2024
Care Provider Manual

Physician, Care Provider, Facility and Ancillary

UnitedHealthcare Community Plan of Massachusetts
UnitedHealthcare Connected® for One Care (Medicare-Medicaid Plan)
UnitedHealthcare Senior Care Options (HMO D-SNP)

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One Care
MassHealth+Medicare
Bringing your care together

United Healthcare®
Community Plan

Welcome

Welcome to the UnitedHealthcare Connected® for One Care and Senior Care Options 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 submit prior authorization requests. This manual also includes important phone numbers and websites on the **How to Contact Us** page. Find operational policy changes and other electronic transactions 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: UHCprovider.com > Resources > Care Provider Administrative Guides and Manuals > Community Plan Care Provider Manuals for Medicaid Plans by State

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

In this manual, we refer to UnitedHealthcare Connected for One Care and UnitedHealthcare Senior Care Options as "UnitedHealthcare Community Plan."

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should utilize the Agreement instead.
If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- "Community Plan" refers to the UnitedHealthcare Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this care provider manual
- Any reference to "ID card" includes a physical or digital card

Thank you for your participation in our program and the care you offer our members.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	Senior Care Options: **1-888-867-5511**, TTY 711 One Care: **1-877-790-6543**, TTY 711
Training	**UHCprovider.com/training** Chat with provider services: **UHCprovider.com** > Sign in > Contact Us	
UnitedHealthcare Provider Portal	**UHCprovider.com,** then Sign In using your One Healthcare ID. Or go to **UnitedHealthcare Provider Portal Self Service**. New users: **UHCprovider.com > New User and User Access**	Senior Care Options: **1-888-867-5511**, TTY 711 One Care: **1-877-790-6543**, TTY 711
CommunityCare Provider Portal Training	**CommunityCare Provider Portal User Guide**	
Resource Library	UHCprovider.com > Resources > **Resource Library**	

UnitedHealthcare Community Plan supports Massachusetts' goals of increased access, improved health outcomes and reduced costs by offering the following dual Medicare and Medicaid benefits:

- Senior Care Options (SCO) is a fully integrated Medicare Advantage Special Needs plan serving members within the UnitedHealthcare SCO service area who are age 65 and older and are dually eligible for Medicare and Medicaid
- Connected for One Care serves adults with disabilities within the UnitedHealthcare Community Plan service area who are age 21 through 64 and are dually eligible for Medicare and Medicaid

If you have questions about the information in this manual or about our policies, please visit **UHCprovider.com** or call **Provider Services** for SCO at **1-888-867-5511** and Connected for One Care at **1-877-790-6543.**

How to join our network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information. If you are interested in joining the Long-Term Support Services network, email **maph_hcbspra@uhc.com**.

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile at UHCprovider.com > Our Network > **Demographics and Profiles.**

Care provider onboarding

Disclosure of Ownership

Federal regulation to collect information from providers participating in the UnitedHealthcare Community Plan of Massachusetts Senior Care Options and/or Connected for One Care managed care networks.

To learn more see: **UHCprovider.com** > content > dam > provider > docs > public > commplan > ma > forms-and-references > MA-Provider-Disclosure-of-ownershipwnership-Forms-FAQs.pdf

21st Century Cures Act

Enroll with MassHealth today to keep billing privileges and avoid termination.

Action required

To fulfill these requirements, all health care professionals contracted with UnitedHealthcare Community Plan of Massachusetts must enroll with MassHealth within 120 days of this notification. This will prevent billing delays and termination from the network.

For further information see: **UHCprovider.com** > content > dam > provider > docs > public > commplan > ma > forms-and-references > MA-21st-Century-Cures-Act-Federal-Requirement-Law-Provider-Notice.pdf

Our approach to health care

The following principles guide the direction and focus of the UnitedHealthcare Community Plan 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 Community Plan program, every member is screened and stratified into a level 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 care plan (ICP) in conjunction with the member's Interdisciplinary Care Team (ICT). Subsequent assessments are conducted on a scheduled basis and also ad hoc whenever a member experiences a significant change in condition. The care coordinator/care manager documents all orientation findings, health assessments, reassessments, and ICP in the member's centralized enrollee record (CER).

For members stratified as highest acuity, a UnitedHealthcare Community Plan care coordinator is assigned to support the member and ICT.

Members in long-term care facilities, the facility staff and the UnitedHealthcare Community Plan 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.

Interdisciplinary Care Team (ICT)

For members with complex medical needs, the UnitedHealthcare Community Plan care model is structured to support a partnership between the ICT, care manager and the member and their family/caregiver through a supportive, primary care team approach. At a minimum, an ICT includes the PCP, care manager, member and family/caregivers. The team may also include behavioral health providers or other specialists. Depending on the member's risk stratification level and primary conditions/needs, the individual serving in the care manager role on the ICT may be a geriatric support services coordinator, behavioral health field care advocate, community health worker, social worker (LICSW), RN care manager, long-term services coordinator (LTS-C), nurse practitioner (NP) or physician assistant (PA). As appropriate, and based on a member's needs, other care providers are included in the member's ICT.

Primary care team members work together to develop and update an integrated ICP, 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 ad hoc meetings, primary care team members review results of initial and ongoing assessments, discuss changes in member status and create new goals, when appropriate.

Care manager and PCP collaboration

Collaboration between the PCP and UnitedHealthcare Community Plan's care manager is critical to our care model success. Our care manager assists the PCP in implementing the ICP, scheduling appointments or arranging for home and community-based services (HCBS). We document in the CER and communicate to the PCP all clinical assessments, member contacts, and ICPs. This exchange of clinical information helps ensure a member's ICP is accurate and addresses their needs.

Compliance

HIPAA mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who handle business electronically.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program. For more information, go to UHCprovider.com > Resources > Resource Library > Patient Health and Safety > **Cultural Competency**.

- **Cultural competency training and education**: Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored with in your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.
- **Translation/interpretation/auxiliary aide services:** You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

  If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

  Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

  Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

  If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to the Virtual Visit.
- **Care for members who are deaf or hard of hearing**: You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides:

- Free aides and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters

  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - It is the care provider's responsibility to assist the member with obtaining interpreter services
- **I Speak language assistance card:** This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.

If you need these services, please call the toll-free member phone number listed on the back of the member's ID card, TTY 711.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual Care Guidelines, local care determination guidelines from CMS Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM) and MassHealth requirements for medical care determinations.

For requests that may not need medical necessity, care managers and utilization management clinicians consult with our medical or behavioral health professionals, as appropriate, to determine the most clinically appropriate decision based on member choice, appropriateness and safety.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our **Digital Solutions Comparison Guide**. Health care professionals in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare **Provider Portal** for maximum efficiency in conducting business electronically.

Application Programming Interface

API is becoming the newest digital method in health care to distribute information to health care professionals and business partners in a timely and effective manner.

API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare **Provider Portal** and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.com/api**.

Electronic Data Interchange

EDI is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses

- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835).

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeEDI**.

Getting started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.
- Contact clearinghouses to review which electronic transactions can interact with your software system.

Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist™ integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

To access the Portal, you will need to **create or sign in using a One Healthcare ID**. To use the portal: If you already have a One Healthcare ID (formerly known as Optum ID), simply go to **UHCprovider.com** and click Sign In in the upper right corner to access the portal. If you need to set up an account on the portal, follow **these steps** to register.

Here are the most frequently used portal tools:

- **Eligibility and benefits** — View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorizations and notifications** — Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty pharmacy transactions** — Submit notification and prior authorization requests for certain medical injectable drugs by selecting the Prior Authorization dropdown in the UnitedHealthcare **https://www.uhcprovider.com/portal**
- You will be directed to Prior Authorization and Notification capability to complete your requests.
- **My Practice Profile** — View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mpp**.
- **Document Library** — Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information on the available correspondence, go to **UHCprovider.com/documentlibrary**.

Go to **UHCprovider.com/portal** to learn more about the portal. You can access self-paced user guides for many of the tools and tasks available in the portal at UHCprovider.com/training > **Digital Solutions**.

5 reasons to use UHCprovider.com

UnitedHealthcare Provider Portal

1 Use self-service to verify eligibility and claims, request prior authorization, provide notifications and access Document Library.

Click "Sign In" in the top right corner of **UHCprovider.com**

Prior Authorization and Notification

2 Request approval for prescriptions, admissions and procedures.

UHCprovider.com/paan

EDI

3 Send batch transactions for multiple members and payers from one place, review claims and submit notifications.

UHCprovider.com/edi

Direct Connect

4 Communicate securely with payers to address errant claims. Email **directconnectsupport@optum.com** to get started.

Policies and Protocols

5 Review guidelines that apply to UnitedHealthcare Community Plan and how you care for our members.

UHCprovider.com/policies

Find more information about these online services and more at **UHCprovider.com** – your hub for online transactions, education and member benefit information.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution time frames.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

All users will access Direct Connect using the Provider Portal. On-site and online training is available.

Email directconnectsupport@optum.com to get started with Direct Connect.

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

Provider Services works closely with all departments in UnitedHealthcare Community Plan.

How to contact us

Topic	Contact	Information
Behavioral, Mental Health & Substance Use/Misuse	Optum providerexpress.com Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit UHCprovider.com/cardiology 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code lists, and more information.
Care Model (Care Management/Disease Management)	Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor Care	myoptumhealthphysicalhealth.com **1-800-873-4575**	We provide members older than 21 with up to 6 visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Sign in to the Provider Portal at UHCprovider.com > Sign In, or go to UHCprovider.com/claims for more information. Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31350 Salt Lake City, UT 84131-0350	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to the Provider Portal at UHCprovider.com > Sign In. Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental	uhcdental.com Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Review dental plan information, check member eligibility, manage dental claims and learn about joining the UHC Dental Provider Network.
Electronic Data Intake (EDI) issues	EDI Transaction Support Form UHCprovider.com/edi ac_edi_ops@uhc.com **1-800-210-8315**	Contact EDI Support for issues.
Eligibility	To access eligibility information, sign in to the Provider Portal at UHCprovider.com > Sign In, or go to UHCprovider.com/eligibility. Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Confirm member eligibility.
Fraud, Waste and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/MAcommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud **1-844-359-7736**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Hearing Services	UHCprovider.com Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Ask about hearing aid services.
Laboratory Services	UHCprovider.com > Our Network > Preferred Lab Network	UnitedHealthcare Community Plan encourages referrals to our Preferred Lab Network laboratories.
MassHealth (Medicaid)	Medicaid.gov 1-800-841-2900	Contact Medicaid directly.

