Coverage Determination Guidelines

As a participating care provider, you must comply and cooperate with all UnitedHealthcare SCO medical management policies and procedures and in UnitedHealthcare SCO quality assurance and performance improvement programs.

Medical policies and coverage determination guidelines may be found at **UHCprovider.com/MACommunityPlan** > Current Policies and Clinical Guidelines.

Prior Authorization

You are required to coordinate member care within the UnitedHealthcare SCO care provider network. UnitedHealthcare SCO members should be directed to UnitedHealthcare SCO contracted care providers. Out-of-network care may be permitted, but only with prior authorization approval from UnitedHealthcare SCO.

The prior authorization procedures are particularly important to the UnitedHealthcare SCO managed care program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare SCO care provider. Prior authorization is one of the tools used by UnitedHealthcare SCO to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other care providers are required to comply with UnitedHealthcare SCO prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the primary care provider coordinates most services provided to a member, it is typically the primary care provider who initiates requests for prior authorization. However, specialists and ancillary providers may also request prior authorization for services within specialty areas.

Unless another department or unit has been specifically designated to authorize a service and you have been notified of such designation, requests for prior authorization are routed through the prior authorization department, where nurses and medical directors are available by phone. Requests are made by phone to the UnitedHealthcare SCO call center at 888-867-5511 or online at **UHCprovider.com/priorauth**.

Specialist Guidelines

PCPs may refer UnitedHealthcare SCO members to contracted network specialists. If a member wants to receive care from a different specialist, their PCP should try to coordinate specialty referrals within the list of contracted network specialists. UnitedHealthcare SCO should be contacted for assistance in locating contracted care providers within a specialty field.

If a PCP needs to refer a member to a specialist outside of the contracted network, prior authorization is required.

UnitedHealthcare SCO members are encouraged to coordinate primary and specialty care services through their designated PCP. Members have the ability to self-refer to a contracted network specialist without a written referral from a designated PCP.

The PCP should provide the specialist with the following clinical information:

- Member name;
- Referring primary care provider;
- Consultation reason;
- History of the present illness;
- Diagnostic procedures and results;
- Pertinent past medical history;
- Current medications and treatments;
- Problem list and diagnosis; and
- Specific request for the specialist.

Services Requiring Prior Authorization

The presence or absence of a procedure or service on the following list does not define whether or not coverage or benefits exist for that procedure or service. For a list of services and steps to obtain prior authorization, please refer to Chapter 2 of this manual.

Denial of Prior Authorization Requests

Authorization denials occur only after a UnitedHealthcare SCO medical director has reviewed the request. A UnitedHealthcare medical director is always available to speak to you and review a request.

Prior authorization requests are frequently denied because they lack supporting medical documentation. You are encouraged to call or submit additional information for review.

Hospital Admission Notification

For coordination of care, PCPs or the admitting hospital facilities should notify UnitedHealthcare SCO if they are admitting a UnitedHealthcare SCO member to a hospital or other inpatient facility, as follows:

- Weekday admissions: you must notify us within 24 hours, unless otherwise indicated.
- Weekend and holiday admissions: you must notify us by 5 p.m. local time on the next business day.

To notify UnitedHealthcare SCO of an admission, the admitting hospital should call UnitedHealthcare SCO at 888-867-5511 and provide the following information:

- Notifying primary care provider or hospital;
- Name of admitting primary care provider;
- Member's name, sex, and UnitedHealthcare Dual Complete ID number;
- Admitting facility;
- Primary diagnosis;
- Admission reason; and
- Admission date.

Concurrent Hospital Review

UnitedHealthcare SCO will review all member hospitalizations within 48 hours of receiving care provider inpatient emergent admission notification. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews will validate the medical necessity for continued stay.

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to electronic medical records (EMR).

Your cooperation is required with all UnitedHealthcare requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. Eastern time. You must make best efforts to provide requested information within the same business day if the request is received after 1 p.m. Eastern time (but no later than 12 p.m. Eastern time the next business day).

Discharge Planning

UnitedHealthcare SCO will assist participating care providers and hospitals in the inpatient discharge planning process implemented in accordance with requirements under the UnitedHealthcare SCO program. At the time of admission and during the hospitalization, the UnitedHealthcare SCO medical management staff may discuss discharge planning with the participating care provider, member, and family.

Medical Criteria

Qualified professionals who are members of the UnitedHealthcare SCO quality improvement committees and the board of directors will approve the medical criteria used to review medical practices and determine medical necessity.

UnitedHealthcare SCO currently uses nationally-recognized criteria, such as: Medicare, Medicaid, diagnostic-related group's criteria and MCG, (formerly Milliman USA Health Care Management Guidelines™), and evidence-based medicine to guide the prior authorization, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria. For more information or to receive a copy of these guidelines, please call the Provider Service Center at 888-867-5511.

UnitedHealthcare SCO may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the use of specific drugs. We will communicate these guidelines to you through the UnitedHealthcare SCO Practice Matters – a newsletter produced quarterly and available to view on **UHCprovider.com/MACommunityPlan** > Bulletins and Newsletters.

UnitedHealthcare has established the Quality and Utilization Management Peer Review Committee to allow you to provide guidance on medical policy, quality assurance and improvement programs and medical management procedures. You may recommend specific clinical guidelines for a specific diagnosis. These requests should be supported with current medical research and or data and submitted to the UnitedHealthcare SCO Quality and Utilization Management Peer Review Committee.

A goal of the committee is to help ensure practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the enrolled population
- Are developed in consultation with participating care providers
- Are reviewed and updated periodically

We will communicate these guidelines to you, and as appropriate, to members.

Decisions regarding utilization management, member education, coverage of services, and other areas the guidelines apply will be consistent with the guidelines.

If you would like to propose a discussion topic with UnitedHealthcare SCO Quality and Utilization Management Peer Review Committee, please contact a UnitedHealthcare medical director through the prior authorization line.

UnitedHealthcare SCO Care Model

The following principles guide the direction and focus of the UnitedHealthcare SCO care model:

- Members are at the center of all care decisions.
- Care and services should be provided in a variety of settings at differing levels of intensity.
- Care management activities must emphasize the provision of the right services, at the right time, in the right place, for the right reason, and at the right cost.
- Care management guidelines and practices are built from evidence-based practices.

Initial and Ongoing Assessment Process

Upon joining the UnitedHealthcare SCO program, every member is screened and stratified into one of five levels of acuity and assigned a care coordinator or care manager. Each new member then receives a face-to-face initial assessment to confirm the appropriate level of acuity has been assigned, to help ensure appropriate services are in place, and to develop an individualized plan of care (IPC) in conjunction with the member's primary care provider. Subsequent assessments are conducted on a scheduled basis and also adhoc whenever a member experiences a significant change in condition. The care coordinator/care manager documents all orientation findings, health assessments, reassessments, and IPC in the member's centralized enrollee record (CER).

