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Chapter 1: Introduction

Welcome

Welcome to UnitedHealthcare Senior Care Options (SCO), also branded as UnitedHealthcare Community Plan. We recognize that quality providers are the key to delivering quality health care to members. In order to better assist providers, UnitedHealthcare SCO has provided this Manual as a resource to answer questions regarding care for enrolled members.

Our goal is to assist providers in ensuring that our members receive the highest quality health care. This Provider Manual explains the policies and procedures for the UnitedHealthcare SCO network. We hope it provides you and your office staff with helpful information and guides you in making the best decisions for your patients.

Background

UnitedHealthcare SCO is a fully integrated Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare SCO service area. Members of UnitedHealthcare SCO must be 65 years of age or older, eligible for MassHealth Standard, and if eligible enrolled in Medicare Part A/Medicare Part B. Certain individuals who are Medicaid-eligible but not eligible for Medicare may also be enrolled in this Medicare Advantage Plan, receiving all the same benefits and services as dually-eligible individuals.

UnitedHealthcare SCO is currently available in the following counties: Bristol, Essex, Hampden*, Middlesex, Norfolk, Plymouth*, Suffolk and Worcester* counties. (* indicates partial county).

Contacting UnitedHealthcare SCO

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

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

Provider Service Center

This is the primary point of contact for providers who require assistance. The Provider Service Center is staffed with Provider Service representatives trained specifically for UnitedHealthcare SCO. The Provider Service Center can assist you with questions on benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc. They can be reached at 800-905-8671/TDD from 8 a.m. to 8 p.m. (EST) Monday through Friday to meet your needs. If you are hearing impaired, you can call the Provider Service Center at 888-336-6086. The Provider Service Center works closely with all UnitedHealthcare SCO departments.

UnitedHealthcare SCO Network

UnitedHealthcare SCO maintains and monitors a network of Participating Providers, including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which members obtain covered services.

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

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

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

UnitedHealthcare Community Plan of Massachusetts Website

UnitedHealthcareOnline.com offers the convenience of online support 24 hours a day, 7 days a week. This site was developed specifically with the providers in mind, allowing for personal support. Providers can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, and submit prior authorization requests at UnitedHealthcareOnline.com.
Occasionally, UnitedHealthcare SCO will distribute communication documents on administrative issues and general information of interest regarding UnitedHealthcare SCO to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special communications and that you retain them with this Provider Manual, so you can incorporate the changes into your practice. All policy and procedure information, including changes to existing policies and procedures, found in our newsletters and other communications are incorporated into this Provider Manual.

### Participating Providers

#### Primary Care Physicians

UnitedHealthcare SCO contracts with certain physicians/providers with whom members may choose to coordinate their health care needs. These physicians/providers are known as primary care physicians. With the exception of member self-referral covered services, the primary care physician is responsible for providing or authorizing covered services for members of UnitedHealthcare SCO. Primary care physicians are generally physicians of internal medicine, family practice or geriatricians. These providers must have a minimum of two years geriatric experience. All members must select a primary care physician when they enroll in UnitedHealthcare SCO and may change their designated primary care physician at any time.

#### Specialists

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

### Quick Reference Guide

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Chapter 2: Prior Authorization

Covered Benefits

The Evidence of Coverage included below list those services covered by UnitedHealthcare SCO.

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

Prior Authorization

The presence or absence of a procedure or service on the list does not define whether or not coverage or benefits exist for that procedure or service or whether such service may be considered medically necessary for a specific individual. A facility or practitioner must contact UnitedHealthcare SCO for prior authorization and some of the services requiring prior authorization may also require a medical necessity review. For the appropriate contact information, please refer the list of contacts in Chapter 1. Our prior authorization form is located at: UHCCommunityPlan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/MA-PriorAuthorizationFaxForm.pdf

Emergency and Urgent Care

Definitions

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

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

Emergency services are covered inpatient and outpatient services that are:

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

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

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

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

- The member is temporarily absent from the UnitedHealthcare SCO service area; and/or
- When such services are medically necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and/or
- It is not reasonable given the circumstances of required immediate care to obtain the services through a UnitedHealthcare SCO network provider.

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

Direct Access Services

Members may access Behavioral Health services without a referral from their primary care physician as long as the member obtains these services from a participating provider. Those services are discussed later in this section. Members requiring Behavioral Health services may call United Behavioral Health at 888-556-4059. Telephonic access is available 24 hours a day, 7 days a week. Behavioral Health inpatient services as well as detoxification programs are available after coordination for emergency admissions or mental health provider’s evaluation has taken place.