Topic	Contact	Information
Medical Claim, Reconsideration and Appeal	Sign in to the Provider Portal at **UHCprovider.com** > Sign In, or go to **UHCprovider.com/claims** for more information. Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31350 Salt Lake City, UT 84131-03350 Appeals mailing address: **UnitedHealthcare Community Plan** Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-0023	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Assist members with issues or concerns. Available 8 a.m. – 8 p.m. ET, 7 days a week.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.	Self-service functionality to update or check credentialing information.
NurseLine (One Care only)	**1-866-385-6728**	Available 24 hours a day, 7 days a week.
Obstetrics/Pregnancy and Baby Care (One Care members)	Healthy First Steps Sign in to the **Provider Portal** or at **UHCprovider.com** to access the Pregnancy Notification form. **1-800-599-5985** Healthy First Steps Rewards **UHChealthyfirststeps.com**	For pregnant **One Care** members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **UHChealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > **Oncology** Optum **1-888-397-8129** Monday – Friday 7 a.m. – 7 p.m. CT	For current list of CPT codes that require prior authorization for oncology

Topic	Contact	Information
One Healthcare ID Support Center	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-855-819-5909**	Contact if you have issues with your ID. Available 6 a.m.–10 p.m. CT, Monday through Friday; 6 a.m.–6 p.m. CT, Saturday and Sunday.
Pharmacy Services	**professionals.optumrx.com** **1-877-305-8952** (OptumRx)	OptumRx oversees and manages our network pharmacies.
Prior Authorization/ Notification for Pharmacy	UHCprovider.com > Prior Authorization and Notification > **Clinical Pharmacy and Specialty Drugs** **1-800-310-6826**	Request authorization for medications as required. Use the **Provider Portal** to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred Check coverage and price, including lower-cost alternatives.
Prior Authorization Requests/Advanced & Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications" or call Provider Services: Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/prior authorization lists: UHCprovider.com/ MAcommunityplan > **Prior Authorization and Notification**
Provider Relations	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.	A team of provider relation advocates. Ask about contracting and care provider services.
Provider Services	**UHCprovider.com/MAcommunityplan** Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	Available 8 a.m.–6 p.m. ET, Monday through Friday.

Topic	Contact	Information
Radiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit: **UHCprovider.com/radiology** **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Reimbursement Policy	UHCprovider.com/MAcommunityplan > **Current Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates. **Note:** UnitedHealthcare Community Plan of Massachusetts ensures that nonpayment of Serious Reportable Events (SREs), Serious Reportable Adverse Events (SRAEs) and Provider Preventable Conditions (PPCs) will not prevent access to care and continued service for our members.
Technical Support	Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **1-866-209-9320** (Optum support) **1-866-842-3278** option 1 (web support)	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare **modivcare.com** 1-866-428-1967	To arrange non-emergent transportation, please contact ModivCare at least 3 business days in advance.

Topic	Contact	Information
Utilization Management	Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM Policies and Protocols, go to: UHCprovider.com > Resources > **Plans, Policies, Protocols and Guides**. Request a copy of our UM guidelines or information about the program.
Vision Services	**One Care MMP** MARCH Vision Care **marchvisioncare.com** 1-844-576-2724	Contact MARCH Vision Care's provider relations department for information on benefits, lab order submissions and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers and federal TINs. Attend a training session on eyeSynergy®. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
	Senior Care Options UnitedHealthcare Vision® **spectera.com** **1-800-638-3120**	
Website for Massachusetts Community Plan	**UHCprovider.com/MAcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: UnitedHealthcare Connected for One Care (MMP)

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com/MAcommunityplan	**1-877-790-6543**, TTY 711
Member Services	myuhc.com	**1-866-633-4454**
NurseLine		**1-866-385-6728**
Dental	uhcdental.com	Senior Care Options:**1-888-867-5511** TTY 711 One Care:**1-877-790-6543** TTY 711
Vision	marchvisioncare.com	**1-844-576-2724**
Healthy First Steps	uhchealthyfirststeps.com	**1-800-599-5985**
Eligibility	UHCprovider.com/eligibility	**1-877-790-6543**, TTY 711
Provider Directory	UHCprovider.com > Our Network > Find a Provider	

Member eligibility

UnitedHealthcare Community Plan of Massachusetts Connected for One Care is for adults with disabilities ages 21-64 who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Community Plan service area.

Members include adults with the following conditions:

- Physical disabilities
- Intellectual or developmental disabilities (ID/D)
- Serious mental illness (SMI)
- Substance use disorders (SUD)
- Disabilities with multiple chronic illnesses or functional or cognitive limitations
- Homeless members with disabilities

Members must be eligible for MassHealth Standard or MassHealth CommonHealth, enrolled in Medicare Parts A and B and eligible for Medicare Part D, and are without other comprehensive public or private insurance.

The Massachusetts Executive Office of Health and Human Services (EOHHS) determines enrollment eligibility.

Verify member enrollment

Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Check Eligibility and Benefits on the Provider Portal by clicking Sign In in the top right corner of UHCprovider.com, then select Eligibility and Benefits
- Call One Care Provider Services at **1-877-790-6543**, TTY 711.
- Go to MassHealth at mass.gov > Check member eligibility

Member ID card

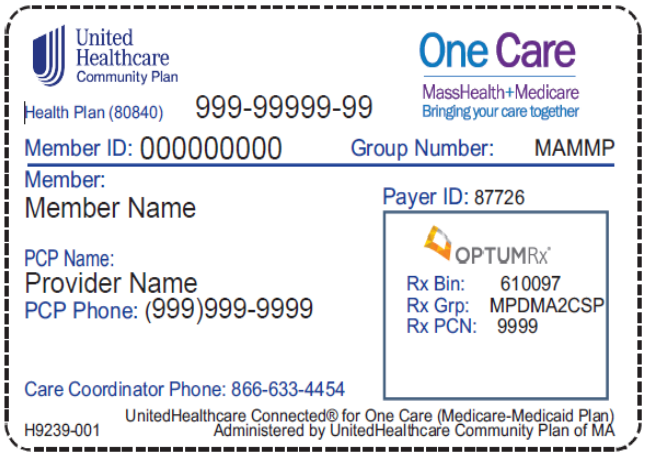
Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

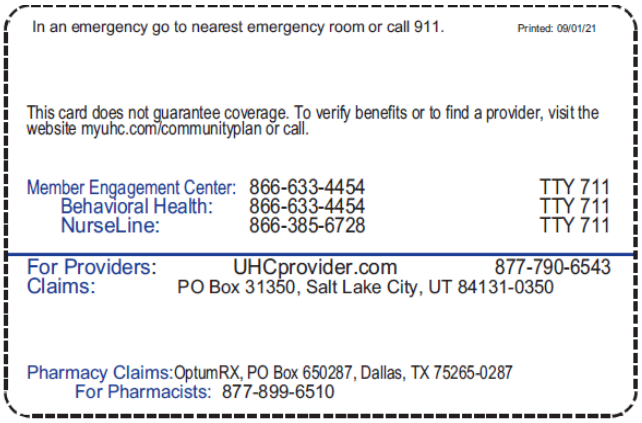
The member's ID card shows the PCP assignment on the front of the card. If a member does not bring their card, call **Provider Services** at **1-877-790-6543**, TTY 711 and document the call in the member's chart.

Member identification number

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Massachusetts EOHHS Medicaid Number is also on the member ID card.

Sample member ID card





Covered services

The One Care plan offers the following services:

- Participation in initiatives, processes and activities of member-affiliated EOHHS agencies. Such agencies include, but are not limited to:
  - Department of Developmental Services (DDS)
  - Department of Mental Health (DMH)
  - Department of Public Health and Bureau of Substance Addiction Services (DPH/BSAS)
  - Massachusetts Commission for the Blind (MCB)
  - Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH)
  - Massachusetts Rehabilitation Commission (MRC)
  - Executive Office of Elder Affairs (EOEA)
- Preventive health care services
- Family planning services
- Systems designed to make members' medical history and treatment information available, within applicable legal limits, at the various sites where the same member may be seen for care, especially for members identified as homeless.

For more information about specific One Care member benefits, go to **UHCCommunityPlan.com/MA** or UHCprovider.com > **Eligibility and Benefits**.

Services not subject to prior authorization

UnitedHealthcare Community Plan does not require prior approval for the following One Care plan services:

- Any emergency medical services, including behavioral health emergencies
- Urgent care outside of the service area
- Urgent care under unusual or extraordinary circumstances in the service area when the contracted care provider is unavailable or inaccessible
- The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand or generic formulations
- Family planning services
- Renal dialysis services outside of service area
- Inpatient SUD services if medically necessary
- Acute treatment services (ATS) for SUD if medically necessary
  - You must notify us within 48 hours of a member's admission
- Clinical support services (CSS) for SUD
  - You must notify us within 48 hours of a member's admission
- Outpatient services for covered SUD treatment services
- Day treatment: Structured Outpatient Addiction

Program (SOAP)
- Intensive outpatient program (IOP)
- Partial hospitalization for American Society of Addiction Medicine (ASAM) level 2.5, with short-term day or evening mental health programming
- Transitional support services (TSS) for SUDs

Dental

UnitedHealthcare Community Plan covers dental checkups and preventive dental services. Refer to the Dental Provider Manual for applicable exclusions, limitations and covered services. Standard ADA coding guidelines apply to all claims.

For more details, go to uhcdental.com.

To find a dental provider, go to UHCprovider.com > Our Network > Find a Provider > Dental Providers by State, Network or Location.

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. The member's use of family planning and reproductive health services remains confidential and is not disclosed to family members or unauthorized parties without the member's consent.

UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- HIV/STD counseling and risk reduction practices
- Laboratory services

Blood tests to determine paternity are covered **only** when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact MassHealth to verify state coverage.

Voluntary sterilization

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the EOHHS Regulations for more information on sterilization.

Hysterectomies

Hysterectomies cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.

Find the form on mass.gov.

Exception: Massachusetts EOHHS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before

the procedure. You must also state the cause of the sterility.

2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

A member has only given informed consent if the Massachusetts Department of Social Services Medical Assistance Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The Massachusetts Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on mass.gov.

Have 3 copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Home and community-based services

Home and community-based services (HCBS) are health care and supportive services provided to members with functional limitations or chronic illnesses for members who want to remain in the community and avoid long-

term placement. They help members with routine daily activities such as bathing, dressing, preparing meals and taking medications. Benefits include the following:

- Adult foster care
- Adult day care
- Health care rehabilitation
- Home-delivered meals
- Group foster care
- Home health aide
- Personal care attendant
- Personal emergency response services

Community-based organizations

Community-based organizations (CBOs) are local agencies that manage HCBS and coordinate designated social services for Connected for One Care members. These agencies include aging service access points (ASAPs), independent living centers (ILCs) and recovery learning centers (RLCs). Long-term support coordinators from the CBOs coordinate HCBS, community and social support services with CBOs.