UnitedHealthcare SCO Program Acuity Levels

Acuity Level	Description
Level 1	Individuals at low health risk, who are capable of remaining in the community with little support and regular communication with UnitedHealthcare.
Level 2	Individuals who are medically stable and may have chronic conditions with intermittent acute episodes and are generally supported in some manner by home and community-based services.
Level 3	Individuals who are medically complex but are capable of remaining in community settings with strong support from physicians, UnitedHealthcare, family, and home and community-based care providers.
Level 4	Individuals who are medically complex and require additional behavioral health or palliative care support to remain in community settings with strong support from care providers, behavioral health care providers, UnitedHealthcare, family, and home and community-based care providers.
Institutional	Individuals who are institutionalized and who will remain in the nursing home, barring any significant improvement in health status.

For members stratified as Level 3 and Level 4, a UnitedHealthcare SCO registered nurse care manager is assigned to support the member and primary care provider. For members residing in a long-term care setting, either a nurse practitioner or physician assistant is assigned. Working with the primary care provider, or in the instance of members in long-term care facilities, the facility staff and the UnitedHealthcare SCO case manager convene a primary care team meeting to determine the most appropriate services that support the member's goals of care.

After the initial assessment, members are then assessed at regular intervals depending on their care level as listed.

Member Risk Stratification: Acuity Levels

Level (Risk)	Acuity	Visits	Functional/ Cognitive Impairment	Condition Management	Care Coordinator or Care Manager
Level 1 (Low)	Low use of acute medical services and inpatient care	Twice per year	Minimal to no impairment	Managed effectively with office care	Telephonic care coordinator
Level 2 (Low to Moderate)	Moderate use of acute medical services and inpatient care	Twice per year or as needed	Impairment necessitates supervision with instrumental activity daily living (IADL)s	Inadequate self-management may be compliance issues	Geriatric Social Service Coordinator (GSSC)
Level 2 Yellow (Moderate)	Moderate use of acute medical and behavioral health services, and inpatient care	Twice per year or as needed	Cognitive impairment necessitates supervision with activity daily living (ADL)s or instrumental activity daily living (IADL)s	Inadequate self-management may be compliance issues	GSSC with registered nurse (RN) support
Level 3 (High)	High use of acute medical and behavioral health services, inpatient care and LTSS	Quarterly or as needed	Impairment requiring assistance with ADLs or IADLs	Multiple co-morbid conditions requiring close management	RN care manager
Level 4 Green (High)	High use of acute medical services, inpatient care and LTSS May be receiving hospice or end-of-life care	Quarterly or as needed	Impairment requiring assistance with ADLs and IADLs	May be end of life Recent severe progression of disease	RN care manager
Level 4 (Highest)	Highest use of acute medical and behavioral health services, inpatient, ICU care and LTSS	Quarterly or as needed	Impairment requiring assistance with ADLs and IADLs	Multiple co-morbid conditions not being adequately managed	RN care Manager
Institutional (Intensive)	Requires 24/7 skilled nursing services	Every other month or as needed	Dependent in most ADLs or IADLs	Requires 24/7 skilled nursing services	Nurse practitioner/ physician assistant

Roles and Responsibilities of the Primary Care Provider

PCPs are the core of the UnitedHealthcare SCO care model. Working collaboratively with members and their respective primary care teams, PCPs:

- Provide overall clinical direction and serve as a central point for integration and coordination of services
- Provide medical oversight to the care management process and, along with the other members of the primary care team, be fully aware of all services delivered through the IPC
- Provide primary care services, including acute and preventive care
- Working with the primary care team, maintain the centralized enrollee record (CER)
- Working with the UnitedHealthcare SCO care manager, convene and lead the primary care team meetings for members with complex medical needs
- Together with the primary care team/care manager, create and maintain an IPC, including establishing goals with the member

Panel Roster

PCPs may print a monthly Primary Care Provider Panel Roster by visiting **UHCprovider.com/reports**.

The PCP Panel Roster provides a list of UnitedHealthcare Community Plan members currently assigned to the care provider.

UnitedHealthcare Community Plan works with members and care providers to help ensure all participants understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, seven days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which immediately pages an on-call medical professional so referrals may be made for non-emergency services or information may be given about accessing services or managing medical problems. Recorded messages are not acceptable.

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters may be viewed electronically on **UHCprovider.com/reports**. The portal requires a unique user name and password combination to gain access.

Use the **UnitedHealthcare Reports Quick Reference** for specific instructions.

Care Manager Interface with the Primary Care Provider

Critical to the success of the UnitedHealthcare SCO care model is the collaboration between the primary care provider and UnitedHealthcare SCO care managers. All clinical assessments, contact with members, and IPCs are documented in the CER and communicated to the primary care provider. For example, the care manager assists the primary care provider in implementing the IPC, scheduling appointments or arranging for home and community-based services (HCBS).The bi-directional exchange of clinical information is critical to help ensure a member's IPC is accurate and addresses their needs.

Primary Care Team

For members with complex medical needs, the UnitedHealthcare SCO care model is structured to support a partnership between the primary care provider, care manager and the member and their family/caregiver through a supportive, primary care team approach. At a minimum, a primary care team includes the PCP, care manager, member and family/caregivers. Depending on the member's risk stratification level and primary conditions/needs, the individual serving in the care manager role on the primary care team may be a geriatric support services coordinator, behavioral health field care advocate, RN care manager or nurse practitioner/ physician assistant. As appropriate and based upon a member's needs, other care providers are included in the member's primary care team.

Primary care team members work together to develop and update an integrated IPC, which includes treatment goals (medical, behavioral, social and long-term care) and measures progress and success in meeting those goals. With the collective input from primary care team members, the team promotes independent functioning of the member and provides services in the most appropriate, least restrictive

setting. The member's primary care team works to help ensure effective coordination and delivery of covered services. The team provides ongoing direction for member care, creating consensus and facilitating an interdisciplinary team approach to provide comprehensive care management. During regular and adhoc meetings, primary care team members review results of initial and ongoing assessments, discuss changes in member status and create new goals, when appropriate.

Aging Services Access Point

Aging Service Access Points are the local agencies within the aging network that manage home and community-based funds and coordination of designated social services. In the UnitedHealthcare SCO care model, coordination of community long-term care and social support services are provided by the geriatric support services coordinators (GSSC), who are employees of the Aging Service Access Points. Home and community-based services are important because they are designed to help SCO members to remain living at home and to delay or avoid long-term care placement.

Centralized Enrollee Records

The SCO care model incorporates the concept of a CER, affording around-the-clock access to clinical information critical to medical decision-making. This concept supports service delivery integration across the continuum of care settings and improves quality of care. UnitedHealthcare SCO facilitates continuous access to the CER across care settings. We achieve this in three ways:

1. Create an electronic or fax summary CER accessed by relevant clinicians and the primary care provider/primary care team at the time of clinical decision-making.
2. Work with the primary care provider to ensure the medical records housed in the primary care provider's office contain relevant clinical information housed in the UnitedHealthcare SCO's care management system
3. Establish protocols that feed information concerning primary care team members(s), care provider(s), and member interactions into the CER.

