2024 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Tennessee UnitedHealthcare Dual Complete (HMO SNP)

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UnitedHealthcare Community Plan

Welcome

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

Click to access different manuals

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage enrollee information
- Regulatory Appendix: In conjunction with the state of Tennessee, provider agreements and provider guides are subject to state law and federal guidelines, including the **TennCare Regulatory Appendix Addendum**

Easily find information in this manual using the following steps

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

If available, use the binoculars icon on the top right-hand side of the PDF.

Manuals and the regulatory appendix may change. Visit **UHCprovider.com/guides** > Select Your State for the most current version and information. If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our enrollees.

Important information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Table of Contents

Chapter 1: Introduction

Background

UnitedHealthcare Dual Complete (HMO SNP) is a Medicare Advantage Special Needs Plan, serving enrollees who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Dual Complete (HMO SNP) Service Area. UnitedHealthcare Dual Complete (HMO SNP) enrollees have already demonstrated eligibility for and been enrolled in Medicare Part A, Medicare Part B and TennCare (Medicaid) benefits. UnitedHealthcare Dual Complete (HMO SNP) enrollees may also belong to UnitedHealthcare Community Plan.

Medicare Special Needs Plan (SNPs) are a type of Medicare Advantage Plan (e.g., HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics and provide benefits, care provider choices and drug formularies to best meet the specific needs of the groups they serve.

The Centers for Medicare and Medicaid Services (CMS) requires the SNP care provider enter into an agreement with the State to provide or arrange for Medicaid benefits to its Dual Eligible enrollees.

To join UnitedHealthcare Dual Complete (HMO SNP), a beneficiary must be entitled to Medicare Part A, be enrolled in Medicare Part B and TennCare and live in our service area.

The UnitedHealthcare Dual Complete (HMO SNP) network

UnitedHealthcare Dual Complete (HMO SNP) maintains and monitors a network of participating care providers. It includes physicians, hospitals, skilled nursing facilities (SNF), ancillary providers and other health care providers through which enrollees obtain covered services.

UnitedHealthcare Dual Complete (HMO SNP) enrollees must choose a PCP to coordinate their care. PCPs are the basis of the managed care philosophy.

UnitedHealthcare Dual Complete (HMO SNP) works with contracted PCPs who manage enrollees' health care needs and arrange for medically necessary covered medical services. You may, at any time, advocate on their behalf without restriction to help ensure they get the best care possible. In particular, you are not prohibited or otherwise restricted from advising or advocating, on behalf of an enrollee who is your patient for:

A. The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered

B. Any information the enrollee needs to decide among all relevant treatment options

C. The risks, benefits and consequences of treatment or non-treatment

D. The enrollee's right to take part in decisions about their behavioral health care. This includes the right to refuse treatment and to express preferences about future treatment decisions.

To help ensure continuity of care, enrollees must coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine preventive health services, dental, routine vision and behavioral health). Participating care professionals are required to coordinate care within the UnitedHealthcare Dual Complete (HMO SNP) care provider network. If possible, all enrollees should be directed to UnitedHealthcare Dual Complete (HMO SNP) care providers. If a participating care provider is not available to provide services, referrals outside the network are permitted. However, prior authorization is required by UnitedHealthcare Dual Complete (HMO SNP), the services must be a covered benefit and the enrollee must be eligible on the date of service. All out-of-network services will be denied unless prior authorization has been obtained and services are emergent in nature.

The referral and prior authorization procedures explained in this manual are particularly important to the UnitedHealthcare Dual Complete (HMO SNP) program. Understanding and adhering to these procedures are essential for successful participation as a UnitedHealthcare Dual Complete (HMO SNP) care provider.

Occasionally UnitedHealthcare Dual Complete (HMO SNP) will distribute communication documents on administrative issues and general information of interest regarding UnitedHealthcare Dual Complete (HMO SNP) to you and your office staff. You and/or your office staff must read the newsletters and other special mailings. Keep them with this care provider manual so you can incorporate the changes into your practice. When you submit demographic updates, list only those addresses where an enrollee may make an appointment and see the care provider. Do not list on-call and substitute care providers who are not regularly available to provide covered services.

Participating care providers

Primary care providers

UnitedHealthcare Dual Complete (HMO SNP) contracts with certain PCPs who may choose to coordinate enrollees health care needs. Except for self-referral covered services (Chapter 2), the PCP provides or authorizes covered services for UnitedHealthcare Dual Complete (HMO SNP) enrollees. PCPs are generally physicians of internal medicine, pediatrics, family practice or general practice. However, they may also be other care provider types who accept and assume PCP roles and responsibilities. All enrollees must select a PCP when they enroll in UnitedHealthcare Dual Complete (HMO SNP). They may change their designated PCP once a month.

Specialists

A specialist is any licensed participating care provider (as defined by Medicare) who provides specialty medical services to enrollees. A PCP may refer an enrollee to a specialist as medically necessary.

Network management department

Within UnitedHealthcare Community Plan, the Network Management Department is the point of contact for when you need help with your contract, credentialing and in-services. The Network Management Department is staffed with network account managers who are available for visits, contracting, credentialing and specific issues in working with UnitedHealthcare Dual Complete (HMO SNP).

UHCprovider.com website

You can verify enrollee eligibility, check claim status, submit claims, request an adjustment, review a remittance advice or review an enrollee roster at any time.

You can register by going to **UHCprovider.com** and completing the form found online under Tools and Resources > Welcome Kit for New Physicians and Providers.

UnitedHealthcare Dual Complete (HMO SNP) roster

PCPs are given access to a roster of all assigned enrollees at **UHCprovider.com**. PCPs should use this to determine if they are responsible for providing primary care to a particular enrollee.

The PCP Panel Roster provides a list of our enrollees currently assigned to the provider. To print a monthly PCP Panel Roster, sign in to the UnitedHealthcare Provider Portal at **UHCprovider.com**. Then select Reports from the Tools and Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pulldown menu. Complete additional fields as required. Click on the available report you want to view.

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

Care provider coverage shall include anytime availability. During non-office hours, access by phone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

Addendum

TennCare pays for Medicare deductibles and coinsurance for Medicare beneficiaries classified as QMBs and SLMB Plus and other dual eligible recipients. TennCare is not required to pay Medicare coinsurance for non-covered services for SLMB Plus and other dual eligible recipients unless the enrollee is younger than 21 years or an SSI beneficiary.

Cost-sharing obligations do not include:

- Medicare premiums TennCare pays under the State Plan on behalf of dual eligible enrollees
- Payments for any Medicaid services covered solely by TennCare
- Cost-sharing for a Part D prescription drug

UnitedHealth Community Plan care providers are required to refer dual-eligible enrollees who are QMB Plus or other FBDE recipients to their TennCare MCO for the provision of TennCare benefits not covered by their SNP.

TennCare offers a broad array of long-term services and supports (LTSS) that help meet enrollees' unique needs. LTSS is a variety of services that help people with chronic illnesses, physical disabilities and intellectual disabilities who cannot care for themselves for long periods of time. Long-term care often provides custodial and non-skilled care, such as assisting with dressing, bathing and using the bathroom.

Increasingly, long-term care involves providing a level of medical care that requires skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. LTSS may be needed by people of any age, even although it is a common need for senior citizens.

The Tennessee CHOICES program provides seniors 65 and older and adults 21 years and older with physical disabilities who are eligible for TennCare with long-term services and supports in the home, community setting or nursing home.

Information about the TennCare Managed Care Organization and available TennCare Program Benefits can be found at the following TennCare Program websites:

- tn.gov/tenncare/providers
- tn.gov/tenncare/members
- tn.gov/tenncare/longtermcare

Refer to the TennCare Bureau Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau website at tn.gov for claims submission requirements.

How to contact us

Topic	Contact	Information
Benefits	tn.gov/tenncare > Members/Applicants > Covered Services **UHCprovider.com/benefits** **1-800-690-1606**	Confirm a person's benefits and/or prior authorization.
Cardiology prior authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/cardiology** Click Menu on the top left, select Prior Authorization and Notification, then Cardiology **1-800-690-1606**	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Claims	**EDI: UHCprovider.com/edi** > Companion Guides Payer ID 95378 **UnitedHealthcare Provider Portal: UHCprovider.com/claims** (policies, instructions and tips) **1-877-842-3210** (follow the prompts for status information) Mailing address: **UnitedHealthcare Community Plan** P.O. Box 5220 Kingston, NY 12402-5220 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claims overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal, then select the UnitedHealthcare Online app **1-800-690-1606** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental services	DentaQuest dentaquest.com 1-800-417-7140	DentaQuest providers dental coverage for TennCare covered persons younger than 21 years.
Electronic data intake claim issues	**ac_edi_ops@uhc.com** **1-800-210-8315**	Ask about claims issues or questions.
Electronic data intake log-on issues	**1-800-842-1109**	Information is also available at **UHCprovider.com/edi**.
Eligibility	**EDI:** Transaction code 270 and response 271 **Online:** tn.gov/tenncare > Providers > Verify Eligibility To access eligibility information, go to **UHCprovider.com** then Sign In to the UnitedHealthcare Provider Portal or go to **UHCprovider.com/eligibility**. Phone: Division of TennCare: 1-800-852-2683 UnitedHealthcare Community Plan voice portal: **1-800-690-1606** (follow the prompts)	Confirm covered persons' eligibility.
Enterprise voice portal	**1-877-842-3210**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse	tn.gov/tenncare > Providers > Fraud and Abuse **1-800-690-1606** (UnitedHealthcare Community Plan tipline) 1-800-433-3982 (Division of TennCare and Office of Inspector General)	Notify us of suspected fraud or abuse by a care provider or individual.