Hospital Services

Acute Inpatient Admissions

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

UnitedHealthcare SCO case managers will assist in coordinating services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding primary care physicians.
Chapter 3: Provider Responsibilities

Non-Covered Services

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

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

Information in the section relates to the MassHealth benefit chart. The MassHealth benefit chart can be found in the Member’s EOC for UnitedHealthcare SCO, which can be found at UnitedHealthcareOnline.com.

If members receive services that are not covered, they must pay for such services themselves.

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

Services Not Covered by UnitedHealthcare SCO

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

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

Covered Benefits

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

- Routine foot care, except for the limited coverage provided according to Medicare guidelines, except as described in the MassHealth benefit chart.
- Hearing aids or exams to fit hearing aids, except as described in the MassHealth benefit chart.
• Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids, except as described in the MassHealth benefit chart. Eyeglasses are covered for people after cataract surgery.
• Acupuncture
• Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease; except as described in the MassHealth benefit chart.
• Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease; except as described in the MassHealth benefit chart.

General Provider Responsibilities
UnitedHealthcare SCO contracted providers are responsible for:

A. Verifying member enrollment through UnitedHealthcareOnline.com, or contacting the Provider Service Center prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.
B. Rendering covered services to UnitedHealthcare SCO members in an appropriate, timely, and cost-effective manner and in accordance with their specific contract as well as the Centers for Medicare and Medicaid Services (CMS) and state of Massachusetts requirements.
C. Maintaining all licenses, certifications, permits, or other prerequisites required by law, regulation and policy to provide covered services, and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare SCO.
D. Rendering services to members who are diagnosed as being infected with the human immunodeficiency virus (HIV) or having acquired immune deficiency syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract.
E. Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility.
F. Making a concerted effort to educate and instruct members about the proper utilization of the physician’s office in lieu of hospital emergency rooms. The physician shall not refer or direct members to hospital emergency rooms for non-emergent medical services at any time.
G. Abiding by the UnitedHealthcare SCO referral and prior authorization guidelines.
H. Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare SCO; or, (2) the member’s condition is emergent and use of a contracted hospital is not feasible for medical reasons. The physician agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
I. Using contracted hospitals, specialists, and ancillary providers. A member may be referred to a non-contracted physician or provider only if the medical services required are not available through a contracted physician or provider and if prior authorization is obtained.
J. Obtaining prior authorization from UnitedHealthcare SCO for all hospital admissions.
K. Providing culturally competent care and services.
L. Compliance with Health Insurance Portability and Accountability Act (HIPAA) provisions.
M. Adhering to member advance directives (Patient Self Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member’s choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. Physicians are required to maintain policies and procedures regarding advance directives and document in individual medical records whether or not a member executed an advanced directive. Information about advance directives is included in the UnitedHealthcare SCO Member Handbook.
N. Provider must establish standards for timeliness and in-office waiting times that consider the immediacy of member needs and common waiting times for comparable services in the community.

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

1. Members must be entitled to Medicare Part A and be enrolled in Medicare Part B.
2. Members must be entitled and enrolled in Medicaid Title XIX benefits, specifically MassHealth Standard.
3. Members must reside in the UnitedHealthcare SCO service areas: Worcester County (partial), Suffolk County, Norfolk County, Middlesex County, Plymouth County (partial), Bristol County, Hampden County (partial) Essex
County. A member must maintain a permanent residence within the service area, and must not reside outside the service area for more than six months.

4. Members who do not have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) at time of application.

Each UnitedHealthcare SCO member will receive a UnitedHealthcare SCO identification (ID) card containing the member’s name, member number, primary care physician name, and information about their benefits. The SCO ID membership card does not guarantee eligibility. It is for identification purposes only.

Some members may be eligible for UnitedHealthcare SCO if they are not eligible for Medicare Parts A or B – please check the UnitedHealthcare SCO website to ensure that an individual is in fact a SCO member.
Chapter 4: Claims Process/Coordination of Benefits/Claims

Primary Care Physician Member Assignment

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

Each enrolled UnitedHealthcare SCO member must choose a primary care physician within the UnitedHealthcare SCO Provider Directory. Members receive a letter notifying them of the name of their primary care physician, office location, telephone number, and the opportunity to select a different primary care physician. Members may be assigned a primary care physician if not chosen by the member, and can request a change at any time should they prefer someone other than the primary care physician assigned. If the member elects to change the initial primary care physician assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare SCO to change his/her primary care physician at any other time, the change will be made effective on the date of the request.

Verifying Member Enrollment

Primary care physicians should verify member eligibility either by going to UnitedHealthcareOnline.com or by calling Member Services at 877-651-6677. At each office visit, your office staff should:

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

All providers should verify member eligibility prior to providing services.