To supplement these primary approaches, UnitedHealthcare SCO employs the following strategies to improve record keeping and coordinate access to information:

1. Use the Health Service Access Line (HSAL) to provide timely access to the summary CER.
2. Help ensure HIPAA compliance.
3. Link care manager and primary care team to the summary CER for timely and relevant action following significant encounters.

In the traditional medical model, mechanisms for consistent communication to the PCP and the medical record are often lacking or not systematically executed. Current practices in the health care industry leave gaps in your ability to access critical information about an individual's history and current service plan. Real-time access to medical information for all types of care providers is critical to meeting emergent and urgent member needs and to reducing fragmentation in service delivery.

The primary medical record is maintained by the primary care provider or the long-term care facility and through communication with the primary care team, which feeds updates to the CER.

The following key documents are stored in the CER:

- Medical history
- Problem list (both active and inactive medical problems)
- History of hospitalizations and surgeries (both inpatient and outpatient)
- Medication list
- Medical progress notes
- Results of comprehensive geriatric assessment, if done
- Record of all specialty referrals and results of evaluations, including non-physician referrals (physical therapy, occupational therapy, nutrition)
- Results of all laboratory, imaging, radiology and other diagnostic procedures ordered

UnitedHealthcare SCO uses the usual and customary protocols within the medical community by using the medical records maintained by primary care providers and nursing facilities. These records include member's diagnoses, medical conditions, medications, scheduled appointments and progress notes.

Confidentiality and accuracy of a member's medical record must be maintained at all times. UnitedHealthcare SCO requires you comply with HIPAA standards for privacy and protection of member data. The privacy of any information that identifies a particular member must be safeguarded.

Information from or copies of a member's medical record may only be released to authorized individuals. You must ensure unauthorized individuals cannot gain access to or alter a member's medical record. You may only release medical records in accordance with state laws, court orders or subpoenas. You must ensure timely member access to the information that pertains to them. Additionally, you and UnitedHealthcare SCO must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, and other health and member information.

All medical records must be maintained for 10 years. Additionally, there must be prominent documentation in the medical record demonstrating whether or not a member has executed an advance directive. UnitedHealthcare SCO, CMS, or any federal agency and their designees, must have access to member medical records.

Health Services Access Line

UnitedHealthcare SCO's HSAL uses a toll-free number to provide a centralized approach to care management interfaces that provides members and care providers with access to a clinician regardless of the time of day. The following communications and interactions are facilitated through HSAL:

- The HSAL allows members to contact their care manager during normal business hours. Calls ring into the HSAL during business hours. If the member's assigned care manager is out in the field, the HSAL may schedule a home visit appointment or page the care manager to contact the member. The care manager assess the member's needs, triages the call based on the assessed situation, and coordinates services as appropriate.
- The HSAL reverts to an on-call service after business hours. The on-call service is staffed by UnitedHealthcare SCO nurse practitioners and physician assistants. The on-call clinician has access to the summary CER and triages the call, documents changes in condition in the summary CER, and follows up with the member's assigned care manager on the following business day.
- If a member elects to call their primary care provider's after-hours service, then the primary care provider on-call may contact UnitedHealthcare SCO through the HSAL to gain access to critical information on the member stored in the CER.
- Primary care providers may also contact the HSAL during normal business hours to reach a member's care manager, request authorizations, notify UnitedHealthcare SCO of changes in the member's condition, make verbal updates to the CER, and access member information and IPCs.

Chapter 6: Care Provider Performance Standards and Compliance Obligations

Evidence-Based Medicine/Clinical Practice Guidelines

UnitedHealthcare SCO promotes the use of evidence-based clinical practice guidelines to improve the health of its members and provide a standardized basis for measuring and comparing outcomes. Outcomes are compared with the standards of care defined in the evidence-based clinical practice guidelines for these diseases.

You must be compliant with clinical practice guidelines found on our care provider online portal at **UHCprovider.com/MACommunityPlan** > Current Policies and Clinical Guidelines, or call the Provider Service Center at 888-867-5511 to request a hard copy of these guidelines.

UnitedHealthcare Community Plan randomly conducts chart reviews and audits. Your care provider office may be selected for an audit.

Care Provider Responsibility with Termination of Services-Notification of Medicare Non-Coverage

Home Health Agency (HHA), Skilled Nursing Facility (SNF) and Comprehensive Outpatient Rehabilitation Facility (CORF) Notification Requirements

There are several components outlined in the process regarding your role as a participating UnitedHealthcare SCO SNF, HHA, or CORF care provider. The **Notice of Medicare Non-Coverage (NOMNC)** is a short, straightforward notice that informs the member of the date coverage of services ends and describes what should be done if the member wants to appeal the decision or needs more information.

CMS has developed a single, standardized NOMNC designed to make notice delivery as simple and burden-free as possible for you. The NOMNC essentially includes only three variable fields (member name, ID/Medicare number and last day of coverage) you must fill in.

When to Deliver the NOMNC

Based on the determination by UnitedHealthcare SCO upon when services should end, the SNF, HHA, or CORF is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage SNF, HHA, and CORF care providers to work with UnitedHealthcare SCO so we may deliver these notices as soon as the service termination date is known.

How to Deliver the NOMNC

SNF, HHA, and CORF providers must carry out "valid delivery" of the NOMNC. This means the member, or authorized representative, must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by phone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the notice contents, the call must be documented and the notice must be mailed to the representative.

Expedited Review Process

If the member decides to appeal the end of coverage, they must contact the quality improvement organization (QIO) by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO for Massachusetts is MassPro, which you may contact at:

- Toll-free telephone number: 866-815-5440
- Toll-free TTY: 866-868-2289
- Fax number for appeals: 855-236-2423
- Fax number for other reviews: 844-420-6671

The QIO will inform UnitedHealthcare SCO and you of the request for a review and UnitedHealthcare SCO is responsible for providing the QIO and the member with a detailed explanation of why coverage is ending.

UnitedHealthcare SCO may need to present additional information needed for the QIO to make a decision. You should cooperate with UnitedHealthcare SCO's requests for assistance in getting needed information. Based on the expedited time frames, the QIO decision should take place by close of business the day coverage ends.

Exclusions from NOMNC Delivery Requirements

You are not required to deliver the NOMNC if coverage is terminated for any of the following reasons:

1. The member's benefit is exhausted;
2. Denial of an admission to an SNF, HHA or CORF;
3. Denial of non-Medicare covered services; or
4. A reduction or termination of services that do not end the skilled stay.

When a Detailed Explanation of Non-Coverage (DENC) will be Issued

UnitedHealthcare SCO will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 p.m. Eastern time) the day of the QIO's member appeal notification, or the day before coverage ends, whichever is later.

Where to locate the NOMNC form

You may find a copy of the NOMNC form, instructions, additional details about NOMNC and other beneficiary notifications requirements on **CMS.gov** > Medicare.