To request HCBS services, members may call Member Services. A care team member will determine eligibility using the appropriate functional assessments and approve HCBS services based on the member's needs and functional status. Services include the following:

- Information and referral
- Interdisciplinary case management
- Intake and assessment
- Development, implementation and monitoring of service plans
- Reassessment of needs
- Investigation of abuse and neglect

Visit these websites for more information about:

ASAPs: **Aging Services Access Points (ASAP) | Mass.gov**

RLCs: **Mass.gov**

Or email your HCBS provider relations advocate at **mahp_hcbspra@uhc.com**.

Maternity/pregnancy/well-child care

Pregnancy Notification Risk Screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Access the digital Notification of Pregnancy form on the Provider Portal at **UHCprovider.com**. You may also call Healthy First Steps at **1-800-599-5985** or fax the notification form to 1-877-353-6913.

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs

Program staff act as a liaison between members, care providers, and United Healthcare for care coordination.

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-877-790-6543, TTY 711** or go to or go to **UHCprovider.com/paan.** For more information about prior authorization requirements, go to UHCprovider.com/MAcommunityplan > **Prior Authorization and Notification**.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. The woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. If she has an established relationship with a non-participating obstetrician.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB-GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Pregnancy termination services

Pregnancy termination services over 24 weeks are not covered, except in cases to preserve the woman's life. In this case, follow the Massachusetts consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member's PCP. Members must use the UnitedHealthcare Community Plan care provider network.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or by calling **1-877-790-6543, TTY 711**.

Provide the following information within 1 business day of the admission:

- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number, care provider ID
- Facility name (care provider ID)
- Vaginal or cesarean delivery

If available at time of notification, provide the following birth data:

- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name

Newborn/infant care is not covered by One Care

MassHealth requires care providers to assist in enrolling newborns into an alternative MassHealth program. The care provider delivering the newborn must download and complete a **Notification of Birth (NOB) form** and fax it to MassHealth's NOB unit at 617-887-8777. Submit

the NOB form as soon as possible after birth and no later than 10 days after birth whenever possible. Newborns will be retroactively enrolled in the MassHealth program effective on date of birth.

Vision

Vision services are covered by March Vision Care. Please see the Reference Guide at **marchvisioncare.com** for information such as compliance, electronic payment information, safety resources and training or call 1-844-576-2724.

Value-added services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **1-877-790-6543, TTY 711** unless otherwise noted.

Foot care (routine)

Up to 6 foot care visits per year with $0 copay to help keep feet healthy with routine exams and preventive care.

HouseCalls

Yearly check-ups at home to help stay up-to-date on the member's health between regular doctor's visits at no extra cost.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy.

Call **1-866-385-6728** to reach a nurse.

Quit for Life®

The Quit For Life® Program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching, and web-based learning tools, the Quit For Life Program produces an average quit rate of 25.6% for a Medicaid population. It also has an 88% member satisfaction. Quit for Life is for members 18 years and older.

Telehealth

- Virtual provider visits to discuss medical concerns, get a diagnosis and treatment for non-emergency conditions
- Virtual mental health visits to get a private evaluation and treatment for general mental health conditions

UHC Latino

Latino | UnitedHealthcare (uhc.com), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Chapter 3: UnitedHealthcare Senior Care Options (HMO D-SNP)

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com/MAcommunityplan	**1-888-867-5511**, TTY 711
Member Services	myuhc.com	
Member Enrollment Guide	UHCCommunityPlan.com/MA > Go to Plan Details > Scroll Down (right sidebar) > Enrollment Kit	
Dental	dbp.com	1-855-812-9210
Vision	spectera.com	1-800-638-3120
Eligibility	UHCprovider.com/eligibility	**1-888-867-5511**, TTY 711
Provider Directory	UHCprovider.com > Our Network > Find a Provider	

Member eligibility

UnitedHealthcare Community Plan of Massachusetts Senior Care Options (SCO) is a fully integrated Medicare Advantage Special Needs Plan, serving members who are age 65 and older, and are dually eligible for Medicare and Medicaid within the UnitedHealthcare SCO service area.

UnitedHealthcare Community Plan SCO is currently available in the following counties: Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties.

Members of UnitedHealthcare Community Plan SCO must meet the following qualifications:

- Must be entitled to Medicare Part A and be enrolled in Medicare Part B
- Must be entitled and enrolled in Medicaid Title XIX benefits, specifically MassHealth Standard
- Must reside in the UnitedHealthcare Community Plan SCO service area
  - A member must maintain a permanent residence within the service area, and must not reside outside the service area for more than 6 months

Some members may be eligible for SCO if they are not eligible for Medicare Parts A or B.

Verify member enrollment

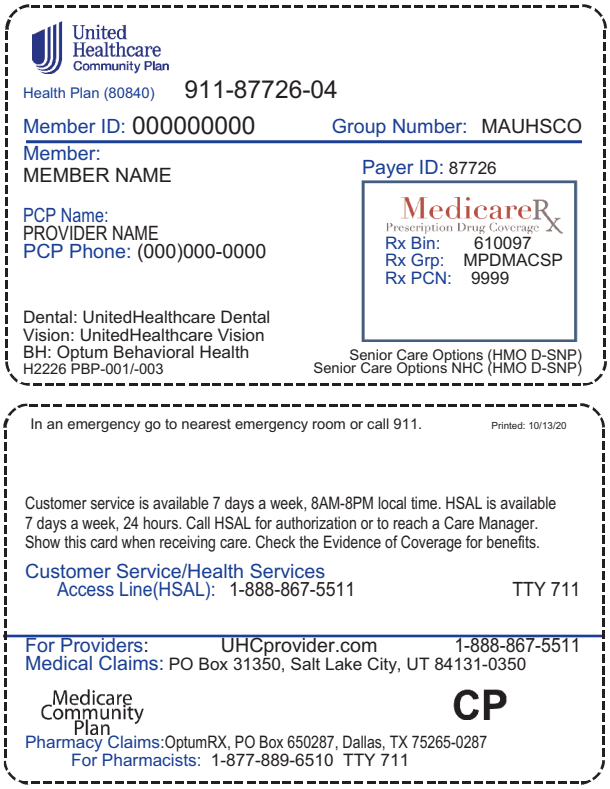
Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Check Eligibility and Benefits on the Provider Portal by clicking Sign In in the top right corner of UHCprovider.com, then select Eligibility and Benefits
- Call Provider Services.
- Go to MassHealth at mass.gov > Check member eligibility

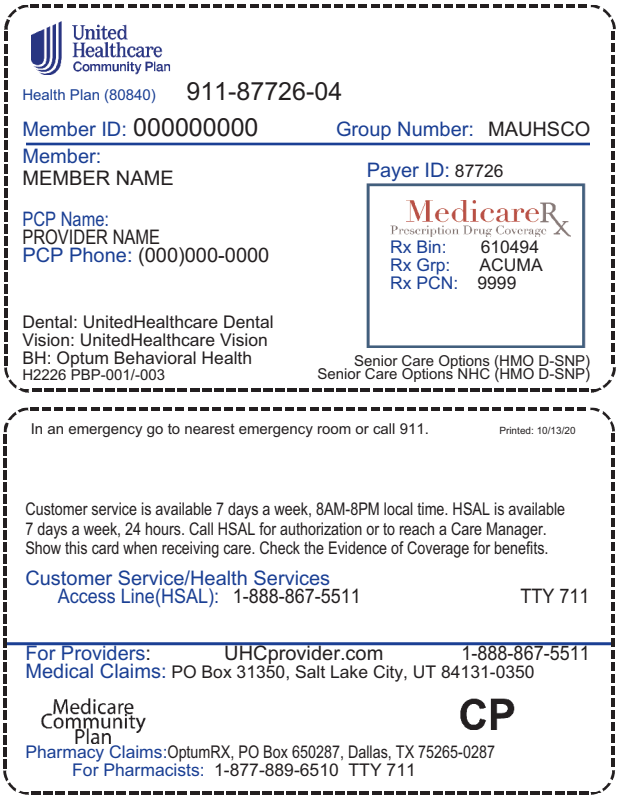
Member ID card

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

Sample member ID card - Medicaid



Sample member ID card - Dual members



Covered services

Coverage includes Medicare Part A and Part B, MassHealth and some additional benefits that are offered as part of the UnitedHealthcare Community Plan Senior Care Options plan.

For a list of covered services, refer to the Evidence of Coverage at UHCCommunityPlan.com/MA > Senior Care Options > Evidence of Coverage.

Aging services access points

ASAPs are local agencies that provide HCBS and benefits for SCO. The ASAP's geriatric support services coordinators manage community long-term care and social support services for SCO members.

Members' case managers determine eligibility using the appropriate functional assessments.

For more information about ASAPs, go to Aging Services Access Points (ASAP) | Mass.gov or email your HCBS provider relations advocate at mahp_hcbspra@uhc.com.

Dental services

A dental provider manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers dental check-ups and preventive dental services including implants.

Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims.

For more details, go to: uhcdental.com.

To find a dental provider, go to UHCprovider.com > Our Network > Find a Provider > Dental Providers by state, network or location.

Long-term support services

Long-term support services (LTSS) are HCBS that help provide health care and supportive services to members with functional limitations or chronic illnesses. It helps pay for services provided to members so they can remain safely in their own home. The types of services included through LTSS are:

- Housecleaning
- Meal preparation
- Laundry
- Grocery shopping
- Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

LTSS allows members to self-direct care through selection, hiring, supervising, training and terminating caregivers(s).

Eligibility – Members must be older than 65 years of age, or disabled, or blind. Additional eligibility requirements:

- Massachusetts resident physically residing in the United States
- Meet Medicaid recipient eligibility criteria
- Reside in own home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home")

Referral – Anyone may initiate an LTSS application on behalf of a member. Adult members are encouraged to self-refer by calling their UnitedHealthcare Community Plan care manager.

Assessment and Approval – The member's care manager will assess for LTSS services in accordance with state guidelines. We will notify the member if services are approved or denied.

Vision

Vision services are covered by UnitedHealthcare Vision®.

Phone: 1-800-638-3120

- 8 a.m. - 11 p.m. ET, Monday - Friday
- 9 a.m. - 6:30 p.m., Saturday

Online: spectera.com

Value-added services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at 1-888-867-5511, TTY 711 unless otherwise noted.