Topic	Contact	Information
Healthy First Steps/ obstetrics (OB) referral	**1-800-599-5985**	• Refer high-risk OB individuals • Fax initial prenatal visit form
Laboratory services	Labcorp 1-800-833-3984	Labcorp is the preferred network laboratory
Medicaid (TennCare Provider Services)	tn.gov/tenncare/providers TennCare Provider Services 1-800-852-2683 Family Assistance Service Center 1-866-311-4287 TennCare Solutions 1-800-878-3192 TennCare Advocacy Program 1-800-758-1638 Medicare/Medicaid Crossover Claims Unit 1-800-852-2683	Contact Medicaid directly.
Medical and behavioral claim, reconsideration and appeal	Sign in to the UnitedHealthcare Provider Portal at **UHCprovider.com** or go to **UHCprovider.com/claims** for more information. **1-800-690-1606** Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5220 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 5220 Kingston, NY 12402-5220	Claim issues include overpayment, underpayment, payment denial or an original or corrected claim determination you don't agree with.
Member services	**1-800-690-1606**	Assist individuals with issues or concerns. Available 7 a.m.–5 p.m. CT, Monday–Friday.
Mental health and substance abuse (Optum Behavioral Health)	Optum Behavioral Health: **1-800-690-1606**	Refer individuals for behavioral health services. (A PCP referral is not required).
Multilingual/ telecommunication device for the deaf (TDD) services	1-800-758-1638 TDD 711	Available 8 a.m.–5 p.m. CT, Monday–Friday, except state-designated holidays.
National credentialing center (VETTS line)	**1-877-842-3210**	Self-service functionality to update or check credentialing information.

Topic	Contact	Information
National plan and provider enumeration system (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management phone team	**1-866-574-6088**	Ask about contracting and care provider services.
NurseLine	**1-800-690-1606** > Ask for NurseLine	Available any time.
Obstetrics and baby care	Healthy First Steps **1-800-599-5985** Fax: 1-877-353-6913 Prenatal risk assessment form **uhcbabyblocks.com**	Links for pregnant moms and newborn babies.
Optum ID support center	**providertechsupport@uhc.com** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday–Friday; 6 a.m.–6 p.m. CT, Saturday; and 9 a.m.–6 p.m. CT, Sunday.
Pharmacy services	**optumrx.com** Prior Approval/Clinical: **1-866-434-5524** Fax: 1-866-434-5523 Pharmacy Help Desk: **1-866-434-5520** Enrollee inquiries: 1-888-816-1680	Optum Rx oversees and manages our network pharmacies.
Prior authorization/ notification of health services (intake)	EDI: See EDI transactions and code sets on **UHCprovider.com/edi** UnitedHealthcare Provider Portal: Prior Authorization and Admission Notification (PAAN) app **UHCprovider.com/tncommunityplan** > **Prior Authorization and Notification Resources** **1-877-842-3210**	• Request authorization/notify of the procedures and services outline in the prior authorization/notification requirements section of this manual • Review current list of prior authorizations
Prior authorization notification tool, quick references and other helpful resources	**UHCprovider.com/priorauth** > **Prior Authorization Notification Tool** **1-877-842-3210**	The process for completing the notification/prior authorization request and time frames remains the same. Learn how to use the prior authorization advanced notification (PAAN) tool, complete the notification/prior authorization process or confirm a coverage decision. Call 7 a.m.–7 p.m. local time, Monday–Friday.

Topic	Contact	Information
Provider advocates	**1-800-690-1606** Network providers, email **uhc_tn_outreach@uhc.com** Fax: 1-888-808-4420 Out-of-network providers, email **uhccp_tn_outreach@uhc.com** Fax: 1-888-823-7285	When calling, choose Provider option, enter Tax ID, enter specific Member ID or wait for provider services representative to request call from appropriate provider advocate.
Provider services	**UHCprovider.com/tncommunityplan** **1-800-690-1606**	Ask about behavioral health, benefits and eligibility, claims, medical management and prior authorizations. Representatives are available 8 a.m.–6 p.m. ET, Monday–Friday.
Radiology prior authorization	**UHCprovider.com** > Prior Authorization and Notification > **Radiology** **1-866-889-8054**	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.
Referrals	**UHCprovider.com** > Menu > **Referrals** or use the UnitedHealthcare Provider Portal Provider Services **1-800-690-1606**	View reimbursement policies that apply to UnitedHealthcare Community Plan enrollees. Visit this site often to view reimbursement policy updates.
Reimbursement policy	Policy **UHCprovider.com/tncommunityplan** > Bulletins and Newsletters	The process for completing the notification/prior authorization request and time frames remains the same. Learn how to use the prior authorization advanced notification (PAAN) tool, complete the notification/prior authorization process or confirm a coverage decision. Call 7 a.m.–7 p.m. local time, Monday–Friday.
TennCare	tn.gov/tenncare Provider links Rules for Tennessee Department of Finance and Administration	• Find phone numbers, policies, eligibility and other information • Helpful links to TennCare information • TennCare rules for providers
Tobacco free quit line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation (nonemergent)	Tennessee Carriers 1-866-405-0238	Call Tennessee Carriers to schedule non-emergent transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.

Topic	Contact	Information
UnitedHealthcare Dual Complete (HMO SNP)	**UHCprovider.com** > Health Plans by State > Tennessee > Medicare Advantage > **Dual Complete Special Needs** **1-800-690-1606** (enrollees) **1-888-834-3721** (non-enrollees)	Enrollees of UnitedHealthcare Dual Complete (HMO SNP) have already demonstrated eligibility for and been enrolled in Medicare Part A, Medicare Part B and TennCare (Medicaid) benefits. UnitedHealthcare Dual Complete (HMO SNP) enrollees may be enrolled in UnitedHealthcare Community Plan. Call any time between 8 a.m.–8 p.m. CT.
Utilization management	**1-877-842-3210**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) Program	Tennessee Department of Health (TDH) Immunization Program 1-615-741-1954	You must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Enroll as VFC providers with DHSS to bill for the administration of the vaccine.
Vision services	March Vision marchvisioncare.com 1-844-966-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from March Vision Care.
Whole person care person-centered care model (care management/disease management): population health	**1-800-690-1606**	Refer high-risk individuals (e.g., asthma, diabetes, obesity) and those who need private-duty nursing.

Chapter 2: Covered services

Enrollees have choices about how to get their medicare benefits

- One choice is to get Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get Medicare benefits by joining a Medicare health plan (such as UnitedHealthcare Dual Complete [HMO SNP])

Tips for comparing medicare choices

The following gives you a summary of what UnitedHealthcare Dual Complete (HMO SNP) covers and what enrollees pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Find on medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in the current Medicare and You handbook. View it online at medicare.gov. You can also get a copy by calling 1-800-MEDICARE (1-800-633-4227) at any time. TTY users should call 1-877-486-2048.

This document may be available in a non-English language. For additional information, call us at **1-800-690-1606**.

Es posible que este documento esté disponible en otro idioma. Para información adicional llame al **1-800-690-1606**.

Which doctors, hospitals and pharmacies can the enrollee use?

UnitedHealthcare Dual Complete (HMO SNP) has a network of doctors, hospitals, pharmacies and other care providers. If the enrollee uses the care providers that are not in our network, the plan may not pay for these services.

The enrollee must generally use network pharmacies to fill prescriptions for covered Part D drugs. You can see our plan's care provider and pharmacy directory at our website (**UHCprovider.com**).

Or call us, and we will send you a copy of the care provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and more. For details, see Tennessee's Dual Complete SNP page on **UHCprovider.com** > Health Plans by State > Tennessee > Medicare Plans.