Quality Management Program

All care providers and practitioners are required to participate in and cooperate with the UnitedHealthcare Quality Management program and related activities. These include:

- 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.

The UnitedHealthcare Quality Management program is allowed to use practitioner and care provider performance data to conduct quality activities.

Care Provider Evaluation

When evaluating your performance, UnitedHealthcare SCO will review at a minimum the following areas:

- **Quality of Care:** measured by clinical data related to the appropriateness of member care and member outcomes.
- **Efficiency of Care:** measured by clinical and financial data related to a member's health care costs.
- **Member Satisfaction**: measured by the members' reports regarding accessibility, quality of health care, member-participating care provider relations, and the comfort of the practice setting.
- **Administrative Requirements:** measured by the participating care provider's methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards:** measured by the participating care provider's involvement with panels used to monitor quality of care standards.

Care Provider Compliance to Standards of Care

As a UnitedHealthcare SCO participating care provider, you must comply with all applicable laws, regulations, SCO contractual, and licensing requirements. In addition, you must furnish covered services in a manner consistent with standards related to medical and surgical practices generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare SCO standards, which include, but are not limited to:

- Guidelines established by the federal Center for Disease Control (or any successor entity)
- All federal, state, and local laws and regulations regarding the conduct of their profession

You must also comply with UnitedHealthcare SCO policies and procedures, including those regarding the following:

- Committee and clinical task force participation to improve the quality and cost of care.
- Prior authorization requirements and timeframes.
- Participating care provider credentialing requirements, including but not limited to, having a minimum of two years geriatric experience.
- Case management program referrals.
- Appropriate release of inpatient and outpatient utilization and outcomes information.
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare SCO.

- Cooperating with efforts to assure appropriate levels of care.
- Maintaining a collegial and professional relationship with UnitedHealthcare SCO personnel and fellow participating care providers.
- Providing equal access and treatment to all UnitedHealthcare SCO members.

Compliance Process

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare SCO.
- Failure to pre-notify UnitedHealthcare SCO of admissions.
- Member complaints/grievances determined against you.
- Underutilization, overutilization, or inappropriate referrals.
- Inappropriate billing practices.
- Non-supportive actions and/or attitude or failure to disclose potential fraud waste and abuse activities, as well as failure to disclose any actions against your federal/state licensure.

Your noncompliance is continuously monitored. Remediation and/or corrective action is taken, as necessary.

Acting within the lawful scope of practice, you are encouraged to advise patients who are members of UnitedHealthcare SCO about:

1. The health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the member to decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
4. The importance of preventive care at no cost to the member.

Laws Regarding Federal Funds

Payments you receive for furnishing services to UnitedHealthcare SCO members are, in whole or part, from federal funds. Therefore, you and any subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including, but not limited to: Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act (ADA) of 1990.

Marketing

You may not develop and use any materials that market UnitedHealthcare SCO without the prior approval of UnitedHealthcare SCO in compliance with Medicare Advantage and state MassHealth requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS, and not disapproved within 45 days. State MassHealth laws are similar, and UnitedHealthcare SCO works with both CMS and the state Executive Office of Health and Human Services to have marketing or outreach materials approved prior to distribution to members or prospective members.

Sanctions under Federal Health Programs and State Law

You must ensure no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by you. You must disclose to UnitedHealthcare SCO whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Massachusetts, the federal government, or any public insurer. You must notify UnitedHealthcare SCO immediately if any such sanction is imposed on you, a staff member or subcontractor.

Selection and Retention of Participating Care Providers

UnitedHealthcare SCO is responsible for arranging covered services provided to thousands of members through a comprehensive care provider network of independent physicians and facilities contracted with UnitedHealthcare SCO. The network includes health care professionals such as primary care providers, specialist care providers, medical facilities, allied health professionals, and ancillary service providers.

The UnitedHealthcare SCO network has been carefully developed to include those contracted health care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care, cultural competency and acceptance of UnitedHealthcare SCO managed care principles and financial considerations. UnitedHealthcare SCO continuously reviews and evaluates your information and recredentials participating care providers every three years. The credentialing guidelines are subject to change based on industry requirements and UnitedHealthcare SCO standards. Additionally, UnitedHealthcare SCO periodically evaluates its current care provider network to help ensure appropriate network optimization, which is based upon several different criteria.

Per the federal 21 Century Cures Act, care providers should enroll with MassHealth to obtain a Medicaid ID number. You should provide these Medicaid ID numbers during contracting, credentialing and/or recredentialing with UnitedHealthcare SCO. You may apply for a Medicaid ID number at **mass.gov/service-details/masshealth-provider-enrollment-credentialing**.

Once you obtain the Medicaid ID number and request to become contracted with us, you must be credentialed with UnitedHealthcare. The credentialing application you submit to UnitedHealthcare will request your Medicaid ID number. After you obtain the Medicaid ID number, you may submit updates through the provider portal at **UHCprovider.com**.

Appeal Process for Care Provider Participation Decisions

Care Providers

If UnitedHealthcare SCO decides to suspend, terminate or not renew your participation status, UnitedHealthcare SCO must:

- Give you written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate you and the numbers and mix of care providers needed by UnitedHealthcare SCO.
- UnitedHealthcare SCO will allow you to appeal the action to a hearing panel, and give the care provider written notice of their right to a hearing, the process and timing for requesting a hearing.
- UnitedHealthcare SCO will help ensure the majority of the hearing panel members are peers of the affected care provider.

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare SCO must give written notice of that action to the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law.

If you use subcontracted provider groups, you must communicate the following to them:

- Appeal procedures apply equally to care providers within those subcontracted groups,
- Subcontracted groups must adhere to all UnitedHealthcare SCO, federal, and state requirements.

Other Care Providers

UnitedHealthcare SCO decisions subject to appeal include decisions regarding reduction, suspension, or termination of your participation resulting from quality deficiencies. UnitedHealthcare SCO will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law. Written communication to you will detail the limitations and inform you of your appeal rights.

Member Notification of Care Provider Termination

When a contract termination involves a primary care provider, UnitedHealthcare SCO will notify all members who are patients of that primary care provider of the termination. For all other care providers, UnitedHealthcare SCO will make a good-faith effort to provide written or verbal termination notice of a participating care provider to all members who are patients seen on a regular basis by that care provider at least 30 calendar days before the termination effective date, regardless of the reason for the termination.

Chapter 7: Medical Records

Medical Record Review

UnitedHealthcare SCO may initiate a medical record review at any time. This review may be based upon specific circumstances related to billing practices, internal audit criteria, external audit criteria, consistent need to obtain medical records for claims, or other circumstances/criteria. A UnitedHealthcare SCO representative will make arrangements with the participating care provider office in advance to review or obtain medical record copies of UnitedHealthcare SCO members to obtain information regarding medical necessity and quality of care, or to obtain other information related to billing for either specific members, a set of members, or for other specific criteria. We will evaluate medical records and clinical documentation based on the standards for medical records listed below. The quality management committee will review the medical record results up to quarterly. We will use quality management record review results in the re-credentialing process.