Adult pain management/chiropractic services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

We provide SCO members with up to 20 visits per calendar year without prior authorization.

Use the following steps to access the fee schedules online:

1. Go to myoptumhealthphysicalhealth.com.
2. Enter your provider ID & password.
3. Click "Tools & Resources."
4. Click "Plan Summaries" or "Fee Schedules."

For more information on chiropractic care, go to myoptumhealthphysicalhealth.com or call 1-800-873-4575.

Fitness program

Renew Active™ is a fitness program for body and mind to help stay active, at a gym or from home, at no additional cost.

Foot care (routine)

Up to 6 foot care visits per year with $0 copay to help keep feet healthy with routine exams and preventive care.

HouseCalls

Yearly check-ups at home to help stay up-to-date on your health between regular doctor's visits at no extra cost.

OTC+Healthy Food

$90/month on a prepaid card for over-the-counter products and healthy food at many retailers or online for home delivery.

Telehealth

- Virtual provider visits to discuss medical concerns, get a diagnosis and treatment for non-emergency conditions.
- Virtual mental health visits to get a private evaluation and treatment for general mental health conditions.

UHC Latino

Latino | UnitedHealthcare (uhc.com), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Chapter 4: Care provider standards and policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	**Senior Care Options:** 1-888-867-5511, TTY 711 **One Care MMP:** **1-877-790-6543**, TTY 711
Eligibility	UHCprovider.com/eligibility	**Senior Care Options:** **1-888-867-5511**, TTY 711 **One Care MMP:** **1-877-790-6543**, TTY 711
Provider Directory	UHCprovider.com > Our Network > Find a Provider	**Senior Care Options:** **1-888-867-5511**, TTY 711 **One Care MMP:** **1-877-790-6543**, TTY 711

General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services. Providers cannot refuse services to a member because the member has an outstanding debt with the provider from before the member joined the One Care Plan.

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

You may use the care provider demographic information update form for demographic changes or to update NPI information for care providers in your office. This form is located at UHCprovider.com > Resources > Demographics and Profiles > My Practice Profile > **Care Provider Paper Demographic Information Update Form**.

Provide notice of care provider panel closing

When closing a practice to new UnitedHealthcare Community Plan members or other new patients, you should:

- Give us prior written notice that the practice will be closing to new members as of the specified date
- Keep the practice open to our members who were members before the practice closes
- Close the practice to all new patients including private payees, commercial or governmental insurers
- Give us prior written notice of the practice reopening, including a specified date

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals.

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com > Our Network > **Find a Provider**

Obtain a Medicaid ID number

The federal 21 Century Cures Act requires you to enroll with MassHealth and have a Medicaid ID number, even if you will not submit claims to and receive payments directly from them. Provide your 10-digit MassHealth Medicaid ID number to us during contracting, credentialing and/or recredentialing.

You must be enrolled with MassHealth once your contracting process with us is complete. If you are not enrolled, you will be sent details on how to do so. This may include submitting a non-billing contract through **mass.gov**. If you do comply with this federal requirement, we may terminate our contract with you.

Change an existing TIN or add a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > **Form W-9**
- Download the Care Provider Demographic Information Update Form using the Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile
- To update your care provider information online, go to the Provider Portal at **UHCprovider.com** > Sign In > My Practice Profile

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the demographic change request form.

Update your practice or facility information

You can update your practice information through the Provider Portal on UHCprovider.com. Go to UHCprovider.com, then Sign In > My Practice Profile. Or submit your change by completing the Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by States government agencies and professional specialty societies. See Chapter 9 for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's protocols, including those contained in this manual.

You may view protocols at UHCprovider.com.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference Chapter 8 for Medical Record Standards.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

UnitedHealthcare Community Plan reserves the right to audit medical records for the presence of advanced directives.

Notification of Medicare Non-Coverage

Home health agency (HHA), skilled nursing facility (SNF) and comprehensive outpatient rehabilitation facility (CORF) notification requirements

You must deliver required Notice of Medicare Non-Coverage (NOMNC) to our members before their Medicare-covered service(s) of SNF, HHA or CORF services end. The NOMNC informs members the date coverage ends and how to appeal the decision or request more information.

Based on the determination by UnitedHealthcare Community Plan on when services should end, the SNF, HHA or CORF is responsible for delivering the NOMNC no later than 2 days before the end of coverage.

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. Admission denial to a SNF, HHA or CORF
3. Denial of non-Medicare covered services
4. A reduction or termination of services that do not end the skilled stay

If the member decides to appeal the end of coverage, they must contact the quality improvement organization (QIO) no later than noon on the day before services are to end to request a review.

The Massachusetts QIO is MassPro:

- Phone: 1-866-815-5440
- TTY: 1-866-868-2289
- Appeal fax number: 1-855-236-2423
- Review fax number: 1-844-420-6671

UnitedHealthcare Community Plan will issue a Detailed Explanation of Non-Coverage (DENC) to the member only if they request an expedited determination. The DENC will explain why services are ending.

For more information about instructions, notification requirements and to download the NOMNC form, see Chapter 11 of the Care Provider Administrative Guide for Commercial and Medicare Advantage or visit cms.gov > Medicare.

Appeal process for care provider participation decisions

Participating care providers

If UnitedHealthcare Community Plan suspends, terminates or does not renew your participation status, we must:

- Give you written notice of the action reasons, including, if relevant, the standards and profiling data used to evaluate you, and the numbers and mix of care providers needed by us
- Allow you to appeal the action to a hearing panel, and give you written notice of your right to a hearing, the process and timing for requesting a hearing
- Help ensure the majority of the hearing panel members are peers of yours

If a suspension or termination is the result of quality of care deficiencies, we 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 as required by law.

If you use subcontracted care 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 Community Plan, federal and state requirements

Other care providers

UnitedHealthcare Community Plan decisions subject to appeal include those about reduction, suspension or termination of your participation resulting from quality deficiencies.

We will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body as 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 PCP, UnitedHealthcare Community Plan will notify members who are patients of that PCP of the termination. For all other care providers, we 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 termination reason. Members may call Member Services to change their PCP. Otherwise, we will assign one.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for 1 year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for 1 year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

CMS and state of Massachusetts reporting requirements

UnitedHealthcare Community Plan must abide by CMS and the state of Massachusetts reporting requirements. You must provide any information we need to meet those obligations.

Your agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will investigate your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com/MA**.

Also reference **Chapter 11** of this manual for information on provider claim reconsiderations, appeals, and grievances.

Access to care and appointment availability standards

Use the following appointment availability guidelines to help ensure timely access to medical and behavioral health care.

Primary care

PCPs will provide coverage 24 hours a day, 7 days a week. When you are unavailable to provide services, you must ensure another participating care provider is available.

You must provide after-hours access to respond to emergency phone calls within 30 minutes and urgent phone calls within 1 hour.

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

- **Emergency care:** Immediately or referred to an emergency facility (24 hours a day, 7 days a week)
- **Urgent care:** Within 48 hours
- **Non-symptomatic office visits:** Within 30 calendar days
- **Individuals with disabilities:** Physical and phone access required. You must make reasonable accommodations to ensure physical and/or communication barriers do not inhibit access to care.
- **All other care:** Within 14 calendar days

You should see a member within 30 minutes of a scheduled appointment, or inform them of the reason for delay and provide them with an alternate appointment.

Specialty care

Specialists should arrange non-symptomatic appointments within 30 working days of request/referral.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for One Care members during:

- First and second trimester: Within 7 calendar days of request
- Third trimester: Within 3 days of request
- High-risk: Within 3 calendar days of identification of high risk

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

We will monitor your access guidelines' adherence through office site visits, long-term care visits and by tracking complaints and grievances related to access and/or discrimination. Network management will review deviations from the policy for educational and/or counseling opportunities, and track for your recredentialing.

Provider directory

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our care provider directory after 10 business days.

If we receive notification the directory information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of incorrect provider information. We are required to confirm your information.

To help ensure we have your most current provider directory information, submit applicable changes to:

For delegated providers: Email your changes to delprov@uhc.com.

For non-delegated providers: Visit UHCprovider.com for the Care Provider Demographic Change Submission Form and further instructions.

Online provider directory

The medical, dental and mental health care provider directory is located at UHCprovider.com. Click Our Network, then Find a Provider.

Provider attestation

Confirm your data every quarter through the Provider Portal at UHCprovider.com or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access the My Practice Profile tool in the Provider Portal to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Requirements for PCP and specialists serving in PCP role

PCPs are an important partner in the delivery of care, and the Massachusetts EOHHS members may seek services from any participating care provider. The Massachusetts EOHHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP may provide integrated primary care and behavioral health care. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs)* and physician assistants (PAs)* from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Obstetrics/gynecology

Senior Care Options: These care providers must have a minimum of 2 years' geriatric experience.

*NPs may enroll with the state as solo providers, but PAs cannot. PAs must be part of a group practice.

Members may change their assigned PCP by contacting Member Services at any time during the month. Customer service is available 8 a.m.–8 p.m. ET, Monday through Friday.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs 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 would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

Consult with other appropriate health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1 MD practice and at least 30 hours per week for a 2 or more MD practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of PCPs and specialists serving in PCP role

In addition to meeting the requirements for all care providers, PCPs must:

- Offer office visits on a timely basis, according to the standards outlined in the Access to care and appointment availability section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate
- Render services to members who have acquired the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in the same manner and extent as other members, and under their contract compensation terms
- Provide overall clinical direction and serve as a central point of service integration and coordination

PCP checklist

- Verify eligibility and benefits on **UHCprovider.com**. Click "Sign In" in the top right corner to access the Provider Portal, or call Provider Services.
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/paan**.
- Refer patients to UnitedHealthcare Community Plan participating specialists when needed.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

- Provide medical oversight to the care management process and be fully aware of all ICP-delivered services
- Provide primary care, acute and preventive care services
- Work with the primary care team to maintain the CER
- Work with the UnitedHealthcare Community Plan care manager to lead the primary care team meetings for members with complex medical needs
- Create and maintain an ICP with the primary care team/care manager, including establishing goals with the member
- Admit UnitedHealthcare Community Plan members only to contracted hospitals unless
  - Prior authorization for admission to another facility has been obtained from us; or
  - The member's condition is emergent
- Obtain prior authorization for all hospital admissions. Coordinate their medical care while they are hospitalized
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards, CMS and the state of Massachusetts requirements
- Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the Massachusetts EOHHS access and availability standards **referenced earlier in this chapter** for scheduling emergency, urgent care and routine visits
- Maintain licenses, certifications, permits or other prerequisites as required by law, regulation and policy to provide covered services. Submit evidence that each is current and in good standing upon our request

Rural health clinic, federally qualified health center or primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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.