Also see the following benefit summaries:

- UnitedHealthcare Dual Complete (HMO D-SNP): **UHCCommunityPlan.com/tn** > UnitedHealthcare Dual Complete > View Plan Details > Member Resources > **Summary of Benefits**
- UnitedHealthcare Dual Complete ONE (HMO D-SNP, FIDE): **UHCCommunityPlan.com/tn** > UnitedHealthcare Dual Complete ONE > View Plan Details > Member Resources > **Summary of Benefits**
- UnitedHealthcare Dual Complete ONE Plus (HMO D-SNP, ECF): **UHCCommunityPlan.com/tn** > UnitedHealthcare Dual Complete ONE Plus > View Plan Details > Member Resources > **Summary of Benefits**

UnitedHealthcare Dual Complete (HMO SNP) enrollees may also be covered by UnitedHealthcare Community Plan (Medicaid). Refer enrollees to their Medicaid Member Handbook for further details on Medicaid benefits. Individuals enrolled in another (Medicaid) plan must coordinate their benefits with that plan. As applicable, UnitedHealthcare Dual Complete (HMO SNP) will also help coordinate Medicaid and Medicare benefits.

Medicare cost-shares

The table at the end of this section shows Medicare cost-shares for enrollees enrolled in UnitedHealthcare Dual Complete (HMO SNP). Costs may vary based on the enrollee's type of Medicaid assistance.

Medicaid (Medicaid contractor) pays the Medicare cost-sharing (coinsurance, deductible or copayments except for Part D), up to the lesser of the Medicare or Medicaid rate, for Medicare covered benefits. It does not pay prescription drug copayments (unless institutionalized, and then no prescription drug copayments).

Supplemental benefits (dental, vision, product catalog, etc). are covered by the Medicare Plan. There is no Medicare cost-sharing. Once a supplemental benefit is exhausted, if it's not covered by Medicare, the enrollee pays, unless otherwise covered by Medicaid.

Excerpt from medicare cost-sharing policy – HMO

Non-QMB Dual

Referred to as United Healthcare Dual Complete Preferred. All health and medical services covered under Medicare Part A and Part B may be covered except hospice services and additional benefits. All UnitedHealthcare Dual Complete enrollees Preferred receive all basic benefits. (Prior Authorization rules may apply).

Contractors (Medicaid HMO) pay cost-sharing for only covered services for Non-QMBs. Contractors (Medicaid HMO) are not responsible for the services listed:

- Chiropractic services for adults
- Inpatient and outpatient occupational therapy coverage for adults
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum)
- Other behavioral health services such as partial hospitalization
- Any services covered by or added to the Medicare program not covered by TennCare (Medicaid)

Out-of-network services

1. **Care provider**

   If an out-of-network referral is made by a participating provider, and we, acting as the managed care organization (MCO) (Medicaid HMO), prohibit out-of-network referrals in the care provider contract, the care provider may be in violation of the contract. In this instance, we (Medicaid HMO) have no cost-sharing obligation. The care provider who referred the enrollee to an out-of-network care provider is obligated to pay any cost-sharing. The enrollee does not pay the Medicare cost-sharing except as noted in the enrollee section.

   However, if the Medicare HMO and we (Medicaid HMO) have networks for the same service that have no overlapping care providers, and we (Medicaid HMO) choose not to have the service performed in our network, we (Medicaid HMO) pay the cost-sharing for that service. If the overlapping care providers have closed their panels, and the enrollee goes to an out-of-network care provider, we (Medicaid HMO) pay the cost-sharing.

2. **Enrollee**

   If an enrollee has been advised of our (Medicaid HMO) network, the enrollee's responsibility is delineated in the Member Handbook and the enrollee elects to go out of network, the enrollee pays the Medicare cost-sharing amount. (Emergent care, pharmacy and other prescribed services are the exceptions). This responsibility must be explained in our (Medicaid HMO) Member Handbook.

Eligibility Category	If the Benefit is Covered by:		Then Medicare Cost-Sharing Paid by*
	Medicare	Medicaid	
Qualified Medicare Beneficiary (QMB) Dual No premiums	Yes	Yes	Medicaid (Medicaid HMO) pays Medicare cost-sharing.
	Yes	No	Medicaid (Medicaid HMO) pays Medicare cost-sharing.
	No	Yes	No Medicare cost-sharing since not covered by Medicare. Please bill Medicaid.
	No	No	Member pays for all services.
Non-QMB Dual May pay Part B premium if not paid by the State Medicaid agency. Otherwise, no premiums.	Yes	Yes	Medicaid (Medicaid HMO) pays Medicare cost-sharing.
	Yes	No	Member pays Medicare cost-sharing listed in the Summary of Benefits
	No	Yes	No Medicare cost-sharing since not covered by Medicare. Please bill Medicaid. Member pays for any Medicaid costsharing.
	No	No	Member pays for all services.

* Out-of-network services

Prior authorization

Services requiring prior authorization are listed on **UHCprovider.com**. The presence or absence of a procedure or service on the list does not define whether coverage or benefits exist for it. A facility or practitioner must contact UnitedHealthcare Dual Complete (HMO SNP) for prior authorization.

How to obtain a Prior Authorization:

- Phone: **1-800-690-1606**
- Online: **tenncloud.com** > My Dashboard > Patient Eligibility and Benefits application
- Ability to add attachments using the TennCloud Application
- Medical Fax: 1-800-743-6829

Referral guidelines

PCPs initiate and coordinate coverage for medically necessary services beyond the scope of their practice for Dual Complete (HMO SNP) enrollees if a participating care provider is not available. A referral to a non-participating care provider may be requested, but UnitedHealthcare Community Plan must authorize it. PCPs monitor the progress of care for referred enrollees and see that enrollees are returned to their care as soon as possible.

All referrals to non-participating care providers require the completion of a referral form with the following exceptions:

- Contracted vision care providers
- Contracted medical care providers
- Contracted dental care providers
- Contracted radiologists
- Female enrollees who self-refer for their well-woman exam

Write referrals on the same form you use for UnitedHealthcare Community Plan Medicaid enrollees. Prior authorization is required when services are performed by a non-participating provider.

The PCP completes, dates and signs (a signature stamp is acceptable) the referral form. Forward a copy of the referral form to the non-participating specialist. Referrals are limited to an initial consultation and two follow-up visits. Follow-up visits must be completed within 180 calendar days from the date the referral is signed and dated.

Your office may contact dental, vision, pharmacy and mental health/substance abuse services directly on behalf of the enrollee, or call the Health Plan at **1-800-690-1606** for assistance with coordination.

Contact information for other covered services is in the manual.

Coordination of care between physical, mental health and substance abuse care providers is important for improved outcomes in treatment. Evaluate individuals in your care for other health care needs and refer as appropriate.

If referral information to other care providers is needed, call Customer Service at **1-800-690-1606.**

Referrals should include, at a minimum: the individual's identifying information, the reason(s) for the referral, medication(s) the individual is currently being prescribed, diagnosis(es), current course of treatment and any other pertinent information. All referrals should be documented in the enrollee's chart.

Referrals for hematology/oncology, radiation oncology, gynecology oncology, allergy, orthopedic services and nephrology are valid for unlimited visits within the 180-day timeframe.

Communication with PCP and other health care professionals – behavioral health

To appropriately coordinate and manage care between behavioral health care clinicians and medical professionals, get the enrollee's consent to exchange treatment information with medical care professionals (e.g., PCP, medical specialists) and/or other behavioral health care clinicians (e.g., psychiatrists, therapists). Coordination and communication should take place at the time of intake, during treatment, the time of discharge or termination of care, and between levels of care.

The coordination of care between behavioral health care clinicians and medical care professionals improves the quality of care to our plan participants in several ways:

- Communication can confirm for a PCP that their patient followed through on a referral to a behavioral health professional

- Coordination minimizes potential adverse medication interactions for an enrollee's prescribed psychotropic medication
- Coordination allows for better management of treatment and follow-up for enrollees with both behavioral and medical disorders
- Continuity of care across all levels of care and between behavioral and medical treatment modalities is enhanced
- Enrollees with substance abuse disorders may be less at risk for a relapse

The following guidelines facilitate effective communication.

During the diagnostic assessment session, request the patient's written consent to exchange information with all appropriate treatment professionals. Following the initial assessment, provide other treating professionals with the following information within two weeks:

- Summary of patient's evaluation
- Diagnosis
- Treatment plan summary (including any medications prescribed)
- Primary clinician treating the patient
- Update other behavioral health clinicians and/or primary or referring care providers when the patient's condition or medications change.

At the completion of the treatment, send a copy of the termination summary to the other treating professionals.

- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the patient's mental health or substance abuse problems
- Some enrollees may not allow for release of their information. This decision must be noted in the clinical record. Both accreditation bodies and the health plan expect all clinicians to make a "good faith" effort to communicate with other behavioral health clinicians and any medical care professionals treating the plan participant.