Pursuant to HIPAA, a health plan, or its contracted care provider(s), does not need to receive member consent for you to transfer medical records or other protected health information (PHI) to the health plan. This is an accepted use and disclosure of PHI as part of the HIPAA "Treatment, Payment and Healthcare Operations" provisions. Health plans and contracted care providers are covered entities under the HIPAA definitions, and as such are permitted to exchange PHI under these use and disclosure provisions without member consent.

Medical Records Standards

You must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in the members' medical chart.

Each medical record chart must have documented at a minimum:

- Member name;
- Member identification number;
- Member age;
- Member sex;
- Member date of birth;
- Service date;
- Allergies and any adverse reaction;
- Past medical history;
- Chief complaint/visit purpose;
- Subjective findings;
- Objective findings, including diagnostic test results;
- Diagnosis/assessment/impression;
- Plan, including services, treatments, procedures and/or medications ordered, recommendation and rationale;
- Name of participating care provider, including signature and initials;
- Instructions to member;
- Evidence of follow-up with indication that test results and/ or consultation was reviewed by primary care provider and abnormal findings discussed with member/ legal guardian; and
- Health risk assessment and preventive measures.

In addition, you must document in a prominent part of the member's current medical record whether or not the member has executed an advance directive. If a member refuses to develop an advance directive, you should document the conversation in the member's medical record. You should obtain a copy of the advance directive, as applicable, and insert it in the member medical record.

Advance directives are written instructions, such as living wills or Durable Powers of Attorney for Health Care, recognized under the laws of Massachusetts and signed by a patient that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of Member Information

Confidentiality and accuracy of a member's medical record must be maintained at all times. The privacy of any information that identifies a particular member must be safeguarded. Information from or copies of a member's medical record may only be released to authorized individuals. You must ensure unauthorized individuals cannot gain access to or alter a member's medical record. You must comply with all state and

federal laws concerning privacy and confidentiality of health and other confidential information about members. You must have policies and procedures regarding use and disclosure of health information that comply with all applicable federal and state laws. Should members wish to have their medical record information shared with family or others, they must submit an authorization of representative form with member signature.

Member Record Retention

All medical records must be maintained for 10 years. UnitedHealthcare SCO, CMS, or any federal agency, and their designees, must have access to a member's medical records. CMS or any federal agency or designees must make the correct request for such information, which may include issuing subpoenas.

You must retain the original or copies of a member's medical records as follows:

- Keep records for at least 10 years after last medical or health care service for all adult members.

You must comply with all state and federal laws on record retention.

Chapter 8: Reporting Obligations

Cooperation in Meeting the CMS and State of Massachusetts Reporting Requirements

UnitedHealthcare SCO must provide CMS and the state of Massachusetts information necessary for CMS and the state of Massachusetts to administer and evaluate the UnitedHealthcare SCO program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare and MassHealth services. You must cooperate with UnitedHealthcare SCO in its data reporting obligations by providing to UnitedHealthcare SCO any information that it needs to meet its obligations.

Certification of Diagnostic Data

UnitedHealthcare SCO is specifically required to submit to CMS and the state of Massachusetts data necessary to characterize the context and purposes of each encounter between a member and a care provider, supplier, physician, or other practitioner (encounter data). If you furnish diagnostic data to assist UnitedHealthcare SCO in meeting its reporting obligations to CMS and the state of Massachusetts, you must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Risk Adjustment Data

You are encouraged to comprehensively code all members' diagnoses to the highest level of specificity possible. All members' medical encounters must be submitted to UnitedHealthcare SCO.

Critical Incidents

Critical incidents must be reported to the state of Massachusetts by SCO within one business day. It is extremely important you contact us immediately to provide us with information on critical incident as soon as you are made aware of such incident. Examples of what constitutes a critical incident include, but are not limited to:

- Mistreatment or allegation of mistreatment of a member including abuse, neglect, emotional harm, sexual or financial exploitation, or any other mistreatment
- Facility or physical threats to staff, patients or others
- Suicide threats or death of a member from non-natural cause, including suicide, homicide, or any other unexpected cause for death
- Serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the member requires medical treatment beyond basic first aid
- Any serious communicable disease required to be reported to health authorities pursuant to state and/or local ordinances
- Natural disaster such as fire, serious flooding, or incidents causing displacement in which the member is harmed or in danger of being harmed due to displacement
- Exposure to hazardous material (including blood-borne pathogens)
- Medication error (requiring medical intervention)
- Person missing from scheduled care
- Unexplained deaths
- Witnessed or un-witnessed falls requiring emergency room treatment or hospitalization
- Member-to-member, other residents-to-member, staff-to-member or other encounters or assaults that have adverse consequences requiring emergency room treatment or hospital admission
- Any incident reported to another state agency
- Any incident reported to police, public safety, or other local agency including protective services

Email your critical incidents and questions to **Critical_Incident_SCO@uhc.com**. Provide as much detail as you are able, including any history and any resolution, so that we may immediately report to the state. The state will often ask for additional detail, and it may be necessary for a representative to contact you to gain additional information if you do not initially provide a full accounting and history.

Chapter 9: Initial Decisions, Appeals and Grievances

Initial Decisions

The initial decision is the first decision UnitedHealthcare Clinical Services makes regarding coverage or payment for care. In some instances, you, acting on behalf of UnitedHealthcare Clinical Services, may make an initial decision regarding whether a service will be covered.

- If a member asks us to pay for medical care the member has already received, this is a request for an initial decision about payment for care.
- If a member or you, acting on behalf of a member, asks for prior authorization for treatment, this is a request for an initial decision about whether the treatment is covered by UnitedHealthcare SCO.
- If a member asks for a specific type of medical treatment from you, this is a request for an initial decision about whether the treatment the member wants is covered by UnitedHealthcare SCO.

UnitedHealthcare SCO will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UnitedHealthcare SCO will cover medical care may be a standard decision made within the standard time frame (typically within 14 days) or it may be an expedited decision made more quickly (typically within 72 hours).

A member may ask for an expedited decision only if the member or you believe waiting for a standard decision could seriously harm the member's health or ability to function. The member or you may request an expedited decision. If you request an expedited decision, or support a member in asking for one, and you indicate waiting for a standard decision could seriously harm the member's health or ability to function, UnitedHealthcare SCO will automatically provide an expedited decision.

If a member requests UnitedHealthcare SCO provide a detailed notice of your or UnitedHealthcare SCO's decision to deny a service in whole or part or to reduce the amount of services previously authorized, UnitedHealthcare SCO must give the member a written notice of the determination and must also provide the member with their appeal rights.

If UnitedHealthcare SCO does not make a decision within the required time frame and does not notify the member regarding why the time frame must be extended, the member may treat the failure to respond as a denial and may appeal.