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to

UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the Massachusetts EOHHS access and availability standards for scheduling routine visits
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Prenatal care provider responsibilities

Pregnant UnitedHealthcare Community Plan Connected for One Care (MMP) members should only receive care from UnitedHealthcare Community Plan One Care participating providers.

Access the digital Notification of Pregnancy form on the Provider Portal at **UHCprovider.com**. You may also call Healthy First Steps at **1-800-599-5985** or fax the notification form to 1-877-353-6913.

Ancillary provider responsibilities

Ancillary providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary provider checklist

- Verify the member's enrollment before rendering services. Sign in to the Provider Portal at **UHCprovider.com** or contact Provider Services.
- Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/paan**.
- Identify and bill other insurance carriers when appropriate.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at UHCprovider.com > Sign In. The portal requires a unique user name and password combination to gain access.

1. Go to UHCprovider.com.
2. Select Sign In in the top right.
3. Log in.
4. Click on Community Care on your Provider Portal dashboard.

The CommunityCare roster has member contact information, clinical information to include HEDIS measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individuals practitioner level or TIN level.

You may also use Document Library for member contact information in a PDF at the individual practitioner level.

For more information about CommunityCare, including a user guide, go to UHCprovider.com > Resources > UnitedHealthcare Provider Portal Resources and then scroll down to Community Care.

Choosing a PCP

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Deductibles/copayments

Deductibles and copayments are waived for covered services.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet members' basic health needs
- Cost-efficient and appropriate for the covered services

Member assignment

Assignment to UnitedHealthcare Community Plan

Massachusetts EOHHS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. Massachusetts EOHHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Enrollment Guide. The Guide explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Enrollment Guide at UHCCommunityPlan.com/MA > Go to Plan Details > Scroll down (right sidebar) > Enrollment Kit.

PCP-initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, call the Member Services number on the back of the member's card or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   950 Winter Street, Suite 3800
   Waltham, MA 02451
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

We will determine reasonable cause for a transfer based on your submitted written documentation. You may not transfer a member to another participating care provider due to the member's covered services costs.

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

UnitedHealthcare Dual Complete (D-SNP)

D-SNP is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to uhc.com > Community Plan > D-SNP > **What is a D-SNP?**

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the **UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Special Needs Plans)**

Chapter 5: Medical management

Key contacts

Topic	Link	Phone Number
Prior Authorization	UHCprovider.com/paan	**Senior Care Options:** **1-888-867-5511**, TTY 711
		One Care MMP: **1-877-790-6543**, TTY 711
Pharmacy	professionals.optumrx.com	**1-877-305-8952**
Transportation	modivcare.com	**1-866-428-1967**

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Non-emergent air ambulance requires prior authorization.

For authorization, go to UHCprovider.com/paan or call Provider Services.

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health
- Impairment to bodily functions
- Dysfunction of a bodily organ or part

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled runs and transports to nursing facilities or the member's residence.

Non-emergent ambulance transportation

UnitedHealthcare Community Plan members may get non-emergent stretcher/ambulance transportation services through ModivCare for covered services. Members may get transportation when they are bed-confined before, during and after transport.

Non-emergent stretcher/ambulance transportation must be requested at least 3 business days in advance. Go to modivcare.com or call 1-866-428-1967.

Schedule non-emergent ambulance or stretcher rides up to 30 days in advance.

Non-emergency medical transportation (NEMT)

Non-emergency medical transportation services are arranged by ModivCare. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

NEMT must be requested at least 3 business days in advance. Go to modivcare.com or call 1-866-428-1967.

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants)

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone.

- Online: UHCprovider.com/cardiology. Select the Go to Prior Authorization and Notification Tool
- Phone: 1-866-889-8054, 7 a.m.–7 p.m. local time, Monday through Friday

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to UHCprovider.com/cardiology > Specific Cardiology Programs.

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the

member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Centralized enrollee record

We use centralized enrollee records (CER), making access to clinical information available 24 hours a day, 7 days a week. The CER is a centralized and comprehensive medical record detailing illnesses and chronic medical conditions. We use an electronic documentation system that stores our CERs. This technology helps to support and store care coordination documentation within the CER.

You can find the following records in the CER:

- Medical history
- Problem list
- Hospitalizations and surgeries
- Medications
- Progress notes
- Specialty referrals and evaluations
- Lab results

We enable continuous access to the CER by:

- Creating an electronic or fax CER summary accessible by clinicians and the primary care team for clinical decision-making
- Working with you to help ensure the medical records in your office have relevant clinical information from our care management system
- Establishing protocols for the primary care team to store information in the CER

To coordinate information access and improve record keeping:

- Help ensure HIPAA compliance
- Link the care manager and primary care team to the summary CER after medical encounters

Discharge planning

UnitedHealthcare Community Plan will assist you and hospitals in the inpatient discharge planning process. At the time of admission and during hospitalization, our medical management staff may discuss discharge planning with you, the member or their family.

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

See our Coverage Determination Guidelines at UHCprovider.com > Resources > Plans, Policies, Protocols and Guides > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plans**.

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and other care by in and out-of-network care providers.
- Medical examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services
- Emergency ground and air transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision, or if it does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called post-stabilization services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services**.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.).

The criteria are available in writing upon request or by calling **Provider Services**.

For policies and protocols, go to UHCprovider.com > Resources > Plans, Policies, Protocols and Guides > **For Community Plans**.

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

All elective inpatient admissions require prior authorization from UnitedHealthcare Community Plan.

Facility admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Inpatient concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. We perform an electronic medical record (EMR) review or fax review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 24 hours or next business day following admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. We perform a concurrent review by EMR or fax.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to EMR.

Your cooperation is required with all UnitedHealthcare Community Plan requests from our 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.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member

We don't consider experimental treatments medically necessary.

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair.

Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. EOHHS covers residential inpatient hospice services. EOHHS will cover hospice provider benefits for both the hospice services provided and the facility residential services.

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to UHCprovider.com > Our Network > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment (CLIA) number. Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and Submission** chapter for more information.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com > Resources > Plans, Policies, Protocols and Guides > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan**.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat Opioid Use Disorders (OUD). The Food and Drug Administration (FDA) approved medications for OUD include Buprenorphine, Methadone and Naltrexone.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT provider in Massachusetts:

1. Go to **UHCprovider.com**
2. Select "Our Network," then "Find a Provider."
3. Select the care provider information
4. Click on "Medical Directory"
5. Click on "Medicaid Plans"
6. Click on applicable state
7. Select applicable plan
8. Refine the search by selecting "Medication Assisted Treatment"

If you have questions about MAT, please call Provider Services at **1-888-867-5511, TTY 711 (SCO)** or **1-877-790-6543, TTY 711 (One Care)** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Personal care attendant program

UnitedHealthcare Community Plan expects all personal care attendants (PCAs) and transitional living providers participating in MassHealth, as well as all personal care management (PCM) agencies and fiscal intermediaries under contract with MassHealth, to comply with all MassHealth rules, regulations and policies.

Refer to your provider contract and state transmittal letters at **mass.gov/masshealth** for contractual obligations. Refer to the **Personal Care Attendant Services Manual** for regulations and requirements of the MassHealth PCA program.

Oncology

Prior authorization

To help ensure our member benefit coverage is medically appropriate, we regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence, published clinical guidelines and specialty society guidance.

For information about our Oncology prior authorization program, including radiation and/or chemotherapy guidelines, requirements and resources, go to UHCprovider.com > **Prior Authorization** or call Optum at 1-888-397-8129 Monday – Friday 7 a.m.–7 p.m. CT.

Pharmacy

In most cases, member prescriptions are covered if the drugs are listed on our formulary and only if they are filled at a network pharmacy. Generally, we only cover drugs filled at an out-of-network pharmacy when a network pharmacy is not available. The following list includes, but is not limited to, examples of when we would cover prescriptions filled at an out-of-network pharmacy.

1. If the prescriptions are related to a medical emergency or urgently needed care. Members will need to pay the full cost when filling their prescription and submit the bill for reimbursement with the appropriate documentation.
2. A member is traveling in the United States, but outside of the plan's service area, and becomes ill, loses or runs out of their prescription drugs. The member will need to pay the full cost when filling their prescription and submit the bill for reimbursement with the appropriate documentation.
   - Before submitting a prescription to an out-of-network pharmacy, call Member Services to see if a network pharmacy is in the member's traveling area. If there are no network pharmacies in that area, Member Services may be able to arrange for the member to get their prescription(s) from an out-of-network pharmacy.
3. A member is unable to get a covered drug timely and in our service area because there are no network pharmacies in a reasonable driving distance providing 24-hour service.
4. A member need to fill a covered prescription drug not regularly stocked at an eligible retail network pharmacy (this includes orphan drugs or other specialty pharmaceuticals).

Formulary

UnitedHealthcare Community Plan determines and maintains its list of covered medications. This list applies to all UnitedHealthcare Community Plan of Massachusetts members.

We cover drugs listed on our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or network mail order pharmacy service, and other coverage rules are followed. We have additional coverage requirements or limits for certain prescription drugs.

The formulary drugs include the Medicare Part D formulary drugs and any additional drugs selected by us with the help of a team of health care providers. The formulary includes brand name drugs, generic drugs and over-the-counter (OTC) medications.

The formulary does not include all drugs. In some cases, the law prohibits coverage of certain drug types, or we decide not to include a particular drug. We may add or remove drugs from the formulary at any time.

We will notify the member of formulary changes at least 60 days before the effective date. If a drug is removed from our formulary because it has been recalled from the market, we will not give a 60-day notice before removing the drug from our formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

For **One Care MMP formulary** and **Senior Care Options** drug list**,** go to UHCprovider.com/MAcommunityplan > **Pharmacy Resources and Physician Administered Drugs** > Prescription Drug Lists, Drug Search and Updates.

In addition to drugs covered under Medicare Part D and the MassHealth Drug List, our plan also covers certain OTC and prescription drugs not covered under Medicare Part D.

To view the most current MassHealth drug lists (including OTC and Medicare Part D exclusions), go to **mass.gov/masshealth**.

Pharmacy prior authorization

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-711-4555**. We review expedited requests within 24 hours and standard requests within 72 hours.

Utilization management program

We have additional coverage requirements or limits for certain prescription drugs. A team of doctors and

pharmacists developed the following requirements and limits to help us provide quality coverage to our members. The following are utilization management examples.