Emergency and Urgent Care

- Encourage enrollees to receive emergency services from their PCP or a participating hospital or facility
- Behavioral Health Crisis Services are available at any time. For adults, 18 years and older, crisis services can be accessed by calling 1-855-CRISIS1 (1-855-274-7471). For children younger than 18 years, the toll-free numbers are:

  Davidson County:
  Mental Health Cooperative: 1-615-726-0125

  Tri-Cities Region:
  Frontier Health: 1-877-928-9062

  Greater Knoxville Region:
  Helen Ross McNabb Center: 1-865-539-2409

  For all other areas call Youth Villages:
  East Region: 1-866-791-9224
  South Middle Region: 1-866-791-9222
  Southeast Region: 1-866-791-9225
  Rural West Region: 1-866-791-9227
  North Middle Region: 1-866-791-9221
  Memphis Region: 1-866-791-9226

Definitions

An emergency medical condition is a medical condition with acute, serious symptoms 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 person's health, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any body part

Emergency services are inpatient and outpatient covered services that are:

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

Instruct enrollees with an emergency medical condition to go to the nearest emergency care provider.

Emergency services in the emergency room

The health plan covers necessary emergent services to stabilize enrollees, without pre-certification, where a prudent layperson would believe an emergency medical condition existed. Screening services that determine whether an emergency medical condition exists are covered services. If there is disagreement about the enrollee's stabilized condition at the expected time of discharge or transfer, the attending physician's decision prevails. The health plan may arrange for a participating physician with appropriate emergency room (ER) privileges to stabilize, treat and transfer the enrollee. This situation can only occur when the arrangement does not delay the provision of emergency services.

Emergency Inpatient Admission

Should the attending physician admit the enrollee, the health plan must be notified no later than the end of the next working day. Once the enrollee's condition is stabilized, the health plan requires notification for hospital admission and follow-up care. Should the hospital fail to notify the health plan within 10 calendar days following an enrollee's need for emergency services, charges the health plan's medical director deems not medically necessary could become the hospital's financial responsibility.

Billing for hospital observation beds

Used to determine whether a patient requires admission or other treatment.

- Observation status is consistent with CMS guidelines
- Billing guidelines
  - Use observation revenue codes 760, 761 or 762
  - Place number of hours in observation in the unit field (1 hour = 1 unit)

Bill for observation, even if the enrollee is later admitted. You may bill observation and inpatient on the same claim, in compliance with CMS standards. The end time of observation services may coincide with the time the patient is discharged from the hospital or is admitted as an inpatient. If the end of observation coincides with an inpatient admission, bill charges based on CMS requirements found at cms.gov.

Post-stabilization care services

Services related to an emergency medical condition provided after an enrollee is stabilized or to improve their condition are covered. Claim coverage decisions are based on the severity of symptoms at the time of presentation. Post-stabilization services, including all medical health services necessary to prevent the enrollee's condition from getting worse after discharge or during transport to another facility are also covered based upon the prudent layperson standard. If either the enrollee's PCP or the health plan directs the enrollee to the ER, emergency screening services and other medically necessary emergency services will be reimbursed, whether the condition meets the prudent layperson definition of an emergency medical condition.

Enrollees who need urgent (but not emergency) care are advised to call their PCP, if possible before getting urgently needed services. However, prior authorization is not required. **Urgently needed services are covered services that are not emergency services. They are provided when:**

- The enrollee is temporarily absent from the UnitedHealthcare Dual Complete (HMO SNP) service area
- When such services are medically necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition and 2) enrollees cannot reasonably obtain the services through a UnitedHealthcare Dual Complete (HMO SNP) network provider under the circumstances

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the enrollee is in the service area, but UnitedHealthcare Dual Complete's (HMO SNP) care provider network is temporarily unavailable or inaccessible.

Out-of-area renal dialysis services

An enrollee may obtain medically necessary dialysis services from any qualified care provider they select when they are temporarily absent from UnitedHealthcare Dual Complete's (HMO SNP) service area and cannot reasonably access UnitedHealthcare Dual Complete (HMO SNP) dialysis providers. No prior authorization or notification is required. However, an enrollee may advise UnitedHealthcare Dual Complete (HMO SNP) if they will temporarily be out of the service area. UnitedHealthcare Dual Complete (HMO SNP) may provide medical advice and recommend they use a qualified dialysis provider.

Preventive services

Enrollees may access the following services from a participating care provider without a referral from a PCP:

- Influenza and pneumonia vaccinations
- Routine and preventive women's health services (such as pap smears, pelvic exams and annual mammograms)
- Dental
- Routine vision
- Routine hearing

Enrollees may not be charged a copayment for pneumonia vaccinations or pap smears.

Hospital services

Acute inpatient admissions

All elective inpatient admissions require prior authorization from the UnitedHealthcare Dual Complete (HMO SNP) Prior Notification Service Center.

UnitedHealthcare Dual Complete (HMO SNP) Concurrent Review nurses and staff, in coordination with admitting physicians and hospital-based physicians (hospitalists) coordinate and conduct Continued Stay Reviews, provide appropriate referrals for extended care facilities and coordinate services required for adequate discharge. UnitedHealthcare Dual Complete (HMO SNP) case managers will assist in coordinating necessary services identified in the discharge planning process as well as coordinating the required follow-up by the corresponding PCPs.

Non-emergent transportation (NEMT)

UnitedHealthcare Community Plan extends NEMT benefits to our Dual Special Needs (HMO SNP) enrollees. This extension will have many positive results for NEMT providers:

- Easier claim submission — no more CMS 1500 completions
- Quicker turnaround time of your claims
- Faster payment

DSNP enrollees will have limited coverage for NEMT services through the Medicare portion of their benefits. Tennessee Carriers, Incorporated (TCI) handles our NEMT network contracting and is currently maintaining rates and network status. TCI will reach out to NEMT providers to execute new contracts. However, if you perform both NEMT and emergency transport services, bill UnitedHealthcare Community Plan.

Chapter 3: Non-covered benefits and exclusions

Some medical care and services are not covered ("excluded") or are limited by UnitedHealthcare Dual Complete (HMO SNP). View a list of UnitedHealthcare Dual Complete (HMO SNP) policies on coverage guidelines on **UHCprovider.com**. It describes services not covered under any conditions and some that are covered only under specific conditions.

If enrollees receive services that are not covered, they must pay for the services themselves.

UnitedHealthcare Dual Complete (HMO SNP) will not pay for the exclusions. Neither will Original Medicare, unless they are found upon appeal to be services we should have paid or covered.

We regularly review new procedures, devices and drugs to determine whether they are safe. New procedures and technology that are safe and efficacious are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable enrollee copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health.

When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an enrollee, one of our medical directors makes a medical necessity determination based on enrollee medical documentation, review of published scientific evidence and, when appropriate, relevant specialty or professional opinion from an individual with expertise in the technology.

Chapter 4: Care provider responsibilities

General care provider responsibilities

UnitedHealthcare Community Plan Dual Complete does not prohibit or otherwise restrict you from advising or advocating on behalf of an enrollee who is your patient for the following:

- The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the enrollee needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or nontreatment

The enrollee's right to participate in decisions about their health care. This includes the right to refuse treatment and to express preferences about future treatment decisions.

UnitedHealthcare Dual Complete (HMO SNP) participating care providers are responsible for:

- Verifying a person's enrollment and assignment through UnitedHealthcare Dual Complete (HMO SNP) roster, using the Interactive Voice Response (IVR), UnitedHealthcare Community Plan's care provider portal or contacting Provider Services before providing covered services. Not verifying enrollment and assignment may result in claim denial.
- Rendering covered services to UnitedHealthcare Dual Complete (HMO SNP) enrollees in an appropriate, timely and cost-effective manner and based on their specific contract and CMS requirements
- Encouraging enrollees to receive necessary and recommended preventive health procedures based on the **Agency for Healthcare Research and Quality, US Preventive Services Task Force Guide to Clinical Preventive Services**
- Maintaining all licenses, certifications, permits or other prerequisites required by law to provide covered services and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare Dual Complete (HMO SNP)
- Rendering services to enrollees diagnosed with the human immunodeficiency virus (HIV) or having acquired immune deficiency syndrome (AIDS) in the same manner and to the same extent as other enrollees and under the compensation terms set forth in their contract
- Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to enrollees with disabilities. They may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility.
- Educating enrollees about the proper utilization of the practitioner's office in lieu of hospital ERs. Do not refer or direct enrollees to hospital ERs for non-emergent medical services.
- Abiding by the UnitedHealthcare Dual Complete (HMO SNP) referral and prior authorization guidelines
- Admitting enrollees in need of hospitalization only to participating hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare Dual Complete (HMO SNP); or, (2) the enrollee's condition is emergent, and the use of a contracted hospital is not medically feasible. You will provide covered services to enrollees while in a hospital as determined medically necessary by the practitioner or a medical director.
- Using participating hospitals, specialists and ancillary care providers. An enrollee may be referred to a non-participating practitioner or care provider only if the medical services required are not available through a participating practitioner or care provider and if prior authorization is obtained.
- Calling the health plan's Quality Management Department at **1-800-690-1606** for questions related to profiles, enrollee lists, practice guidelines, medical records, government quality reporting, HEDIS, etc.
- Providing all EPSDT services to UnitedHealthcare Dual Complete (HMO SNP) enrollees younger than 21 years
- Screening UnitedHealthcare Dual Complete (HMO SNP) enrollees for behavioral health problems, using the Screening Tool for Chemical Dependence (i.e., Substance Abuse) and Mental Health. File the completed screening tool in the patient's medical record.
- Making recommendations to participating specialists for health problems the PCP does not manage. The PCP completes a prescription or a note on letterhead indicating the reason for the recommendation and assists the enrollee in making an appointment. No formal referral form is required.
- Being available to enrollees by phone at any time. You can also arrange for phone coverage by another participating PCP. Recorded messages are not permitted.
- Responding to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations
- Referring services requiring prior authorization to the Pre-Certification, Behavioral Health or Pharmacy departments as appropriate