Coordinating 24-Hour Coverage

Primary care physicians are expected to provide coverage for UnitedHealthcare SCO members 24 hours a day, 7 days a week. When a primary care physician is unavailable to provide services, the primary care physician must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent-care centers are not substitutes for covering participating providers. Participating providers can consult their UnitedHealthcare Senior SCO Provider Directory, or contact the UnitedHealthcare SCO Member Services with questions regarding which providers participate in the UnitedHealthcare SCO network.

Claims Submission Requirements

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

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

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

A clean claim is defined as one that has all information necessary to adjudicate the claim and has all supporting documentation (if applicable) and can be processed without obtaining additional information from the provider of service or from a third party. Additional information, which may be necessary to deem a claim complete, could include medical records. Medical records may include, but are not limited to, admitting, operative, anesthesia and/or physicians’ notes. These records may be required in certain circumstances, or in order to determine whether a claim includes the appropriate diagnosis and procedure codes for accurate payment pursuant to contractual and/or state guidelines. If a physician is under investigation for fraud, waste or abuse, or if a claim is selected for medical review by UnitedHealthcare SCO, this claim may not be treated as a clean claim.

Please mail your paper claims to:

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

For electronic submission of claims, please access the UnitedHealthcareOnline.com and sign up for electronic claims submission. If you have questions about gaining access to the UnitedHealthcare SCO website, choose the provider website tab and follow the instructions to gain access.

Submission of CMS-1500 Form Drug Codes

Attach the current National Drug Code (NDC) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LINo3 segment of the HIPAA 837 electronic form.
Chapter 4: Claims Process/Coordination of Benefits/Claims

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

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

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

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

Balance Billing
The balance billing amount is the difference between Medicare and MassHealth’s allowed charge and the provider’s actual charge to the patient. Providers are prohibited from billing, charging or otherwise seeking payment from members for covered services.

UnitedHealthcare SCO members cannot be billed for covered services. If a member requests a service that is not covered by UnitedHealthcare SCO, providers should educate the member that the service is not covered and they are financially responsible for all applicable charges.

You may not bill a member for a non-covered service unless:

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

Coordination of Benefits
If a member has coverage with another plan that is primary to Medicare and MassHealth, please submit a claim for payment to that plan first. The amount payable by UnitedHealthcare SCO will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

Provider Claim Dispute and Appeal
Claims must be received within the timely filing requirements of your agreement with UnitedHealthcare SCO, or 90 days if your agreement does not specify such timely filing period. You may dispute a claims payment decision by requesting a claim review.

Provider Claims Dispute
Stated as “Administrative Appeals by Practitioner” on Provider Remit.
Chapter 4: Claims Process/Coordination of Benefits/Claims

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

UnitedHealthcare SCO policy requires that the dispute, with required documentation, must be received within 60 days of the denial date on the claim. Failure to meet the timely request a claims dispute is deemed a waiver of all rights to further administrative review.

A claim dispute must be in writing and state with particularity the factual and legal basis and the relief requested, along with any supporting documents (e.g., claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the provider believes the action by UnitedHealthcare SCO was incorrect.
Chapter 5: Care Management and Quality of Care Oversight

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

Participating providers must comply and cooperate with all UnitedHealthcare SCO medical management policies and procedures and in UnitedHealthcare SCO quality assurance and performance improvement programs.

Prior Authorization

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

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

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

Specialist Guidelines

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

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

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

The primary care physician should provide the specialist with the following clinical information:

- Member’s name;
- Referring primary care physician;
- Reason for the consultation;
- History of the present illness;
- Diagnostic procedures and results;
- Pertinent past medical history;
- Current medications and treatments;
- Problem list and diagnosis; and
- Specific request for the specialist.

Services Requiring Prior Authorization

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

Denial of Requests for Prior Authorization

Denials of authorization requests occur only after a UnitedHealthcare SCO medical director has reviewed the request. A UnitedHealthcare medical director is always available to speak to a provider and review a request.

Prior authorization requests are frequently denied because they lack supporting medical documentation. Providers are encouraged to call or submit additional information for review.
Chapter 5: Care Management and Quality of Care Oversight

Hospital Admission Notification

For coordination of care, primary care physicians or the admitting hospital facilities should notify UnitedHealthcare SCO if they are admitting a UnitedHealthcare SCO member to a hospital or other inpatient facility as soon as possible but no later than 24 hours post-admission for medically necessary services. Elective procedures require prior authorization and notification.

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

- Notifying primary care physician or hospital;
- Name of admitting primary care physician;
- Member’s name, sex, and UnitedHealthcare Dual Complete ID number;
- Admitting facility;
- Primary diagnosis;
- Reason for admission; and
- Date of admission.