Appeals

It is a requirement under the UnitedHealthcare SCO contract that a member will continue to receive all services in place at the time of filing for the duration of the appeal process.

A member may appeal an adverse initial decision by UnitedHealthcare SCO or you concerning authorization for, or termination or reduction of coverage of, a health care service. A member may also appeal an adverse initial decision by UnitedHealthcare SCO concerning payment for a health care service. A member's appeal of an initial decision about authorizing health care or terminating or reducing coverage of a service must generally be resolved by UnitedHealthcare SCO within 30 calendar days or sooner, if the member's health condition requires (expedited appeal). An appeal concerning payment must generally be resolved within 60 calendar days.

You must also cooperate with UnitedHealthcare SCO and members in providing necessary information to resolve the appeals within the required time frames. You must provide the pertinent medical records and any other relevant information to UnitedHealthcare SCO. In some instances, you must provide the records and information very quickly to allow UnitedHealthcare SCO to make an expedited decision.

If the normal time for an appeal could result in serious harm to the member's health or ability to function, the member or you may request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time period. If you request the expedited appeal and indicate the normal time for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

Further Appeal Rights

If UnitedHealthcare SCO denies the member's appeal in whole or part, it will forward the appeal to an independent review entity (IRE) that has a contract with the federal government

and is not part of UnitedHealthcare SCO. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days.

If the IRE issues an adverse decision, the member may appeal to an administrative law judge (ALJ). If the ALJ issues an adverse decision or refuses to hear the member's case, the member may be able to appeal to a district court of the United States.

Members may only appeal to the Board of Health for Medicaid-based services and they must exhaust all their internal (UnitedHealthcare) appeal options before appealing with the Board of Health. If the Board of Hearings rules in the member's favor, then UnitedHealthcare SCO must reverse its previous denial, reduction, or termination of services.

Special Types

A special type of appeal applies only to hospital discharges. If the member thinks UnitedHealthcare SCO coverage of a hospital stay is ending too soon, the member may appeal directly and immediately to the Massachusetts IRE. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice UnitedHealthcare SCO coverage of the stay is ending. If the member misses this deadline, the member may request an expedited appeal from UnitedHealthcare SCO.

Another special type of appeal applies only to a member dispute regarding when coverage will end for SNF, HHA or comprehensive outpatient CORF. SNFs, HHAs and CORFs are responsible for providing members with a written notice at least two days before their services are scheduled to end.

If the member thinks their coverage is ending too soon, the member may appeal directly and immediately to the IRE. If the member gets the notice two days before coverage ends, the member must request an appeal to the IRE no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date coverage ends. If the member misses the deadline for appealing to IRE, the member may request an expedited appeal from UnitedHealthcare SCO.

Grievances

Members and you have the right to make a complaint if dissatisfied in any aspect of the administration of the plan. You must cooperate in the SCO appeals and grievances process, governed by a contract with CMS and the Commonwealth of Massachusetts, and all state and federal laws and regulations.

- An appeal is the type of complaint a member makes when the member wants UnitedHealthcare SCO to reconsider and change an initial decision about what services are necessary or covered or what UnitedHealthcare SCO will pay for a service.
- A grievance is any expression of dissatisfaction a member makes regarding UnitedHealthcare SCO or a participating care provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room are considered to be grievances.

Resolving Grievances

If a UnitedHealthcare SCO member has a grievance about UnitedHealthcare SCO, a care provider or any other issue, you should instruct the member to contact UnitedHealthcare SCO Member Services at 888-867-5511 (TTY 711). A written grievance should be mailed to:

UnitedHealthcare Community Plan
Attn: Complaints and Appeals Dept
P.O. Box 31364
Salt Lake City, UT 84131

Or fax the written grievance to:

Expedited fax: 801-994-1349
Standard fax: 801-994-1082

UnitedHealthcare SCO will send a confirmation letter within five days of receiving a written grievance. We will make a final decision as quickly as possible, but no later than 30 calendar days after receiving the grievance. We may extend the time frame by up to 14 calendar days if an extension is requested, or if we justify a need for additional information and the delay is in the best interest of the member.

UnitedHealthcare SCO members may ask for an expedited grievance review upon request. We will respond to expedited or fast grievance requests within 72 hours.

Chapter 10: Care Provider Standards and Policies

UnitedHealthcare SCO members have the right to timely, high-quality care, and treatment provided with dignity and respect. As such, it is an expectation you respect the rights of all UnitedHealthcare SCO members. UnitedHealthcare SCO members have been informed they have the following rights:

- To be treated with respect and recognition of their dignity and their right to privacy
- To a choice of a qualified contracted primary care provider and contracted hospital
- To participate with care providers in making decisions about their health care
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- To timely access to their primary care provider and recommendations to specialists when medically necessary
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe an emergency medical condition exists
- To voice grievances or appeals about the organization or the care it provides
- To actively participate in decisions regarding their health and treatment options
- To make recommendations regarding the organization's member rights and responsibilities policy
- To request information regarding the financial condition of UnitedHealthcare SCO
- Have coverage decisions and claims processed according to regulatory standards, when applicable
- Choose an advance directive to designate the kind of care the members wish to receive should they become unable to express their wishes

UnitedHealthcare SCO members have a responsibility to:

- Supply information (to the extent possible) the organization and its care providers need to provide care
- Follow plans and instructions for care they have agreed to with their care providers
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Member Responsibilities

Member responsibilities include:

- Reading and following the evidence of coverage (EOC)
- Treating all UnitedHealthcare SCO staff and health care providers with respect and dignity
- Protecting their SCO ID card and showing it before obtaining services
- Knowing the name of their primary care provider
- Seeing their primary care provider for their health care needs
- Using the emergency room for life-threatening care only and going to their primary care provider, specialists, or urgent care centers, as appropriate, for all other treatment
- Following their doctor's instructions and treatment plan and telling the doctor if the explanations are not clear
- Bringing the appropriate records to the appointment, including their immunization records through age 18
- Making an appointment before they visit their primary care provider or any other UnitedHealthcare SCO health care provider
- Arriving on time for appointments
- Calling the office at least one day in advance if they must cancel an appointment
- Being honest and direct with their primary care provider, including giving the primary care provider the member's health history
- Telling their UnitedHealthcare SCO care manager and/or support coordinator if they have changes in address, or eligibility for enrollment
- Tell UnitedHealthcare SCO if they have other insurance
- Give a copy of their advance directive to their primary care provider as listed in the member EOC

Services Provided in a Culturally Competent Manner

UnitedHealthcare SCO is obligated to help ensure services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. You must cooperate with UnitedHealthcare SCO in meeting this obligation. You may use the UnitedHealthcare language line to assist members with limited English proficiency when they do not have the ability to understand the member's language.

Member Grievances and Appeals

UnitedHealthcare SCO tracks all complaints and grievances to identify areas for improvement. This information is reported at the quality management, service improvement and compliance committees and is reviewed by the senior leadership team. Please refer to the section in this manual for Member Appeal and Grievances Rights.