- Informing UnitedHealthcare Care Management of any enrollee showing signs of end-stage renal disease
- Admitting UnitedHealthcare Dual Complete (HMO SNP) enrollees to the hospital when necessary and coordinating their medical care while hospitalized
- Reporting all services provided to UnitedHealthcare Dual Complete (HMO SNP) enrollees in an accurate and timely manner
- Obtaining authorization from UnitedHealthcare Dual Complete (HMO SNP) for all hospital admissions
- Providing culturally competent care and services
- Complying with the Health Insurance Portability and Accountability Act (HIPAA) provisions
- Documenting procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments
- Transferring medical records upon request. Copies of enrollee's medical records must be provided to enrollees upon request at no charge.
- Allowing timely access to UnitedHealthcare Dual Complete (HMO SNP) enrollee medical records as per contract requirements for medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintaining staff privileges at a minimum of one participating hospital
- Reporting infectious diseases, lead toxicity and other conditions as required by state and local laws and regulations

The patient Self-Determination Act requires that HMO patient records (charts) note whether an advance directive has been made. If the patient has given the care provider a copy, it should be filed in the patient's chart. A notation that the care provider has addressed advance directives should be present on adult (age 18 and older) patient charts.

Advance directives are also available for enrollees to specify their desires for behavioral health services.

These directives are called Declarations for Mental Health Treatment. Additional information is available by calling the Tennessee Department of Mental Health and the Developmental Disabilities' Office of Consumer Affairs at 1-800-560-5767. You can also view their website at: tn.gov/mental/legalcounsel/olc.

Care provider privileges

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

Utilization care management programs

The Utilization Management (UM) Program goal is to help assure:

- The right care is provided for the right patient at the right time
- Care is provided in the most appropriate setting
- Care is provided by the most appropriate care provider

The health plan:

- Uses care management and continuum of care principles
- Uses guidelines for care
- Tracks medical utilization data
- Follows guidelines as established by all applicable regulatory and accrediting bodies including NCQA (National Committee for Quality Assurance) and CMS
- Evaluates annually the effectiveness of the Healthcare Management Programs
- The health plan reports outcomes and customer satisfaction using the standard measures of Medicare, HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems)

You agree to comply with the health plan's medical policies, QI and Care Management programs and ongoing Utilization Management Program.

Our philosophy is that medically appropriate care is cost-effective care. Inappropriate denials of coverage are more costly to the plan than coverage for appropriate care. The health plan seeks to avoid under- and over-utilization of medical services. Only qualified care provider may issue UM denials. Only registered pharmacists or care provider may deny payment authorization for medications that require preauthorization.

Out-of-network procedures for referral to Non-network care providers

When services are not available from a network care provider, preauthorization for a referral to non-network care provider or facilities is required. The health plan must be advised of all requests for preauthorizations (except emergencies). In the case of emergencies, the health plan must be notified the first working day following referral. Prior authorization for extensions must also occur as described. Prior authorization is required for each follow-up visit unless otherwise indicated.

You must arrange for care by non-network physicians or facilities prior to the service except in emergencies or accidents. If an enrollee requests authorization after the fact, please advise them that this is against policy. Refer them to the health plan if they have further questions.

HIPAA and compliance responsibilities

Health Insurance Portability and Accountability Act

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

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

2. **Unique identifiers**
   HIPAA also required the development of unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

   Employers
   Effective July 30, 2002, the Employer Identification Number (EIN) assigned by the Internal Revenue Service was adopted as the standard employer identifier.

   Care providers
   The National Provider Identifier (NPI) is the standard unique identifier for health care providers. The NPI is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While the HIPAA regulation only requires that the NPI be used in electronic transactions, many state agencies require the identifier on fees for service claims and on encounter submissions. For this reason, we require the NPI on paper transactions.

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

   Health plans
   The national identifier for health plans is still under development.

   Individuals
   The development of the individual identifier remains on hold.

3. **Privacy of Individually Identifiable Health Information**
   The privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information, and to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems and individual organizations and individuals.

4. **Security**
   The Security Regulations required that covered entities meet basic security objectives.

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates, receives, maintains and transmits;
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
- Help ensure compliance with the Security Regulations by the covered entity's workforce. UnitedHealthcare Dual Complete (HMO SNP) expects all participating care providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines. Additional information on the HIPAA regulations can be obtained at cms.gov.

Disclosure of criminal conviction, ownership and control interest

Prior to payment for any services rendered to UnitedHealthcare Dual Complete (HMO SNP) enrollees, you must have completed and filed with the health plan disclosure information in accordance with requirements in 42 CFR, Part 455, Subpart B. This disclosure of criminal convictions related to the Medicare and Medicaid programs is required by CMS and/or the state. These requirements hold that individual physicians and other health care professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest.

National provider identifier

What is NPI?

- A 10-character number with no embedded intelligence
- A HIPAA standard
- Mandated for use in ALL standard electronic transactions across the industry (claims, enrollment, remittance, claim status request and response, authorization request and response, NCPDP, etc)
- CMS contracted with Fox Systems to develop the National Plan and Provider Enumeration System (NPPES) on authority delegated by the Secretary of HHS
- The NPPES assists you with your application, processes the application and returns the NPI to you

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

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

NPI compliance

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

NPI is the only health care provider identifier that can be used for identification purposes in standard transactions for those covered health care providers.

How to get an NPI

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System – Home Page and apply online.
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
  - Phone: 1-800-465-3203 or TTY 1-800-692-2326
  - Email: customerservice@npienumerator.com
  - Mail: NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059

How to share your NPI with us

Once you have NPI, let us know.

Change Notification

Report any changes to your information as soon as possible. Some examples of these changes are practice acceptance of new patients. Please call the UHG VETSS line at **1-877-842-3210** or your provider relations consultant at **1-800-690-1606** to make demographic/tax ID changes.

If terminating your participation, you must submit a termination notification to us in the time frames stated in the provider agreement. All notices must be in writing and delivered either personally or sent by certified mail with postage prepaid. If mailed, such notice shall be deemed to be delivered when deposited in the United States Mail addressed to the River Valley Plan to the attention of the account manager, at their respective addresses as they appear on the signature sheet of your provider agreement.

If services the contract agreement covers are added or discontinued, notify the health plan prior to such discontinuation or addition. The health plan will review the changes requested to help ensure adequacy of enrollee access for service. If the need for additional service exists, comply with health plan credentialing requirements for that new service. A current care provider contract will not automatically include a new location. Each request will be evaluated on an individual basis.

Locum tenens

In instances when a participating care provider has a locum tenens covering for a short period of time (less than 60 days), the care provider should help ensure appropriate licensure, malpractice insurance and other pertinent information is validated prior to allowing the locum tenens to treat patients. Submit claims under the participating care provider's name, tax ID and suffix.

Allied Health professional billing

If your office employs an allied health professional (i.e., nurse practitioner, physician assistant) who is providing services to enrollees, the claim must be submitted to the health plan with their assigned provider identification number. These claims should not be filed under the supervising physician's number.

Records and patient information for claims and medical management

Supply medical records and patient information at the request of the health plan or appropriate regulatory agencies as required for claims payment and medical management. You may not charge the health plan or the enrollee for copies of medical records provided for claims payment or medical management. You may charge the enrollee for records provided at their request.

You may not charge the health plan or the enrollee for records provided when an enrollee moves from one PCP to another.

UM decisions are based on the appropriateness of the care and services as determined by national guidelines for best practice taking into consideration individual patient needs as appropriate. The health plan does not compensate or reward UM reviewers for denials of coverage, not do reviewers receive financial incentives to influence UM decisions.

Some services, which you may recommend, are not covered as part of the evidence of coverage. If you have questions about what services or treatments are covered, contact Customer Service.