Concurrent Hospital Review

UnitedHealthcare SCO will review all member hospitalizations within 48 business hours of admission to confirm that the hospitalization and/or procedures were medically necessary. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews will validate the medical necessity for continued stay.

Discharge Planning

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

Medical Criteria

Qualified professionals who are members of the UnitedHealthcare SCO quality improvement committees and the board of directors will approve the medical criteria used to review medical practices and determine medical necessity. UnitedHealthcare SCO currently uses nationally-recognized criteria, such as, Medicare, Medicaid, Diagnostic Related Groups Criteria and Milliman USA Health Care Management Guidelines™ and evidence-based medicine to guide the prior authorization, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria. For more information or to receive a copy of these guidelines, please contact the Provider Service Center at 877-651-6677.

UnitedHealthcare SCO may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to participating providers through the UnitedHealthcare SCO Practice Matters – a newsletter produced quarterly and available to view on UHCCommunityPlan.com.

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

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

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

The guidelines will be communicated to providers, and, as appropriate, to members.

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

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

UnitedHealthcare SCO Care Model

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

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

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

### UnitedHealthcare SCO Program Acuity Levels

<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Individuals at low health risk, who are capable of remaining in the community with little support and regular communication with UnitedHealthcare.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Individuals who are medically stable and may have chronic conditions with intermittent acute episodes and are generally supported in some manner by home and community-based services.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Individuals who are medically complex but are capable of remaining in community settings with strong support from physicians, UnitedHealthcare, family, and home and community-based providers.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Individuals who are medically complex and require additional behavioral health or palliative care support to remain in community settings with strong support from physicians, behavioral health providers, UnitedHealthcare, family, and home and community-based providers.</td>
</tr>
<tr>
<td>Institutional</td>
<td>Individuals who are institutionalized and who will remain in the nursing home, barring any significant improvement in health status.</td>
</tr>
</tbody>
</table>
For all members stratified as Level 3 and Level 4, a UnitedHealthcare SCO registered nurse care manager is assigned to support the member and PCP. For members residing in a long-term care setting, either a nurse practitioner or physician assistant is assigned. Working with the primary care physician, or in the instance of members in long-term care facilities, the facility staff and the UnitedHealthcare SCO case manager convene a primary care team meeting to determine the most appropriate services that will 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 below:

### Member Risk Stratification: Acuity Levels

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

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

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

Care Manager Interface with the Primary Care Physician

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

Primary Care Team

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

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

Aging Services Access Point

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

Centralized Enrollee Records

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

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

To supplement these primary approaches, UnitedHealthcare SCO will employ the following strategies to improve record keeping and coordinate access to information:
Chapter 5: Care Management and Quality of Care Oversight

1. Utilize the Health Service Access Line (HSAL) to provide timely access to the summary CER.

2. Ensure HIPAA compliance.

3. Link care manager and primary care physician/primary care team to the summary CER for timely and relevant action following significant encounters.

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

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

The following key documents are stored in the CER:

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

UnitedHealthcare SCO will make use of the usual and customary protocols within the medical community by utilizing the medical records maintained by primary care physicians and nursing facilities. These records will include patient’s diagnoses, medical conditions, medications, scheduled appointments and progress notes.

Confidentiality and accuracy of a member’s medical record must be maintained at all times. UnitedHealthcare SCO requires that all physician and health care providers comply with HIPAA standards for privacy and protection of member data. The privacy of any information that identifies a particular member must be safeguarded. Information from or copies of a member’s medical record may only be released to authorized individuals. Physicians and other health care physicians must ensure that unauthorized individuals cannot gain access to or alter an member’s medical record. Original medical records may only be released in accordance with state laws, court orders or subpoenas, and timely access by members to the information that pertains to them must be ensured. Additionally, physicians, other health care providers and UnitedHealthcare SCO must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, and other health and member information.

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

Health Services Access Line

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

- The HSAL will allow members to contact their care manager during normal business hours. Calls will ring into the HSAL during business hours. If the member’s assigned care manager is out in the field, the HSAL can schedule a home visit appointment or page the care manager to contact the member. The care manager will assess the member’s needs, triage the call based on the assessed situation, and coordinate services as appropriate.

- The HSAL will revert to an on-call service after business hours. The on-call service is staffed by UnitedHealthcare SCO nurse practitioners and physician assistants. The on-call clinician will have access to the summary CER and will be able to triage the call, document changes in condition in the summary CER, and will follow-up with the member’s assigned care manager on the following business day.

- If a member elects to call their primary care physician’s after-hours service, then the primary care physician on-call provider can contact UnitedHealthcare SCO via the HSAL to gain access to critical information on the member that is stored in the CER.