- **Prior authorization:** We require our members to get prior authorization for certain drugs. This means you will need to get approval from us before a member fills their prescription. We may not cover the drug if they don't get approval.
- **Quantity limits:** For certain drugs, we limit the drug amount covered per prescription or for a defined period of time.
- **Generic substitution:** Our network pharmacies will automatically give the member the generic version of a brand name drug when its available, unless you specifically prescribe for the brand name drug, stating that generic substitution is not permissible for that particular prescription.
- **Step therapy:** In some cases, we require members to first try 1 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 your request.

Refer to our **formulary** to see if the drugs you prescribe are subject to these additional requirements or limits. You may ask us to make a coverage exception if the drug does have these additional restrictions or limits.

Exception request

Members may ask us to make an exception to our coverage rules, such as:

- Members may ask us to cover a drug not listed on our formulary
- You may request us to waive specific drug coverage restrictions or limits
  - For example, we limit the drug amount we will cover for certain drugs. You can submit a request asking us to waive the limit and/or cover the drug.

Generally, we will only approve an exception request 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.

Call Member Services at **1-888-867-5511, TTY 711 (SCO)** or **1-877-790-6543, TTY 711 (One Care)** 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 you continue to prescribe the drug and it continues to be safe and effective for treating the member's condition.

Specialty pharmacy medications

The specialty pharmacy management program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

Prior authorization

Prior authorization request is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

For requests that may not meet medical necessity, care managers and utilization management clinicians consult with our medical or behavioral health professionals, as appropriate, to determine the most clinically appropriate decision based on member choice, appropriateness and safety.

You should take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify eligibility and benefits on the Provider Portal at UHCprovider.com. Click Sign In in the top right corner or call Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
  1. To access the Prior Authorization and Notification tool, click Sign In in the top right corner of UHCprovider.com.
  2. Select the **Prior Authorization and Notification tool**.
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call the UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/MAcommunityplan > Prior Authorization and Notification

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** within 24 hours, unless otherwise indicated
- **Inpatient Admissions; After Ambulatory Surgery:** 1 business day
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering care provider or health care professional name and TIN/NPI
- Rendering care provider or health care professional and TIN/NPI
- ICD Clinical Modification (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

For behavioral health and substance use disorder authorizations, please contact Optum Behavioral Health.

If you have questions, go to your state's prior auth page: UHCprovider.com/MAcommunityplan > Prior Authorization and Notification Resources.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	As soon as the member's health condition requires but no longer than 14 calendar days after request receipt.	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 72 hours of request receipt	Within 72 hours of request	Within 3 days of the request
Concurrent review	Within 24 hours or next business day following admission	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within 2 business days

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- Online: **UHCprovider.com/radiology** > Go to Prior Authorization and Notification Tool
- Phone: **1-866-889-8054** from 7 a.m. - 7 p.m. local time, Monday through Friday. Make sure the medical record is available.

For a current list of CPT codes that require prior authorization, a prior authorization crosswalk table, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Specific Radiology Programs.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the UnitedHealthcare Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services department, or the MassHealth Medicaid eligibility systemp
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Massachusetts EOHHS. These access standards are defined in **Chapter 4**. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan Senior Care Options at **1-888-867-5511, TTY 711** or UnitedHealthcare Connected for One Care at **1-877-790-6543, TTY 711**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Screening, brief interventions, and referral to treatment (SBIRT) services

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

What is included in SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. 3 of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependence s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.**

SBIRT services will be covered when all are met:

- The billing and servicing provider are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per provider, per year.The SBIRT assessment, intervention, or treatment takes places in 1 of the following places of service:
- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter

For more information about E/M services and outreach, see the Department of Health and Human Services Evaluation and Services online guide at cms.gov.

Services not covered by UnitedHealthcare Community Plan

The following services are not covered under Medicare, MassHealth or the UnitedHealthcare Community Plan program:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are otherwise listed by our plans as covered
- 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
- 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
- Any health care not given by a doctor from our list (except emergency treatment)
- Personal comfort items used in the hospital or skilled nursing facility, such as a phone, television or barber
- Fees charged by a member's immediate relative or members of their household, except as 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, unless it is because of an accidental injury or to improve a malformed part of the body. However, all stages of breast reconstruction are covered 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 char.
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

For more information, refer to the MassHealth benefit chart in the member's EOC at UHCCommunityPlan.com/MA.

Transplant services: Solid and Hematopoietic Stem Cell (HSC)

UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants including the transplant evaluation, work-ups, the transplant procedure with post-care follow-up. Optum manages transplants and you must get prior authorization for the transplant evaluation and transplant episode. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Contact Optum Intake at **1-888-936-7246.** Fax clinical records/notes to: 1-877-814-0488

Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT)

Guidelines for TB screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

Responsibilities

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) and local facilities that provide state-supported TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the Massachusetts Department of Public Health (MDPH) immediately, using either a latent or active TB case reporting form located mass.gov.

You may need to encourage members to complete direct observation therapy (DOT). It can be coordinated through MDPH local clinics.

Utilization management guidelines

Utilization Management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decision may file a UM appeal.

See Appeals in **Chapter 11** for more details.

Chapter 6: Mental health and substance use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	**1-800-888-2998**
Provider Services	UHCprovider.com	Senior Care Options: **1-888-867-5511**, TTY 711 One Care MMP: **1-877-790-6543**, TTY 711

Optum Behavioral Health provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) benefits.

The National Optum Behavioral Health manual is located at providerexpress.com.

This chapter does not replace the national Optum network manual.

You must have an NPI number to see members and receive payment from UnitedHealthcare Community Plan. Because UnitedHealthcare Community Plan One Care and Senior Care Options have both Medicare and Medicaid components for dual-eligible members, you need to have a Medicaid ID for any Medicaid-covered services, and be Medicare-credentialed to provide Medicare-covered services.

How to Join Our Network: Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Role of the behavioral health unit

Optum Behavioral Health is an important resource for care providers when members experience mental health or substance use/misuse problems.

- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours a day, 7 days a week
- Fully supports PCPs with assessment and referrals to mental health and chemical dependence services
- Provides behavioral health case management. (Call the number on the member ID card to contact dedicated One Care 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

Screening for behavioral health problems

PCPs must screen UnitedHealthcare Community Plan members for mental health and substance use/misuse issues. File the completed screening tool in the member's medical record.

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 of the member's mental status, call Optum at **1-800-888-2998**.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance use/misuse diagnoses, symptoms, treatments, prevention and other resources in 1 place.

Inpatient services

24-hour services delivered in a licensed or state-operated hospital setting that provides clinical intervention for mental health and/or SUD diagnoses.

- Inpatient mental health services
- Inpatient SUD services
- Observation/holding beds
- Administratively necessary day services
  - 1 or more days of inpatient hospitalization for members who are clinically ready for discharge but an appropriate setting is not available.

Outpatient services

Mental health and SUD services provided in person in an ambulatory care setting such as a mental health center or SUD clinic, hospital outpatient department, community health center or practitioner's office. Services may also be provided at a member's home or school.

- Family consultation
- Case consultation
- Diagnostic evaluation
- Psychiatric consultation in an inpatient medical unit
- Medication visit
- Couples/family treatment
- Group treatment
- Individual treatment
- Inpatient-outpatient bridge visit
- Acupuncture treatment
- Opioid replacement therapy
- Ambulatory detoxification (ASAM Level 2-WM)
- Psychological testing

Member resources

The website - **liveandworkwell.com** - accessed through a link on **myuhc.com**, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to **providerexpress.com** > Clinical Resources > Live and Work Well (LAWW) clinician center > Mind & Body > Recovery and Resiliency. This page includes tools to help members address mental health and substance use issues.

Eligibility

Verify the member's eligibility on the Provider Portal before treating them. Go to **providerexpress.com** > Transactions > Eligibility & Benefits.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services.

Get prior authorization by going to **providerexpress.com** > Transactions > Authorization Inquiry, or call Provider Services.

Collaboration with other health care professionals

Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:

- Is prescribed medication
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition
- Must transition from 1 behavioral health provider to another

Please talk to your patients about the benefits of sharing essential clinical information. It is also essential to coordinate care with state agencies, including but not limited to, Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole.

Portal access

UHCprovider.com

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services. Use the online services to verify eligibility, review electronic claim submission, view claim status, and submit notifications/prior authorizations.

providerexpress.com

Update your practice information, review guidelines and policies, and view the national Optum Network Behavioral Health Manual. Or call Provider Services at **1-877-614-0484**.

Claims

Submit claims using the 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in **Chapter 10**.

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

Brief summary of framework

- Prevention:
  - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment
- Recovery:
  - Support case management and referral to person-centered recovery resources
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids
- Strategic community relationships and approaches:
  - Tailor solutions to local needs
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it.

For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free SUD/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also

be in need of behavioral health services to address the psychological aspects of pain.

Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at UHCprovider.com > Resources > **Drug Lists and Pharmacy**. Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization and if there are prescription limits.

Drug management program

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances, etc.). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive a limited amount of certain medications and prescriptions from a single pharmacy and/or a single prescriber for at least 1 year.

Expanding medication assisted treatment access and capacity

Evidence-based medication assisted treatment (MAT) is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a behavioral health MAT provider in Massachusetts:

1. Go to **UHCprovider.com**,
2. Select "Our Network," then "Find a Provider."
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "(state)" for options
6. If needed, refine the search by selecting "Medication Assisted Treatment"

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT providers, see the MAT section in **Chapter 5**.

SUD recovery coaching

Our SUD recovery coach works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

Chapter 7: Member rights and responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	myuhc.com	Senior Care Options: **1-888-867-5511**, TTY 711
Member Handbook	UHCCommunityPlan.com/MA	One Care MMP: **1-877-790-6543**, TTY 711

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information (PHI)

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them.

Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCCommunityPlan.com/MA.

Members must be allowed to exercise their rights without having their treatment adversely affected.

Member rights

Members have the right to:

- Request information on advance directives
- Choose an advance directive to designate the care they want to receive if they are unable to express their wishes
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their health care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Receive up to 90 days of continuity of care services, or until a comprehensive assessment and the integrated care plan are completed, reviewed and agreed upon by the member
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Give you a copy of their advance directive

- Use the emergency room only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care
- Follow care to which they have agreed
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible

Chapter 8: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records. - Release only to entities as designated consistent with federal requirements - Keep in a secure area accessible only to authorized personnel

Topic	Contact
Procedural Elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance use/misuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for and appropriate referrals made (if applicable) and/or follow-up documented: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance use/misuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate - Abuse, neglect and exploitation identification

Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

***Critical element**

Member copies

A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 10 years unless federal requirements mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times).
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance use/misuse
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

Chapter 9: Quality management program and compliance information

Key contacts

Topic	Link	Phone Number
Credentialing	**Medical:** Network Management Support Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page. **Chiropractic:** myoptumhealthphysicalhealth.com	N/A
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	**1-844-359-7736**

What is the quality improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate
- Identifying disparities in health and health care and creating initiatives to address these identified disparities

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/ provider advocate.