Components of utilization management program

Referral authorization – A documented process for authorizing out-of-network care at an in-network level of benefits as determined by the enrollee's benefit plan.

Preauthorization – A documented process for authorizing procedures and/or hospital admissions using established review criteria.

Inpatient review – A process for reviewing the appropriateness of admission to the hospital and ongoing inpatient care.

Ambulatory review – A process for evaluating the appropriateness of services performed in the ambulatory setting.

Confidentiality of physician specific information – Care provider-specific information gathered during the UM processes is confidential. It will not be released to the public or the enrollee without the physician's written consent.

Organization and responsibility – The program's development and continued improvement is the responsibility of the Health Services Process. Responsibility for ongoing monitoring of the application of the UM Program lies with the chief medical officer.

Authority for medical management decisions

Criteria may allow an Inpatient Care Manager (ICM) to approve payment for a treatment, care provider or location of treatment. The ultimate authority, however, for any denial of a request for payment lies with the medical director.

The attending physician has the ultimate authority for the enrollee's medical care. The medical management process does not override this responsibility. If there is disagreement about the appropriate intensity or location of care, the attending physician may care for the patient without any encumbrances from the medical management process.

Technology review process

The health plan has a technology assessment process in which to evaluate and address the safety, efficacy and appropriateness of emerging and new medical/behavioral technologies, as well as to keep pace with changes to existing medical/behavioral health technologies and to make recommendations about their use for potential inclusion in the benefit plan. This includes medical/behavioral health procedures, devices and selected pharmaceuticals. If you have a technology that you would like to have reviewed, please contact the health plan.

Services out of area (OOA)

UnitedHealthcare Dual Complete (HMO SNP) enrollees must receive routine, preventive and scheduled care within the care provider network. Out-of-area services are only covered if an emergency condition exists or an approved referral has been granted.

- Direct notification pertaining to such services received by the health plan to Health Services
- The health plan processes service requests for treatment authorizations under the direction of the PCP and OOA attending physician
- The health plan, in conjunction with the PCP and the OOA doctor, coordinates the enrollee's transfer back to the Service Area when medically feasible as appropriate
- The health plan provides out-of-network coverage for urgent or emergent stabilization services. This includes the time they are stabilized in the ER prior to admission as an inpatient or discharged from the facility.
- The health plan provides coverage for post-stabilization care services. These are provided after an enrollee is stabilized to help them stay that way.
- Coverage from OOA inpatient services continues only as long as the enrollee's condition prevents transfer to a participating hospital. Transfers should occur within 48 hours of determination of the enrollee's transferability.

Medical hospital utilization management

Admissions are reviewed within one business day of received clinical using Medicare guidelines and InterQual (effective May 2021; formerly MCG Care Guidelines) and taking the individual enrollee circumstances into consideration. The nurse reviewer will verify documentation of admission order. If admission or continued stay does not meet criteria outlined in the guidelines and the individual enrollee circumstance, the nurse reviewer will refer the case to the medical director.

The medical director reviews for appropriateness of admissions and the need for continued stay. They also look at the quality of care being provided for those cases referred by a nurse reviewer.

If the nurse reviewer cannot approve, they will notify the hospital contact that the case will be sent to the medical director and an adverse determination may happen. If the medical director cannot justify the care, the hospital will be notified.

If the hospital or attending physician wants to speak with the medical director (peer to peer), they will be afforded that opportunity. If the enrollee is discharged, peer-to-peer is available within three business days from discharge and before the formal appeal being filed. External Independent Review will be obtained as determined by the health plan or by enrollee request based on applicable state laws.

The ultimate decision regarding medical management of a enrollee lies solely with the attending physician. **An attending physician is never told they must discharge a patient. They are only told the health plan determined the admission/continued stay to be not medically necessary.**

Hospital review process

Concurrent hospital review addresses many aspects of a patient's medical care in the hospital. Nurses review the hospital record for documentation related to medical necessity supporting the acute inpatient level of care, potential quality of care concerns, documented quality of care or service or patient safety issues as well as any system issues with care. Individual patient or physician issues are reviewed on a case-by-case basis with the medical director.

System issues identified by Health Services staff or the medical director are addressed with the individual facilities as needed. The Provider Contracting Department will consider this information during the contracting process.

Inpatient review program

The inpatient review program is a review process in which admissions and hospital stays are reviewed to assure that inpatient care is medically appropriate; to identify quality of care concerns and opportunities for improvement; and to detect and better manage over- and under-utilization. Nurse reviewers also review certain care aspects as they relate to disease management programs and practice guidelines. Discharge planning and care management identification also occur at this time.

If an admission or continued stay is determined to be medically unnecessary, coverage for those services will not be eligible for authorization and payment. The care provider education/sanction process may be applied.

Inpatient concurrent review: clinical information

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

Your cooperation is required with all UnitedHealthcare Dual Complete (HMO SNP) requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our enrollees directly face-to-face or by phone.

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

UnitedHealthcare uses InterQual (effective May 2021; formally MCG Care Guidelines), CMS guidelines or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Notice of termination of hospital benefits

Includes the following:

- Continued hospitalization is determined to be medically unnecessary
- Experimental/investigational treatment occurs, which is a non-covered benefit

If any of these situations occur, tell the health plan UM Program immediately. The health plan and hospital representatives will deliver Notice of Termination of Benefits to the enrollee.

Admission to skilled nursing units

*Inpatient hospitalization is not required for an enrollee to be admitted to a skilled level of care.

SNF care – A level of care in an SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care or skilled rehabilitation services or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise.

Skilled rehabilitation services are physical therapy, speech language therapy and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body. It also involves providing training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy teaches enrollees how to perform usual daily activities, such as eating and dressing themselves. In addition, services the care provider orders must be reasonable and necessary to treat the patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, their particular medical needs and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

The patient must require skilled services on a daily basis (seven days a week). A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services at least five days a week.

The nature and complexity of a service and the skills required for safe and effective delivery of that service are considered in determining whether a service is skilled. Skilled care requires frequent patient assessment and review of the care provider course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care

is goal-oriented to progress the patient toward functional independence. It requires the continuing attention of trained medical personnel.

SNF, Home Health Agency (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) notification requirements

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

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

When to deliver the NOMNC

Based on our determination of 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 2 days 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 us so these notices can be delivered as soon as the service termination date is known. You need not agree with the decision that covered services should end, but you still have a responsibility under its Medicare care provider agreement to carry out this function.

How to deliver the NOMNC

SNF, HHA and CORF providers must carry out “valid delivery” of the NOMNC. This means the enrollee (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 enrollee decides to appeal the end of coverage, they must contact the Quality Improvement Organization (QIO) by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO for Tennessee is QSource.

An enrollee may contact the QIO (QSource) at 1-901-682-0381 or 1-800-528-2655.

The QIO will inform us and the care provider of the request for a review. We provide the QIO and enrollee with a detailed explanation of why coverage is ending.

We may need to present additional information for the QIO to make a decision. Please cooperate with our requests. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Exclusions from NOMNC delivery requirements

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

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

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

We will issue a DENC explaining why services are no longer medically necessary to the enrollee. We will 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 enrollee requested an appeal, or the day before coverage ends, whichever is later.

Where to Locate the UnitedHealthcare NOMNC Form

A copy of the NOMNC can be found in the Forms Appendix Section of this manual or on the provider website at **UHCprovider.com**.

More information

More information on this process, including the required notices and related CMS instructions, is on cms.gov. (Also, the regulations are at 42 CFR 422.624, 422.626 and 489.27, and Chapter 13 of the Medicare Managed Care Manual). See cms.hhs.gov for more information about the manual.

Admission to an observation bed

Observation is considered an outpatient level of care and is used for short-term treatment, assessment and reassessment. Inappropriate use of observation services may result in care provider education/sanction. Enrollees may admit to a SNF directly from the observation level of care.

Observation services may be reviewed for the appropriate use of hospital services and length of stay. Inappropriate use of observation services may result in care provider education/sanction.

Eligibility and enrollment

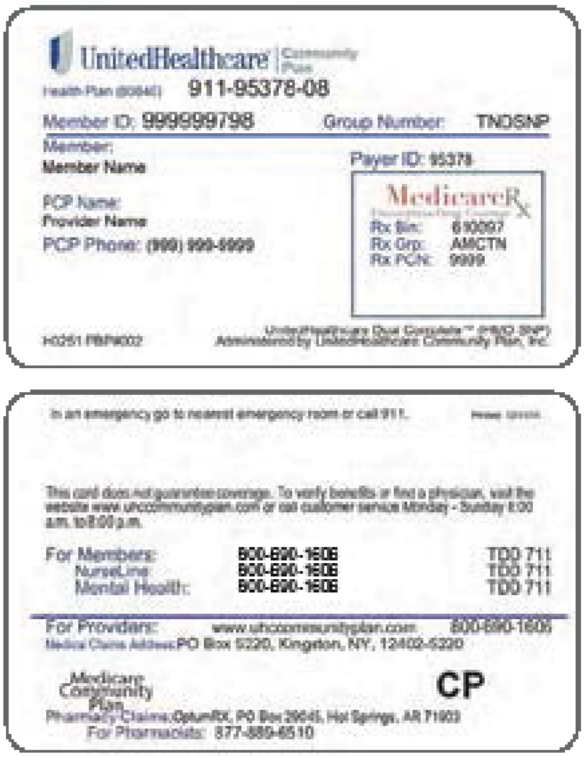
Medicare and (Medicaid) beneficiaries who enroll in UnitedHealthcare Dual Complete (HMO SNP) must meet the following qualifications.