- Primary care physicians and other providers may also contact the HSAL during normal business hours to reach a member’s care manager, request authorizations, notify UnitedHealthcare SCO of changes in the member’s condition, make verbal updates to the CER, and access member information and IPCs.
Chapter 6: Provider Performance Standards and Compliance Obligations

Evidence-Based Medicine/Clinical Practice Guidelines

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

Clinical practice guidelines can be accessed by providers at UHCCommunityPlan.com, or providers may also call the Provider Service Center at 877-651-6677 to request a hard copy of these guidelines.

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

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

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

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

When to Deliver the NOMNC

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

How to Deliver the NOMNC

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

Expedited Review Process

If the member decides to appeal the end of coverage, he or she must contact the quality improvement organization (QIO) by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO for Massachusetts is MassPro, which can be contacted at 800-252-5533.

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

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

Exclusions from NOMNC Delivery Requirements

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

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

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

UnitedHealthcare SCO will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 p.m.) the day of the QIO’s notification that the member requested an appeal, or the day before coverage ends, whichever is later.
Chapter 6: Provider Performance Standards and Compliance Obligations

Where to locate the UnitedHealthcare NOMNC form
A copy of the UnitedHealthcare SCO NOMNC form can be found in the Appendix Section of this Manual or on the UnitedHealthcare SCO website at UHCCommunityPlan.com on the Resources page. Please ensure that the UnitedHealthcare SCO version is used as that form has been approved by both Medicare and MassHealth for submission to UnitedHealthcare SCO members.

More Information
Further information on this process can be found on UHCCommunityPlan.com.

Additional resource links:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

Provider Evaluation
When evaluating the performance of a participating provider, UnitedHealthcare SCO will review at a minimum the following areas:

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

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

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

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

- Participation on committees and clinical task forces to improve the quality and cost of care
- Prior authorization requirements and timeframes
- Participating provider credentialing requirements. Including but not limited to participating providers needing to have a minimum of two years geriatric experience
- Case management program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member-medical record information to fulfill the business and clinical needs of UnitedHealthcare SCO
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with UnitedHealthcare SCO personnel and fellow participating providers
- Providing equal access and treatment to all UnitedHealthcare SCO members

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

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

Participating provider noncompliance is continuously monitored. Remediation and or corrective action is taken, as necessary.
Participating providers acting within the lawful scope of practice are encouraged to advise patients who are members of UnitedHealthcare SCO about:

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

Participating providers must disclose to UnitedHealthcare or other federal health care programs are employed or offended related to their involvement in Medicaid, Medicare programs and State Law

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

Selection and Retention of Participating Providers

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

The UnitedHealthcare SCO network has been carefully developed to include those contracted health care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care, cultural competency and acceptance of UnitedHealthcare SCO managed care principles and financial considerations.

UnitedHealthcare SCO continuously reviews and evaluates participating provider information and credentials participating providers every three years. The credentialing guidelines are subject to change based on industry requirements and UnitedHealthcare SCO standards. Additionally, UnitedHealthcare SCO periodically evaluates its current network of providers to ensure appropriate network optimization, which is based upon several different criteria.

Appeal Process for Provider Participation Decisions

Physicians

If UnitedHealthcare SCO decides to suspend, terminate or not renew a physician’s participation status, UnitedHealthcare SCO must:

- Give the affected physician written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by UnitedHealthcare SCO.
- UnitedHealthcare SCO will allow the physician to appeal the action to a hearing panel, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.
- UnitedHealthcare SCO will ensure that the majority of the hearing panel members are peers of the affected physician.

Laws Regarding Federal Funds

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

Marketing

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

Sanctions under Federal Health Programs and State Law

Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs are employed or subcontracted by the participating provider. Participating providers must disclose to UnitedHealthcare SCO periodically evaluates its current network of providers to have any marketing or outreach materials approved prior to distribution to members or prospective members.
Chapter 6: Provider Performance Standards and Compliance Obligations

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

Providers who utilize subcontracted provider groups must communicate that these procedures apply equally to providers within those subcontracted groups, and that such subcontracted groups must also adhere to all of the UnitedHealthcare SCO, federal, and State requirements.