If you are interested in being a member of the Community Plan's Provider Advisory Committee which meets on the second Thursday of the month 4 times a year, please contact the Director of Quality, Lucille Taylor, at lucille.taylor@UHC.com. A stipend is provided to providers who attend these meetings.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans
- Participation in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, or secure email.
- Practitioner appointment access and availability surveys
- Collaborating with UnitedHealthcare Community Plan and the integrated care team to improve the quality of care you provide to members that is consistent with quality improvement goals

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Collecting data from care providers

UnitedHealthcare Community Plan leverages data from various sources to calculate clinical quality metrics, including:

- Medical, pharmacy and behavioral claim data
- Member enrollment
- Care provider and member demographics
- Electronic medical health records (EMR or EHR)
- Health Information Exchanges (HIE)
- Immunization and other similar registries
- Clinical programs

Certified HEDIS® software is required to develop measures, and deliverables are produced within certified software. A third party Certified HEDIS Auditor audits all data process prior to submission.

Management and oversight of our engagement with the certified HEDIS® software vendor includes contract negotiations, ongoing performance monitoring, access requests, defect resolution, system enhancements and training.

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Town hall meetings

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Member satisfaction

We periodically survey members to measure overall member satisfaction and satisfaction with the care you provide.

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

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Massachusetts statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or another recognized accrediting agency
- Have no Medicare/Medicaid sanctions.

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

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

Go to UHCprovider.com/join to submit a participation request.

For chiropractic credentialing, call **1-800-873-4575** or go to myoptumhealthphysicalhealth.com.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review as required by NCQA standards.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application, chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Failure to meet recredentialing requirements

If you don't meet our recredentialing requirements, we will end your participation with our network. We will send you a written termination notice in compliance with applicable laws, regulations and other requirements.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

UnitedHealthcare Community Plan Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or care coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and **Chapter 11** of this manual.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA.

Otherwise, submit claims using a Clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

National Provider Identifier (NPI)

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 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 educating employees.
- Assessing compliance by monitoring and auditing
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To report questionable incidents involving members or care providers, call our **Fraud, Waste and Abuse line** or go to **uhc.com/fraud**.

Refer to the **Fraud, Waste and Abuse** section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Massachusetts to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the Massachusetts Department of Health and Human Services.

Federal fund laws

Payments you receive for providing services to our members are, in whole or part, from federal funds. You and any subcontractors must comply with laws that apply 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
- The Americans with Disabilities Act (ADA) of 1990

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Massachusetts program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

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

You must cooperate with the state or any of its authorized representatives, the Massachusetts EOHHS, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

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

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

Monitoring audits

We conduct routine care provider on-site audits. These audits focus on the physical environment, policies and procedures, and quality record documentation.

Delegating and subcontracting

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

Critical incidents

We must report critical incidents to the state of Massachusetts within 1 business day. Critical incidents include, but are not limited to:

- Suicide/homicide
- Serious physical injury, including a self-inflicted injury, or unexplained death
- Serious communicable disease required to be reported to health authorities
- Unauthorized use of restraints
- Natural disaster (flood, fire)
- Exposure to hazardous material (including blood-borne pathogens)
- Medication errors
- Mistreatment or allegation of mistreatment of a member including abuse or neglect, emotional harm, sexual or financial exploitation, or any other mistreatment
- Criminal activity/fraud involving care workers or family members impacting the member's health or finances
- Assaults on members causing adverse consequences requiring emergency room treatment or hospital admission
- Any provider or staff assault on a member
- Missing person
- All vehicle accidents involving our transportation vendor, whether resulting in injury or not
- Unsafe living conditions (home not structually sound, not insulated)

Report critical incidents to **Critical_Incident_SCO@uhc.com**, providing as much detail as possible. A state representative may contact you for more details.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and service (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam room(s) for providing member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determine to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determine to pose a risk to patient safety	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Evidence-based medicine/ clinical practice guidelines

UnitedHealthcare SCO and One Care 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** > Clinical Guidelines. Additional provider resources are also available at this site regarding abuse, neglect and exploitation, and appropriate nursing facility institutionalization.

To request a hard copy of these guidelines, call Provider Services. UnitedHealthcare Community Plan randomly conducts chart reviews and audits. Your care provider office may be selected for an audit.

Chapter 10: Billing and submission

Key contacts

Topic	Link	Phone Number
Claims	UHCprovider.com/claims	Senior Care Options: **1-888-867-5511**, TTY 711 One Care MMP: **1-877-790-6543**, TTY 711
EDI	UHCprovider.com/EDI	
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203

Our claims process

For claims, billing and payment questions, go to UHCprovider.com.

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, see the Our Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and DSNP on UHCprovider.com/guides.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call Provider Services.

Your clean claims must include your NPI and federal TIN.

Claims: From submission to payment

1. **You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.**
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

Claims reconsideration and appeals
If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Modifier codes

Use the appropriate **modifier codes** on your claim form. Find our modifier reference policies in our Community Plan Reimbursement Policies by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

We may require additional information for some services, situations or state requirements.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

You must submit your claim within your contracted deadline. Please refer to your Agreement to determine your initial filing requirement.

Claims submitted to us process first against Medicare benefits, where applicable, and then automatically process against Medicaid benefits. You do not need to submit separate claims for the same member.

Mail paper claims to:

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

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as "commercial" through the clearinghouse
- Claim payer ID is 87726
- ERA payer ID: UFNEP

- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms

For more information, see **EDI Claims**.

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices
- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

The companion documents are located on **UHCprovider.com/edi** > Go to companion guides

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our EDI at UHCprovider.com > Resources > Resource Library > Electronic Data Interchange > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, see the Online Resources section in **Chapter 1**.

To find more information about EDI online, go to **UHCprovider.com** > Resources > Resource Library to find Electronic Data Interchange menu.

Electronic payment solutions: OptumPay

UnitedHealthcare Community Plan has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for provider payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Resources, then Resource Library to find the EDI section.

Visit the **National Uniform Claim Committee** website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term "medical group/IPA" interchangeably with the term 'capitated care providers'. Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital, they received emergency room treatment, observation, or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations

UnitedHealthcare Community Plan is the payer of last resort. If a member has coverage with another plan that is primary to Medicare and MassHealth, submit a claim to that health plan first. The amount payable to us will be governed by:

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

When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing care provider's group NPI number is placed in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values.

To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com > Resources > Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan** > Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services
- **Medical practice standards:** Services part of a larger procedure are bundled
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately

Clinical laboratory improvements amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 410-786-3531 or go to the **cms.gov**.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units
- The total bill charge is the unit charge multiplied by the number of units

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims for UnitedHealthcare Community Plan One Care members. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery.
- Use 1 unit with the appropriate charge in the charge column.

Billing guidelines for transplants

UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants including the transplant evaluation and work-ups. Transplants are managed by Optum, and prior authorization must be obtained for the transplant evaluation and episode.

Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Optum Intake phone: 1-888-936-7246
Fax clinicals to: 1-877-814-0488.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP.

National drug code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11–digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

All outpatient and professional claims and encounters must include the “UD” modifier for any claims for drugs purchased through the 340B program provided to members. The required information is necessary to have a clear understanding of the care you provided to our members and to help ensure compliance with the federal Medicaid Drug Rebate Program requirements.

Use the “UD” identifier to the HCPCS for clinician-administered drugs. Always follow Medicare instructions concerning modifiers for drugs purchased through the 340B program if you are required to do so (i.e., for certain dual-eligible members).

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See **Chapter 5** for more information about medical necessity.

You may not charge members for any service if:

1. It is not a medically necessary covered or non-covered service.

2. There are other covered or non-covered services available to meet the member's needs.

The member will not be liable to pay for the provision of any such services. You must document compliance with this provision.

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to UHCprovider.com. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern. Limit phone calls to 5 issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions on the Provider Portal by signing in at UHCprovider.com with your One Healthcare ID. This portal offers you online support any time. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications and allows you to:

- Check member eligibility
- Submit claims reconsiderations
- Review coordination of benefits information
- Use the integrated applications to complete multiple transactions at once
- Reduce phone calls, paperwork

You can even customize the screen to put these common tasks just 1 click away.

Find training on UHCprovider.com/training.

Resolving claim issues

To resolve claim issues, contact Provider Services, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

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

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name
- Date of service
- Claim date submission (within the timely filing period)

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service

All of the above must include documentation the claim is for the correct member and the correct date of

service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

The balance billing amount is the difference between Medicare and MassHealth's allowed charge and your actual charge to the member. Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ
- We deny a claim for late submission, unauthorized service or as not medically necessary
- We are reviewing a claim

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate. Providers cannot refuse services to a member because the member has an outstanding debt with the provider from before the member joined the One Care Plan.

Chat with a live advocate 7 a.m.–7 p.m. CT from the UnitedHealthcare Provider Portal **Contact Us** page.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

Chapter 11: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements. For claims, billing and payment questions got to UHCprovider.com. We no longer use fax numbers. Please use or online options.

The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital Submission and address	Online form for fax or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Original claim resubmission		Care provider	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims	Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to UHCprovider.com, then click Claims.	90 days from date of service or as stated in your contract	30 business days
Claim resubmission	A claim originally denied because of missing documentation and is now being resubmitted with the required information	Care provider		UHCprovider.com/claims	Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	If denied or appealed, follow Medicare process. 90 days from date of denial	45 business days
Corrected claim	A replacement of a previously submitted claim, such as changes or corrections to charges, clinical or procedure codes, dates of service, member information	Care provider		UHCprovider.com/claimss	Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	365 days from date of service or denial, claim completion or provider remittance advice (whichever is later)	45 business days
Claim resubmission after coordination of benefits		Care provider		UHCprovider.com/claimss	Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click Claims.	365 days from date of service or dated in your contract	45 business days

Situation	Definition	Who may submit?	Digital Submission and address	Online form for fax or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim, corrected claim determination which you do not agree	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations see the Reconsiderations and Appeals interactive guide. For those care providers exempted from this requirement, requests may be submitted at the following address **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-800-600-9007** Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday	Use the Claims Management or Claims on the portal. Click Sign in on the top right corner of UHCprovider.com, then click claims	If appeal or dispute, follow Medicare processes. - 120 days from date of payment - 90 days from date of denial	45 business days
Claim formal appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration,	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals see the Reconsiderations and Appeals interactive guide. For those care providers exempted from this requirement, requests may be submitted at the following address **UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007** Senior Care Options **1-888-867-5511** TTY 711 One Care **1-877-790-6543** TTY711 8 a.m. - 8 p.m. ET, Monday - Friday		60 business days	30 business days

The above definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements. UnitedHealthcare Community Plan and its contracted care providers may agree to more stringent requirements within provider agreements than described in the standard process.