- Be entitled to Medicare Part A and be enrolled in Medicare Part B
- Be entitled and enrolled in TennCare (Medicaid) benefits
- Live in the Dual Complete (HMO SNP) service area
- Maintain a permanent residence within the service area. They must not reside outside the service area for more than six months.
- Have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) that were participating in UnitedHealthcare Community Plan at the time of their enrollment in Dual Complete (HMO SNP)

Each UnitedHealthcare Dual Complete (HMO SNP) enrollee will receive a UnitedHealthcare Dual Complete (HMO SNP) identification (ID) card containing their name, enrollee number, PCP name and information about their benefits. The Dual Complete (HMO SNP) ID membership card does not guarantee eligibility. It is for identification purposes only.

UnitedHealthcare Dual Complete (HMO SNP) enrollees are assigned a Dual Complete (HMO SNP) specialist to act as advocates.

Enrollees who lose their eligibility have 180 days to regain certification. If recertification is not obtained, the enrollee may be disenrolled from the plan.



PCP enrollee Assignment

UnitedHealthcare Dual Complete (HMO SNP) manages the enrollee's care on the date they are enrolled with the plan and until the enrollee is disenrolled. Each enrollee can choose a PCP within our Provider Directory. Enrollees receive a letter notifying them of the name of their PCP, office location and phone number. They are also told they may select a different PCP should they prefer someone other than the PCP assigned. If the enrollee elects to change the initial PCP assignment, the effective date will be the day the enrollee requested the change. If they ask UnitedHealthcare Dual Complete (HMO SNP) to change their PCP at any other time, the change will be effective on the date of the request.

Assignment to PCP panel roster

Once an enrollee has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at **UHCprovider.com**. The portal requires a unique username and password combination to gain access.

Sign in to the UnitedHealthcare Provider Portal at **UHCprovider.com**. Select Reports from the Tools and Resources. From the Report Search page, Select the Report Type (PCP Panel Roster) from the pulldown menu. Complete additional fields as required. Click on the available report you want to view.

Verifying enrollment

Verify eligibility prior to providing services.

Once an enrollee has been assigned to a PCP, UnitedHealthcare Dual Complete (HMO SNP) documents the assignment and provides each PCP a roster with the enrollees assigned to them. Rosters can be viewed electronically on **UHCprovider.com**. PCPs should verify eligibility by using their rosters in addition to:

- UnitedHealthcare Dual Complete (HMO SNP): **1-800-690-1606**
- MediFAX
- TennCare (Medicaid) web-based eligibility verification system
- **tenncloud.com** > My Dashboard > Patient Eligibility and Benefit Application

At each office visit, your office staff should:

- Ask for the enrollee's ID card and have a copy of both sides in the enrollee's office file
- Determine if the enrollee is covered by another health plan to record information for coordination of benefits purposes
- Refer to the enrollee's ID card for the appropriate phone number to verify eligibility in the UnitedHealthcare Dual Complete (HMO SNP), deductibles, coinsurance amounts, copayments and other benefit information
- Check their UnitedHealthcare Dual Complete (HMO SNP) panel listing to be sure the PCP is the enrollee's PCP. If the enrollee's name is not listed, your office staff should contact UnitedHealthcare Dual Complete (HMO SNP) Customer Service to verify PCP selection before the participating care provider sees the enrollee.

Coordinating 24-hour coverage

PCPs are expected to provide anytime coverage for UnitedHealthcare Dual Complete (HMO SNP) enrollees. When a PCP is unavailable to provide services, the PCP must help ensure they have coverage from another participating care provider. Hospital ERs or urgent care centers are not substitutes for coverage participating care providers. Participating care providers can consult their UnitedHealthcare Dual Complete (HMO SNP) care provider directory, or contact UnitedHealthcare Dual Complete (HMO SNP) Member Services with questions about the UnitedHealthcare Dual Complete (HMO SNP) network.

Care after hours

During a medical emergency, an enrollee should seek care from the nearest doctor or hospital. Crisis services are available for enrollees with behavioral health emergencies. Behavioral Health Crisis Services for adults (18 years and older) can be accessed by calling 1-855-CRISIS-1 (or 1-855-274-7471). Refer to contact list in **Chapter 1** for additional numbers.

Optum NurseLine services

If the enrollee has questions or needs medical advice, they may contact Optum® NurseLine. Optum NurseLine gives medical facts and access to health information.

Optum NurseLine can be accessed at any time by calling **1-800-690-1606** and TDD (Hearing-Impaired) 1-800-855-2880.

Optum NurseLine can:

- Help avoid unnecessary ER visits
- Provider guidance on appropriate treatment settings
- Educate about the importance of healthy lifestyle choices

Chapter 5: Credentialing

Care provider credentialing

Practitioners wanting to participate in the health plan must call the National Credentialing Center at **1-877-842-3210** and information about their credentials and practice arrangements. When a practitioner is considered for participation, the practitioner receives application submission instructions by fax. The application process includes submission of a complete signed application and supporting documents to the UnitedHealthcare National Credentialing Center by using the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing Datasource.

Care provider recredentialing process

All practitioners are recredentialed at least every 36 months. At the time of recredentialing, the UnitedHealthcare National Credentialing Center tells the practitioner to access the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing Datasource to update and re-attest the validity of credentialing data. The practitioner's professional license, DEA license (if applicable) and professional liability insurance are verified prior to the Credentialing Committee review. Each practitioner's file is also reviewed for any sanctions (the health plan and/or state/federal) and quality of care or quality of service issues. This cycle does not preclude recredentialing for shorter time frames due to quality issues and/or per the direction of the Corporate Credentialing Committee.

Office site review

Office site checks are required as a part of the credentialing process for primary care and obstetrician/gynecology practitioners. Office site checks are also required for physician assistants and nurse practitioners who practice primary care as well as certified nurse midwives. When an office site check is required, a health plan representative contacts the practitioner's office to schedule the site visit.

Nondiscrimination in network participation

We do not deny or limit the participation of any clinician or facility in the health plan network. We do not discriminate against any clinician or facility based on any characteristic protected under state, federal or local law.

We have never had a policy of terminating a clinician or facility because they: (1) advocated on behalf of an enrollee; (2) filed a complaint against the health plan; (3) appealed a decision of the health plan; or (4) requested a review or challenged a termination decision.

We have not, and will not, terminate any clinician or facility from its network based on any of these four grounds. Nothing in our clinician or facility contracts should be read to contradict or modify this long standing practice.

Written notification and correction of information

If, during the process of credentialing or recredentialing, the health plan discovers information that varies substantially from that which was initially provided, we notify the clinician or facility and offer an opportunity to correct the information. You have 10 business days to respond. Responses must be made in writing. Once the corrected information is verified, it becomes part of the clinician's or facility's file and is maintained in the same manner as all other credentialing and recredentialing material. You may review information submitted to support your credentialing application, correct erroneous information and be informed of your credentialing or recredentialing status, upon request. We also tell you your rights. Please provide updated demographic information as changes occur.

Organizational provider credentialing program

The Organizational Provider Credentialing Program includes the credentialing of participating hospitals, ambulatory surgery centers, home health/Infusion agencies and skilled care facilities according to company and external review standards. The process follows established policies and procedures approved annually by our Corporate Quality Improvement Committee. This program selects and monitors organizational providers.

Facility

Application process

You must submit a complete, signed application and supporting documentation for review by the UnitedHealthcare National Credentialing Center. This includes copies of the following as applicable:

- Accreditation certificate/letter
- State license
- Certificate of professional liability insurance
- Laboratory certification

- Information regarding any license sanctions and/or insurance denials
- A list of all subcontracted patient care services (required to confirm the use of plan-accredited care providers).

We contract with only accredited facilities unless otherwise determined by business need. If needed, we may conduct an onsite facility audit.

At our request, an organizational provider must provide evidence of license for any personnel employed legally required to be licensed in the state in which they practice and that each is practicing within the scope of the license. All organizational providers are recredentialed every three years. The recredentialing process includes the collection of an updated application and supporting documents. We also review utilization and quality issues during recredentialing.