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

Notification of Members of Provider Termination
When a contract termination involves a primary care physician, UnitedHealthcare SCO will notify all members who are patients of that primary care physician of the termination. For all other providers, UnitedHealthcare SCO will make a good-faith effort to provide written or verbal notice of a termination of a participating provider to all members who are patients seen on a regular basis by that provider at least 30 calendar days before the termination effective date, regardless of the reason for the termination.
Chapter 7: Medical Records

Medical Record Review

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

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

Standards for Medical Records

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in the members’ medical chart. Each medical record chart must have documented at a minimum:

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

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

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

Confidentiality of Member Information

Confidentiality and accuracy of a member’s medical record must be maintained at all times. The privacy of any information that identifies a particular member must be safeguarded. Information from or copies of a member’s medical record may only be released to authorized individuals. Physicians and other health care providers must ensure that unauthorized individuals cannot gain access to or alter a member’s medical record. Participating providers must comply with all State and federal laws concerning privacy and confidentiality of health and other confidential information about members. Participating providers must have policies and procedures regarding use and disclosure of health information that comply with all applicable federal and state laws. Should members wish to have their medical record information shared with family or others, they must submit an authorization of representative form with member signature.
Chapter 7: Medical Records

Member Record Retention

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

Participating providers must retain the original or copies of patient’s medical records as follows:

- Keep records for at least 10 years after last medical or health care service for all adult patients; and
- Keep records for 10 years after the 18th birthday for all patients who are children or for at least 10 years after their last medical or health care service.

Participating providers must comply with all State and federal laws on record retention.
Chapter 8: Reporting Obligations

Cooperation in Meeting the CMS and State of Massachusetts Reporting Requirements

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

Certification of Diagnostic Data

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

Risk Adjustment Data

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

Critical Incidents

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

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

Please immediately contact the Senior Director of Quality at 781-472-8650 and provide as much detail as you are able, including any history and any resolution, so that we can immediately report to the State. Please note that the State will often ask for additional detail, and it may be necessary for a representative to contact you to gain additional information if you do not initially provide a full accounting and history.
Chapter 9: Initial Decisions, Appeals and Grievances

Initial Decisions

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

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

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

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

A member can ask for an expedited decision only if the member or any physician believes that waiting for a standard decision could seriously harm the member’s health or ability to function. The member or a physician can request an expedited decision. If a physician requests an expedited decision, or supports a member in asking for one, and the physician indicates that waiting for a standard decision could seriously harm the member’s health or ability to function, UnitedHealthcare SCO will automatically provide an expedited decision.

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

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

Appeals

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

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

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

If the normal time period for an appeal could result in serious harm to the member’s health or ability to function, the member or the member’s physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member’s health or ability to function, we will automatically expedite the appeal.

Further Appeal Rights

If UnitedHealthcare SCO denies the member’s appeal in whole or part, it will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of UnitedHealthcare SCO. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days.

If the IRE issues an adverse decision, the member may appeal to an administrative law judge (ALJ). If the ALJ issues an adverse decision or refuses to hear the member’s case, the member may be able to appeal to a district court of the United States.
Chapter 9: Initial Decisions, Appeals and Grievances

At any point in the appeals process, a member may bring an appeal before the Massachusetts State Board of Hearings. If the Board of Hearings rules in the member’s favor, then UnitedHealthcare SCO must reverse its previous denial, reduction, or termination of services.

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

Another special type of appeal applies only to a member dispute regarding when coverage will end for SNF, HHA or comprehensive outpatient CORF. SNFs, HHAs and CORFs are responsible for providing members with a written notice at least two days before their services are scheduled to end. If the member thinks his/her coverage is ending too soon, the member can appeal directly and immediately to the IRE. If the member gets the notice two days before coverage ends, the member must request an appeal to the IRE no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to IRE, the member can request an expedited appeal from UnitedHealthcare SCO.

Grievances
Members and providers have the right to make a complaint if they are dissatisfied in any aspect of the administration of the Plan. All participating providers must cooperate in the SCO appeals and grievances process, governed by a contract with CMS and the Commonwealth of Massachusetts, as well as all State and federal laws and regulations.

- An appeal is the type of complaint a member makes when the member wants UnitedHealthcare SCO to reconsider and change an initial decision about what services are necessary or covered or what UnitedHealthcare SCO will pay for a service.

- A grievance is any expression of dissatisfaction a member makes regarding UnitedHealthcare SCO or a participating provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room are considered to be grievances.