Member Satisfaction

UnitedHealthcare SCO periodically surveys members to measure overall member satisfaction and satisfaction with the care received from you.

CMS conducts annual member surveys to measure their overall member satisfaction and satisfaction with the care received from you. Surveys results are available upon request.

Chapter 11: Access to Care/Appointment Availability

Member Access to Health Care Guidelines

Use the following appointment availability goals to ensure timely access to medical care and behavioral health care:

- **Non-symptomatic office visits** – within 30 days.
- **Urgent care symptomatic** – within 48 hours.
- **Emergency** – immediately (24 hours a day, seven days a week)
- **Individuals with disabilities** – physical and telephonic access required. Reasonable accommodations must be made to ensure physical/communication barriers do not inhibit access to care.

UnitedHealthcare SCO will monitor your adherence to access guidelines through office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination. Network management will review variations from the policy for educational and/or counseling opportunities and tracked for your re-credentialing.

All participating care providers and hospitals will treat all UnitedHealthcare SCO members with equal dignity and consideration in the same manner as their non-UnitedHealthcare SCO patients.

Care Provider Availability

Primary care providers will provide coverage 24 hours a day, seven days a week. When you are unavailable to provide services, you must ensure another participating care provider is available.

The member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g., emergency cases) and be provided with an alternative appointment.

After-hours access will be provided to assure a response to emergency phone calls within 30 minutes and response to urgent phone calls within one hour. Individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services.

Member Transfer and Termination From a Participating Care Provider's Panel

UnitedHealthcare SCO will determine reasonable cause for a transfer based on written documentation submitted by you. You may not transfer a member to another participating care provider due to the costs associated with the member's covered services.

You may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements (for non-covered services only) for services and will collaborate with UnitedHealthcare SCO.

Closing of a Care Provider Panel

When closing a practice to new UnitedHealthcare SCO members or other new patients, you are expected to:

- Give UnitedHealthcare SCO prior written notice the practice will be closing to new members as of the specified date.
- Keep the practice open to UnitedHealthcare, SCO members who were members before the practice closed.
- Uniformly close the practice to all new patients including private payees, commercial or governmental insurers.
- Give UnitedHealthcare SCO prior written notice of the reopening of the practice, including a specified effective date.

Prohibition against Discrimination

Neither UnitedHealthcare SCO nor you may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including, but not limited to, the following:

1. Medical condition, including mental and physical illness;
2. Claims experience;
3. Receipt of health care;
4. Medical history;
5. Genetic information;
6. Evidence of insurability including conditions arising out of acts of domestic violence; and
7. Disability.

Chapter 12: Compliance

Integrity and Compliance

Introduction

UnitedHealthcare SCO 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 SCO is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare SCO corporate 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 UnitedHealth Group Ethics and Integrity 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; and
- 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 SCO has compliance officers responsible for each health plan or business unit. In addition, each health plan has an active compliance committee, consisting of senior managers from key organizational functions. The compliance 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 SCO employee which comes to your attention, should be reported to a UnitedHealthcare SCO senior manager or directly to the Ethics and Compliance Help Center at 800-455-4521.

UnitedHealthcare's Special Investigations Unit (SIU) is an important component of the corporate compliance program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by care providers and/or plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities in all UnitedHealthcare business units. A toll-free fraud and abuse hotline is set up to facilitate the reporting process of any questionable incidents involving plan members or care providers. The number for the hotline is 866-242-7727. Please refer to the Fraud and Abuse section of this care provider manual for additional details about the UnitedHealthcare SCO Fraud and Abuse Program.

An important aspect of the corporate compliance program is assessing high-risk areas of UnitedHealthcare SCO operations and implementing reviews and audits to help ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by you, UnitedHealthcare SCO 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 the participating care provider agreement) 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 SCO plan of the details of this and of the factual situation which gave rise to the inquiry.

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid estimated to reduce program spending by $11 billion over five years. These provisions are specifically aimed at reducing Medicaid fraud.

Under Section 6032 of the DRA, every entity that receives at least $5 million in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any health plan or agent of the entity, providing detailed information about false claims, false statements and whistle blower protections under applicable federal and state fraud and abuse laws. As a contracted care provider with UnitedHealthcare SCO, you and your staff are subject to this provision.

Find the UnitedHealth Group policy titled 'Integrity of Claims, Reports and Representations to Government Entities' at **UHCCommunityPlan.com**. This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, and the rights of employees to be protected as whistle blowers.

Fraud and Abuse

Your assistance in notifying UnitedHealthcare SCO 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 or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. The definition of "intentional" also includes acting in deliberate ignorance or reckless disregard.

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

Examples of fraud and abuse, include:

- Billing for services or supplies not rendered;
- Misrepresentation of services/supplies; and
- Purposefully billing for higher level of service than performed.

Falsifying Claims/Encounters

- Alteration of a claim;
- Incorrect coding;
- Double billing; and
- False date submitted.

Administrative or Financial

- Kickbacks;
- Falsifying credentials;
- Fraudulent enrollment practices; and
- Fraudulent third party liability reporting.

Member Fraud or Abuse Issues

- Fraudulent/altered prescriptions;
- Card loaning/selling;
- Eligibility fraud; and
- 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 may be made in several ways.

Go to **UHCprovider.com** and select 'Contact Us' to report information relating to suspected fraud or abuse.

Call the UnitedHealthcare SCO SIU Fraud Hotline at **866-242-7727**.

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

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

Resolving Disputes

Agreement Concern or Complaint

If you have a concern or complaint about your relationship with UnitedHealthcare SCO, send a letter containing the details to the address in your Agreement with us. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described in your Agreement with us.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare SCO procedures, such as the credentialing or the care coordination process, you and UnitedHealthcare SCO will follow the dispute procedures set forth in those policies and procedures to resolve the concern or complaint. After following those procedures, dissatisfaction remains for either party, an arbitration proceeding may be filed as described in our Agreement with you.

If we have a concern or complaint about your Agreement with us, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in our Agreement.

Arbitration proceedings will be held at the location described in your Agreement with us.

If 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 EOC.

Chapter 13: Prescription Benefits

Network Pharmacies

With a few exceptions, UnitedHealthcare SCO members must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is a pharmacy where members can get their outpatient prescription drugs through their UnitedHealthcare SCO prescription drug coverage. We call them network pharmacies because they contract with our plan. In most cases, member prescriptions are covered if the drugs are on UnitedHealthcare SCO's prescription drug lists (PDLs) and only if they are filled at one of our network pharmacies. A member is not required to continue to go to the same network pharmacy to fill a prescription; a member may go to any of our network pharmacies.

"Covered drugs" is the general term we use to describe all of the outpatient prescription drugs covered by our plan. Covered drugs are listed in our PDL.

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. The following are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy.