Situation	Definition	Who may submit?	Digital Submission and address	Online form for fax or mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Member appeal	A request to change an adverse benefit determination that we made	Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit** P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-0023	UHCprovider.com/claims Member	Call the customer service phone number on the back of the member's ID card		60 business days	Urgent appeals: 72 hours Standard appeals: 30 calendar days
Member grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns	Member • Care provider or authorized representative (such as friend or family member) with written member consent	**UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit** P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-0023		Call the customer service phone number on the back of the member's ID card		N/A	Send a confirmation letteer of received grievance: 1 business day Expedited grievance: Within 24 hours Standard grievance: 30 calendar days

The above definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements. UnitedHealthcare Community Plan and its contracted care providers may agree to more stringent requirements within provider agreements than described in the standard process.

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Use the claims reconsideration application on the Provider Portal. To access the Provider Portal, sign in at UHCprovider.com using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 45 business days to receive payment for initial claims and a response.

Mailing address:

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

Additional information:

When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common reasons for rejected claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

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

Claim reconsideration (step 1 of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

Reconsiderations can be done repeatedly but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail. The appeal and required documentation must be received within 90 days of the claim denial date, or within the time specified in your Agreement.

Electronically: Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the Provider Portal.

- **Phone:** Call Provider Services
  - **1-888-867-5511,** TTY 711 (Senior Care Options)
  - **1-877-790-6543,** TTY 711 (One Care)
  - Or call the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers
- **Mail:** Submit the Claim Reconsideration Request Form to:

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

  Available at **UHCprovider.com/claims**.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically by phone, or mail with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim
- **Mail reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim with the screen showing:
  - Correct member name
  - Correct date of service
  - Claim submission date.

Additional information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Appeals section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/24	14A000000001	01/31/14	$115.03	$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/14	$279.34	$27.19	Contract states $50, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/14	$131.41	$99.81	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/14	$412.26	$412.26	Member has other insurance
55555555	05/05/24	14A000000005	06/15/14	$332.63	$332.63	Member terminated

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a 1-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, by mail. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or Claims on the Provider Portal. Click Sign In in the top right corner of **UHCprovider.com**, then click Claims. You may upload attachments.
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  P.O. Box 6103
  MS CA 124-0187
  Cypress, CA 90630-0023

Questions about your appeal or need a status update?
Call **Provider Services** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure Provider Portal.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances.

Member appeals

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You, with a member's written consent, or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Doesn't act within the time frame CMS or the state requires

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 6103
MS CA 124-0187
Cypress, CA 90630-0023

Senior Care Options: 1-888-867-5511, TTY 711 (TTY 711)

One Care MMP: 1-877-790-6543, TTY 711 (TTY 711)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal and the member must complete the **Appointment of Representative Form 1696**.

A copy of the AOR form-Claim Appeal is at **UHCprovider.com**.

Member grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 6103
MS CA 124-0187
Cypress, CA 90630-0023

Senior Care Options: **1-888-867-5511**, TTY 711 (TTY 711)

One Care: **1-877-790-6543**, TTY 711 (TTY 711)

We will send a confirmation letter within 1 business day of receiving a written grievance. We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires. We offer a 14-calendar-day extension if the member or UnitedHealthcare Community Plan requests additional time.

In some instances, members may request an expedited grievance review. We will respond to expedited grievance requests within 24 hours.

Further appeal rights

If we deny a member's appeal in whole or part, we will forward the appeal to an independent review entity (IRE). The IRE has a contract with the federal government and is not part of UnitedHealthcare Community Plan. They will review the appeal and make a decision within the required time frame for the first-level appeal. For example, an expedited appeal will be reviewed within 72 hours, a standard pre-service appeal will be reviewed within 30 calendar days or 30-60 calendar days if the appeal involves care payment.

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

Members may only appeal to the Board of Health for a State Fair Hearing for Medicaid-based services. They must exhaust all internal (UnitedHealthcare Community Plan) appeal options before appealing to the Board of Health. If the Board of Health rules in the member's favor, then we must reverse our previous denial, reduction, or service termination.

Special appeal types

A special appeal type only applies to hospital discharges. If the member thinks UnitedHealthcare Community Plan hospital stay coverage is ending prematurely, the member may appeal directly and immediately to **Kepro's Quality Improvement Organization (QIO)**. They must request this appeal no later than noon on the first working day after they receive notice UnitedHealthcare Community Plan coverage of the stay is ending. The member may request an expedited appeal from us if they miss this deadline.

Another special appeal type applies only to a member dispute about 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 2 days before their services will end. If the member thinks their coverage is ending too soon, the member may appeal directly and immediately to the IRE.

- If the member receives the notice 2 days before coverage ends, the member must request an appeal to Kepro QIO no later than noon of the day after the member receives the notice
- If the member receives the notice more than 2 days before coverage ends, 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 Kepro QIO, they may request an expedited appeal from us

State fair hearings

What is it?

A stare fair hearing lets members share why they think Massachusetts Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

MassHealth
100 Hancock St.
6th Floor
Quincy, MA 02171

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member's health condition requires or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Fraud, waste and abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at UHCprovider.com/MAcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every

month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management** > Data Access

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 12: Care provider communications and outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > Resource Library	Senior Care Options: **1-888-867-5511**, TTY 711 One Care MMP: **1-877-790-6543**, TTY 711
News and Bulletins	UHCprovider.com > Resources > News	
Provider Manuals	UHCprovider.com/guides	

Communication with care providers

UnitedHealthcare is on a multi-year effort to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates in the following ways:

- Network News email alerts on the first of the month to the email address you provide when you subscribe

There are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

UHCprovider.com

This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs. We encourage you to bookmark the following frequently referenced pages for quick access:

- **UnitedHealthcare Community Plan of Massachusetts page**: UHCprovider.com/MAcommunityplan has resources, guidance and rules specific to Massachusetts.
- **Policies and protocols**: This library includes UnitedHealthcare Community Plan policies and protocols
- **Social media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics
- Facebook
- Instagram
- LinkedIn
- YouTube
- X (Twitter)

(links are available https://uhgazure.sharepoint.com/sites/Digital-Channel-Guidelines).

- **Health plans by state**: UHCprovider.com/ma is the fastest way to review all of the health plans UnitedHealthcare offers in Massachusetts. To review information for another state, simply use the drop down menu at UHCprovider.com/guides > Community Plan Provider Manuals for Medicaid Plans by State to select a state, then select the type of plan (commercial, Medicare Advantage, etc.), then review the specific plans offered in that market.
- **UnitedHealthcare Provider Portal**: This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards.

You can learn more about the portal in Chapter 1 of this guide or by visiting UHCprovider.com/portal. You can also access self-paced user guides for many of the tools and tasks available in the portal.

UnitedHealthcare Network News

Bookmark UHCprovider.com > Resources > News. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Subscribe today to receive personalized Network News emails twice a month. They'll summarize the latest news, policy and reimbursement updates that we've posted on our news webpage. These email briefs include:

- Monthly notification of policy and protocol updates, including medical and reimbursement policy changes
- Announcements of new programs and changes in administrative procedures

You can tailor your subscription to help ensure that you only receive updates relevant to your state, specialty and point of care.

Provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor- led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at UHCprovider.com/training. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a One Healthcare ID, which also gives you access to the UnitedHealthcare Provider Portal. Already have an ID? To review or update your email, simply sign in to the portal. Go to Profile & Settings, then Account Information, to manage your email.
2. Subscribe to Network News email briefs to receive regular email updates
   Need to update your information? It takes just a few minutes to manage your email address and preferences.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

State websites and forms

Find the following forms on the state's website at mass.gov:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Marketing

You may not develop and use any materials that market UnitedHealthcare Community Plan One Care and Senior Care Options without the prior approval of UnitedHealthcare Community Plan in compliance with Medicare Advantage and state MassHealth requirements.

Under Medicare Advantage law, 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 Community Plan works with both CMS and the Massachusetts EOHHS to have marketing or outreach materials approved prior to distribution to member or prospective members.

Chapter 13: Glossary

AABD
Assistance to the aged, blind and disabled

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance Directive
Legal papers that list a member's wishes about their end-of-life health care.

Adverse Benefit Determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
6. For a resident of a rural area, the denial of a member's request to exercise his or her right, to obtain services outside the network.
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Aging Services Access Points (ASAP)

Local agencies that manage home and community-based funds and designated social services. These services help our members remain living at home and to delay or avoid long-term care placement.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care." Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal
A member request that their health insurer or plan review an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary care provider (PCP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

Centralized Enrollee Record (CER)
Centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions.

Clean Claim
A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Community Support Services
Services provided in a home or other community setting that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Contracted Health Professionals
PCPs, specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from 1 level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Electronic Data Interchange (EDI)
The electronic exchange of information between 2 or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute). Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

Individualized Care Plan (ICP)
The plan of care developed by an member and a member's Interdisciplinary Care Team.

In-Network Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

MassHealth
The medical assistance and benefit programs administered by the Massachusetts Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act, the Section 1115 demonstration, M.G.L. c. 118E, and other applicable laws and regulations (Medicaid).

MassHealth CommonHealth
MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain working and non-working disabled adults, including those aged 21 through 64 and those aged 65 and over.

MassHealth Standard
MassHealth coverage type that offers a full range of health benefits to certain Eligible Members, including families, pregnant women, disabled individuals under age 65, and individuals aged 65 and older.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medicare
Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or amyotrophic lateral sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, Durable Medical Equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan (see "Medicare Advantage.") Medicare Part D provides outpatient prescription drug benefits.

Medicare-Medicaid Plan (MMP)
The general term for plans contracted with CMS and states that participate in a demonstration for individuals dually eligible for Medicare and Medicaid, including a successor to a Financial Alignment Demonstration. In Massachusetts, One Care and Senior Care Options plans are MMPs.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Massachusetts EOHHS.

Specialist
A care provider licensed in the state of Massachusetts and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.