Resolving Grievances
If a UnitedHealthcare SCO member has a grievance about UnitedHealthcare SCO, a provider or any other issue, participating providers should instruct the member to contact UnitedHealthcare SCO Member Services at 888-867-5511 (TTY 711). A written grievance should be faxed to 800-891-8034 or mailed to:

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

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

UnitedHealthcare SCO members may ask for an expedited grievance review upon request. We will respond to expedited or fast grievance requests within 72 hours.
Chapter 10: Members’ Rights and Responsibilities

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

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

UnitedHealthcare SCO members have a responsibility to:

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

Member Responsibilities

Member responsibilities include:

- Reading and following the Evidence of Coverage (EOC)
- Treating all UnitedHealthcare SCO staff and health care providers with respect and dignity
- Protecting their SCO ID card and showing it before obtaining services
- Knowing the name of their primary care physician
- Seeing their primary care physician for their health care needs
- Using the emergency room for life-threatening care only and going to their primary care physician, specialists, or urgent care centers, as appropriate, for all other treatment
- Following their doctor’s instructions and treatment plan and telling the doctor if the explanations are not clear
- Bringing the appropriate records to the appointment, including their immunization records through age 18
- Making an appointment before they visit their primary care physician or any other UnitedHealthcare SCO health care provider
- Arriving on time for appointments
- Calling the office at least 1 day in advance if they must cancel an appointment
- Being honest and direct with their primary care physician, including giving the primary care physician the member’s health history
- Telling their UnitedHealthcare SCO care manager and/or support coordinator if they have changes in address, or eligibility for enrollment
- Tell UnitedHealthcare SCO if they have other insurance
- Give a copy of their advance directive to their primary care physician as listed in the member EOC

Services Provided in a Culturally Competent Manner

UnitedHealthcare SCO is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate with UnitedHealthcare SCO in meeting this obligation. Participating providers can use the UnitedHealthcare language line to assist members with limited English proficiency when they do not have the ability to understand the member’s language.
Chapter 10: Members’ Rights and Responsibilities

Member Grievances and Appeals

UnitedHealthcare SCO tracks all complaints and grievances to identify areas for improvement. This information is reported at the quality management, service improvement and compliance committees and is reviewed by the senior leadership team.

Please refer to the section in this Manual for Members Appeal and Grievances Rights.

Member Satisfaction

UnitedHealthcare SCO periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating providers.

CMS conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from participating providers. Surveys results are available upon request.
Chapter 11: Access to Care/Appointment Availability

Member Access to Health Care Guidelines

The following appointment availability goals should be used to ensure timely access to medical care and behavioral health care:

- **Non-symptomatic office visits** – within 30 days.
- **Urgent Care Symptomatic** – within 48 hours.
- **Emergency** – immediately (24 hours/7 Days a week)
- **Individuals with disabilities** – physical and telephonic access required. Reasonable accommodations must be made to ensure physical/communication barriers do not inhibit access to care.

Adherence to member access guidelines will be monitored through office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination. Variations from the policy will be reviewed by Network management for educational and/or counseling opportunities and tracked for participating provider re-credentialing.

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

Provider Availability

Primary care physicians shall provide coverage 24 hours a day, 7 days a week. When a participating provider is unavailable to provide services, he or she must ensure that another participating provider is available.

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

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

Transfer and Termination of Members From Participating Physician’s Panel

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

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

Closing of Provider Panel

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

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

Prohibition against Discrimination

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

1. Medical condition including mental as well as physical illness;
2. Claims experience;
3. Receipt of health care;
4. Medical history;
5. Genetic information;
6. Evidence of insurability including conditions arising out of acts of domestic violence; and
7. Disability.
Chapter 12: Compliance

Integrity and Compliance

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

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

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

UnitedHealthcare SCO has compliance officers responsible for each health plan or business unit. In addition, each health plan has an active compliance committee, consisting of senior managers from key organizational functions. The compliance committee provides direction and oversight of the program with the health plan.

Reporting and Auditing
Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare SCO employee which comes to the attention of a physician should be reported to a UnitedHealthcare SCO senior manager or directly to the Ethics and Compliance Help Center at 800-455-4521.

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

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

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

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

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

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

Chapter 12: Compliance

Fraud and Abuse

Your assistance in notifying UnitedHealthcare SCO about any potential fraud and abuse that comes to your attention, and cooperating with any review of such a situation, is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. The definition of “intentional” also includes acting in deliberate ignorance or reckless disregard.

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

Examples of fraud and abuse, include:

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

Falsifying Claims/Encounters

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

Administrative or Financial

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

Member Fraud or Abuse Issues

- Fraudulent/altered prescriptions;
- Card loaning/selling;
- Eligibility fraud; and
- Failure to report third party liability/other insurance.

Reporting Fraud and Abuse

If you suspect another physician or a member has committed fraud or abuse, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made in several ways.

Go to UHCCommunityPlan.com and select ‘Contact Us’ to report information relating to suspected fraud or abuse.

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

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

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

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

- The person’s name, date of birth, social security number, ID number;
- The person’s address; and
- Specific details about the suspected fraud or abuse.

Resolving Disputes

Agreement Concern or Complaint

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

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

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

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

In the event that a customer has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing customer appeals outlined in the EOC.
Chapter 13: Prescription Benefits

Network Pharmacies

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

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

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before a prescription is filled at an out-of-network pharmacy, please contact the UnitedHealthcare SCO Member Services to see if there is a network pharmacy available.

1. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently-needed care. In this situation, members will have to pay the full cost when they fill their prescription. UnitedHealthcare SCO members are entitled to reimbursement by submitting appropriate documentation.

2. If a UnitedHealthcare SCO member is traveling within the United States, but outside of the Plan’s service area and becomes ill, loses or runs out of their prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost when they fill their prescription and will have to submit the bill for reimbursement.

   The member is entitled to reimbursement by submitting appropriate documentation. Remember, prior to submitting a prescription to an out-of-network pharmacy, call our UnitedHealthcare SCO Member Services or Provider Services department to find out if there is a network pharmacy in their area where the member is traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for the member to get their prescriptions from an out-of-network pharmacy.

3. If a UnitedHealthcare SCO member is unable to get a covered drug in a timely manner within our service area because there are not network pharmacies within a reasonable driving distance that provide 24-hour service.

4. If a member is trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail (these drugs include orphan drugs or other specialty pharmaceuticals).

Paper Claim Submission

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

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

Formulary

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

The drugs on the formulary are a sum of the Medicare Part D Formulary, the MassHealth Standard and/or SCO Formulary, and any additional drugs which may be selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program brand-name drugs, generic drugs, and over-the-counter (OTC) medications are included on the formulary. A generic drug has the same active ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

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

To find out what drugs are on the formulary or to request a copy of our formulary, please contact UnitedHealthcare SCO Member Services at 800-396-1942 (TTY 800-947-6644) or the Provider Services department. Providers can also get updated information about the drugs covered by us at UHCCommunityPlan.com.

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

**Exception Request**

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

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

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

**Drug Management Programs (Utilization Management)**

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require UnitedHealthcare SCO members to get prior authorization for certain drugs. This means the UnitedHealthcare SCO physician or pharmacist will need to get approval from us before a member fills their prescription. If they don’t get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we cover per prescription or for a defined period of time. For example, we will provide up to 30 tablets per prescription for simvastatin. This quantity limit may be in addition to a standard 30-day supply limit.

- **Step Therapy:** In some cases, we require members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a member’s medical condition, we may require a provider to prescribe Drug A first. If Drug A does not work for a member, then we will cover Drug B upon request from the provider.

- **Generic Substitution:** When there is a generic version of a brand-name drug available our network pharmacies will automatically give the member the generic version, unless a provider writes the prescription specifically for the brand-name drug, stating that generic substitution is not permissible for that particular prescription.

You can find out if the drugs you prescribe are subject to these additional requirements or limits by looking in the formulary. If the drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. Please refer to the section above for exception requests.
Chapter 14: Behavioral Health

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

Screening for Behavioral Health Problems

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

Role of the Behavioral Health Unit

Optum Behavioral Health is an important resource to all providers when members experience mental health or substance abuse problems. The Optum Behavioral Health toll-free number is 888-556-4059.

- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours, 7 days a week.
- Fully supports primary care providers with assessment and referrals to mental health and chemical dependence services.
- Provides behavioral health case management.
- Reviews, monitors, and authorizes behavioral health care.
- Responsible for provider relations for behavioral health providers.
- Staffed by professionals with extensive experience in mental health and chemical dependence services.

Behavioral Health Emergencies

If a provider believes the member is having a psychiatric emergency, the provider should either call 911 or direct the member to the designated county screening center or nearest hospital emergency room. If the provider is unsure about the member’s mental status, call Optum Behavioral Health at 888-556-4059.

Referrals for Behavioral Health Services

Primary care physicians and behavioral health providers should communicate with the Optum Behavioral Health Unit by calling 888-556-4059.

Providers should note the request in the patient’s medical record.

A member can self-refer to a participating behavioral health provider at any time. Optum Behavioral Health generally approves a maximum of six initial outpatient visits to allow for full clinical evaluation.

The initial treatment assessment must include a full psychosocial history, a mental status examination, and M.D./D.O. psychiatric evaluation. The assessment and development of a comprehensive treatment plan must be developed within the first 30 days of treatment.

Behavioral Health Guidelines and Standards

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

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), 4th edition.

UnitedHealthcare SCO uses Milliman USA® guidelines for appropriateness of care and discharge reviews.

Resolving Grievances

If a UnitedHealthcare SCO member has a grievance about UnitedHealthcare SCO, a provider or any other issue; participating providers should instruct the member to contact UnitedHealthcare SCO Member Services at 888-867-5511 (TTY 711). A written grievance should be faxed to 800-891-8034 or mailed to:

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

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

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