1. We will cover prescriptions filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently-needed care. In this situation, members will have to pay the full cost when they fill their prescription. UnitedHealthcare SCO members are entitled to reimbursement by submitting appropriate documentation.
2. If a UnitedHealthcare SCO member is traveling within the United States, but outside of the plan's service area and becomes ill, loses or runs out of their prescription drugs, we will cover prescriptions filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost when they fill their prescription and will have to submit the bill for reimbursement.

   The member is entitled to reimbursement by submitting appropriate documentation. Remember, prior to submitting a prescription to an out-of-network pharmacy, call our UnitedHealthcare SCO Member Services or Provider Services department to find out if there is a network pharmacy in the area the member is traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for the member to get their prescriptions from an out-of-network pharmacy.
3. If a UnitedHealthcare SCO member is unable to get a covered drug in a timely manner within our service area because there are not network pharmacies within a reasonable driving distance that provide 24-hour service.
4. If a member is trying to fill a covered prescription drug not regularly stocked at an eligible network retail (these drugs include orphan drugs or other specialty pharmaceuticals).

Before a prescription is filled at an out-of-network pharmacy, please contact the UnitedHealthcare SCO Member Services to see if there is a network pharmacy available.

Paper Claim Submission

When UnitedHealthcare SCO members go to a network pharmacy, their claims are automatically submitted to us by the pharmacy. However, if they go to an out-of-network pharmacy for one of the reasons listed on the previous page, the pharmacy may not be able to submit the claim directly to us. When that happens, members will have to pay the full cost of their prescription. Members should call the pharmacy help desk at 800-922-1557 for a claim form and instructions on how to obtain reimbursement for covered prescriptions. Members may mail the claim form and receipts to:

OptumRx
P.O. Box 29045
Hot Springs, AR 71903

Formulary

A formulary is a list of all the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are a sum of the Medicare Part D Formulary, and any additional drugs which may be selected by our plan with the help of a team of health care providers. We

select the prescription therapies believed to be a necessary part of a quality treatment program brand-name drugs, generic drugs, and over-the-counter (OTC) medications are included on the formulary. A generic drug has the same active ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. In other cases, we have decided not to include a particular drug. We may also add or remove drugs from the formulary during the year. If we change the formulary, we will notify the member of the change at least 60 days before the effective date of change. If we don't notify the member of the change in advance, the member will get a 60-day supply of the drug when they request a refill. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give a 60-day notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

To find out which drugs are on the formulary, or to request a copy of our formulary, please call UnitedHealthcare SCO Member Services at 800-396-1942 (TTY 800-947-6644) or the Provider Services department. You may also get updated information at **UHCprovider.com/MACommunityPlan** > Pharmacy Resources and Physician Administered Drugs.

In addition to drugs covered under Medicare Part D and the MassHealth formularies, the SCO plan also covers certain OTC and prescription drugs not covered under Medicare Part D. The most up-to-date list of additional OTC and prescription drug products are listed on the UnitedHealthcare SCO OTC and Medicare Part D List.

Exception Request

Members may ask us to make an exception to our coverage rules. There are some exceptions members may request:

- Members may ask us to cover a drug even if it is not on our formulary; and
- You may request us to waive coverage restrictions or limits on specific drugs. For example, for certain drugs, we limit the amount of the drug that we will cover. You may submit a request to ask us to waive the limit and/or cover the drug.

Generally, we will only approve a request for an exception if the alternative drugs included on the plan's formulary would not be as effective in treating the member's condition and/or would cause the member to have adverse medical effects.

Please call our UnitedHealthcare SCO Member Services at **800-396-1942** (**TTY 800-947-6644**) to request a formulary exception. If we approve your exception request for a member, our approval is valid for the remainder of the plan year, as long as the care provider continues to prescribe the drug and it continues to be safe and effective for treating the members' condition.

Drug Management Programs (Utilization Management)

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits help ensure our members use these drugs in the most effective way and also help us control drug plan costs.

A team of doctors and pharmacists developed the following requirements and limits for our plan to help us provide quality coverage to our members. The following are examples of utilization management tools:

- **Prior Authorization:** We require UnitedHealthcare SCO members to get prior authorization for certain drugs. This means you will need to get approval from us before a member fills their prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug we cover per prescription or for a defined period of time. For example, we will provide up to 30 tablets per prescription for simvastatin. This quantity limit may be in addition to a standard 30-day supply limit.
- **Step Therapy:** In some cases, we require members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a member's medical condition, we may require you to prescribe Drug A first. If Drug A does not work for a member, then we will cover Drug B upon request from the care provider.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the member the generic version unless you write the prescription specifically for the brand-name drug, stating that generic substitution is not permissible for that particular prescription.

Find out if the drugs you prescribe are subject to these additional requirements or limits by looking in the formulary. If the drug does have these additional restrictions or limits, you may ask us to make an exception to our coverage rules. Please refer to the section above for exception requests.

Chapter 14: Behavioral Health

UnitedHealthcare SCO members receive mental health and substance abuse services through our behavioral health vendor Optum Behavioral Health.

Screening for Behavioral Health Problems

Primary care providers are required to screen UnitedHealthcare SCO members for mental health and substance abuse issues. Primary care providers should file the completed screening tool in the member's medical record.

Role of the Behavioral Health Unit

Optum Behavioral Health is an important resource for care providers when members experience mental health or substance abuse problems. The Optum Behavioral Health toll-free number is 888-867-5511.

- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours a day, seven days a week.
- Fully supports primary care providers with assessment and referrals to mental health and chemical dependence services.
- Provides behavioral health case management.
- Reviews, monitors, and authorizes behavioral health care.
- Responsible for provider relations for behavioral health care providers.
- Staffed by professionals with extensive experience in mental health and chemical dependence services.

Behavioral Health Emergencies

If you believe the member is having a psychiatric emergency, you should either call 911 or direct the member to the designated county screening center or nearest hospital emergency room. If you are unsure about the member's mental status, call Optum Behavioral Health at 888-867-5511.

Referrals for Behavioral Health Services

Primary care providers and behavioral health care providers should communicate with the Optum Behavioral Health Unit by calling 888-867-5511.

You should note the request in the member's medical record.

A member may self-refer to a participating behavioral health care provider at any time.

The initial treatment assessment must include a full psychosocial history and a mental status examination. The assessment and development of a comprehensive treatment plan must be developed within the first 30 days of treatment. Care providers who are qualified may complete assessments, not just M.D./D.O. Since UnitedHealthcare SCO also has a Medicare component for dual-eligible members, care providers would need to be Medicare-credentialed to provide the services.

Behavioral Health Guidelines and Standards

UnitedHealthcare SCO uses the following diagnostic assessment tools and placement criteria guideline, consistent with current industry standards of care:

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), 4th edition.
- ASAM PPC-2 (American Society of Addiction Medicine).

UnitedHealthcare SCO uses MCG (formerly Milliman USA® guidelines), for appropriateness of care and discharge reviews.

Resolving Grievances

See Chapter 9 Appeals and Grievances for resolving behavioral health grievances.