Between credentialing and recredentialing, you must notify us within 15 days of any material changes in your network applications and supporting documentation.

In some instances, we may delegate organizational provider credentialing. In these instances, the delegate must comply with our organizational provider credentialing standards.

Ambulatory record review standard guidelines

Your office medical records will be reviewed against the health plan, NCQA and regulatory guidelines relating to structure and content. All medical records must be in substantial (85%) compliance with these standards.

Chapter 6: Claims process/coordination of benefits/claims

UnitedHealthcare Community Plan care providers contracted with Medicare and Medicaid lines of business, serving UnitedHealthcare for Medicare and Medicaid enrollees, may take advantage of single-claim submission. Claims submitted to UnitedHealthcare Community Plan for dual-enrolled individuals will process first against Medicare benefits under UnitedHealthcare Dual Complete (HMO SNP). Then they will process against Medicaid benefits under the appropriate TennCare (Medicaid) or Division of Developmental Disabilities (DIDD) benefits. You will not need to submit separate claims for the same enrollee.

Electronic claims reduce errors and shorten payment cycles, easing the reimbursement process for both health care providers and the health plan.

For electronic claims submission requirements, please see our companion documents on **UHCprovider.com**. Also see our Quick Reference Guide on **UHCprovider.com** > Health Plans by State > Tennessee > Medicare Plans > **Dual Complete Plans**. This documentation should be shared with your software vendor. For more information about electronic claims, please refer to the EDI section of this manual or the care provider section of **UHCprovider.com**. To enroll, call the e-business unit at **1-800-690-1606** or email **ac_edi_ops@uhc.com**.

If a claim must be submitted on paper, send claims to the following address:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

Chapter 7: Medical management, quality improvement and utilization review programs

UnitedHealthcare Dual Complete (HMO SNP) seeks to improve the quality of care provided to its enrollees. Thus, UnitedHealthcare Dual Complete (HMO SNP) encourages you to take part in health promotion and disease-prevention programs. Work with UnitedHealthcare Dual Complete (HMO SNP) in its efforts to promote healthy lifestyles through enrollee education and information-sharing. UnitedHealthcare Dual Complete (HMO SNP) seeks to accomplish the following objectives through its Quality Improvement and Medical Management programs.

You must comply and cooperate with all UnitedHealthcare Dual Complete (HMO SNP) medical management policies and procedures and in UnitedHealthcare Dual Complete (HMO SNP) quality assurance and performance-improvement programs. We may use your performance data to conduct quality activities.

Referrals and prior authorization

You are required to coordinate enrollee care within the UnitedHealthcare Dual Complete (HMO SNP) care provider network. If possible, all UnitedHealthcare Dual Complete (HMO SNP) enrollees should be seen by UnitedHealthcare Dual Complete (HMO SNP) participating care providers. Services provided outside the network are permitted, but only with prior authorization from UnitedHealthcare Dual Complete (HMO SNP). Referrals are not required for Dual Complete (HMO SNP) enrollees when they are seeing a UnitedHealthcare Dual Complete (HMO SNP) in network care provider.

The prior authorization procedures are particularly important to the UnitedHealthcare Dual Complete (HMO SNP) managed care program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare Dual Complete (HMO SNP) care provider. Prior authorization is one of the tools UnitedHealthcare Dual Complete (HMO SNP) uses to monitor the medical necessity and cost-effectiveness of the health care enrollees receive. Contracted and non-contracted health professionals, hospitals and other care providers are required to comply with UnitedHealthcare Community Plan's Dual Complete (HMO SNP) prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to an enrollee, the PCP initiates requests for prior authorization. However, specialists and ancillary care providers also request prior authorization for services within their specialty areas.

Unless another department or unit has been specially designated to authorize a service, requests for prior authorization are routed through UnitedHealthcare Community Plan's Dual Complete (HMO SNP) Prior Authorization Department. Nurses and medical directors are available anytime.

How to obtain a Prior Authorization:

- Phone: **1-800-690-1606**
- Online: **tenncloud.com** > My Dashboard > Patient Eligibility and Benefit application
- Ability to add attachments using the TennCloud Application

PCP referral responsibilities

If an enrollee self-refers or the PCP coordinates with the enrollee a referral to a specialist, the PCP should check the UnitedHealthcare Dual Complete (HMO SNP) Provider Directory to help ensure the specialist is a participating care provider in the UnitedHealthcare Dual Complete (HMO SNP) network.

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

- Enrollee's name
- Referring PCP
- Reason for the consultation

Marketing

You may not develop and use any materials that market UnitedHealthcare Dual Complete (HMO SNP) without the prior approval of UnitedHealthcare Dual Complete (HMO SNP) in compliance with Medicare Advantage 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.

Sanctions under federal health programs and state law

You must help ensure you don't employ 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.

You must tell UnitedHealthcare Dual Complete (HMO SNP) whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Tennessee, the federal government or any public insurer. You must notify UnitedHealthcare Dual Complete (HMO SNP) immediately if any such sanction is imposed on a participating care provider, staff member or subcontractor.

Selection and retention of participating care providers

We arrange covered services provided to thousands of enrollees through a comprehensive care provider network of independent practitioners and facilities that contract with us. The network includes health care professionals such as PCPs, specialist physicians, medical facilities, allied health professionals and ancillary service providers.

UnitedHealthcare Dual Complete's (HMO SNP) network has been carefully developed to include those participating health care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care and acceptance of our managed care principles and financial considerations.

UnitedHealthcare Dual Complete (HMO SNP) continuously reviews and re-credentials participating care providers' information every three years. The credentialing guidelines are subject to change based on industry requirements and our standards.

Termination of participating care provider privileges

Termination without cause

UnitedHealthcare Dual Complete (HMO SNP) and a participating care provider must provide at least 60 days written notice to each other before terminating a contract without cause.

Appeal process for care provider participation decisions

Physicians

If UnitedHealthcare Dual Complete (HMO SNP) decides to suspend, terminate or non-renew a physician's participation status, UnitedHealthcare Dual Complete (HMO SNP) 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 Dual Complete (HMO SNP)
- Allow the physician to appeal the action to a hearing panel and give written notice of their right to a hearing. We also provide the process and timing for requesting a hearing.
- Help ensure the majority of the hearing panel enrollees are the affected physician's peers

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare Dual Complete (HMO SNP) 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.

Subcontracted physician groups must apply these procedures equally to physicians within those subcontracted groups.

Other care providers

UnitedHealthcare Dual Complete (HMO SNP) decisions subject to appeal include decisions regarding reduction, suspension or termination of a participating care provider's participation resulting from quality deficiencies. UnitedHealthcare Dual Complete (HMO SNP) 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 care provider will detail the limitations and inform them of the rights to appeal.

Notifying enrollees of care provider termination

Provide as much advance notice as possible when preparing to terminate participation with the Dual Complete (HMO SNP) care provider network. CMS requires the notifying enrollees affected by termination a minimum of 30 days' notice before the termination effective date.

Care management

The Care Management program provides coordination of care for patients with complex, chronic or critical health care needs. EPSDT services are also a focus of the Care Management program. The program assists families, patients and doctors in planning care and services. This is part of a team plan, which looks at individual health care needs. Care managers assist enrollees and their families by analyzing all options available to them within the health care delivery system, promoting self management and helping them coordinate their health care.

Care managers use motivational interviewing techniques to interact with enrollees by phone or in person. Their goal is to empower enrollees to better manage their chronic conditions and improve their use of clinical, caregiver/family and community resources to improve their health outcomes. They support the care prescribed by the attending physician.

Miscellaneous functions

Encounter data element collection

All data required for encounter collection and reporting is drawn from submitted claims. Should your office have a capitation arrangement with the health plan, submit encounters with the same level or required information as fee-for-service claims.

Medical review hours

The health plan staff is available for medical review Monday–Friday from 8 a.m.–8 p.m. CT.

For questions regarding the medical review process, contact your provider relations consultant at **1-800-690-1606**. Medical review is available during standard business hours. Emergency services do not require prior authorization.

*The health plan offices will be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day.

Please refer to the website for additional holiday observances and/or closures.

Behavioral health review hours

The health plan staff is available for behavioral health review, routine authorizations and concurrent reviews, Monday–Friday from 7 a.m.–5 p.m. CT. The health plan staff is available for behavioral health inpatient and urgent care authorizations at any time. For questions regarding the behavioral health review process, contact your provider relations consultant at **1-800-690-1606**.

Chapter 8: UnitedHealthcare Dual Complete Dental Program

UnitedHealthcare Dual Complete welcomes you as a participating dental care provider. We are committed to providing accessible quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize that to do so, strong partnerships with our care providers are critical, and we value you as an important part of our program.

See the following quick reference grid. For more in-depth information please call **1-844-275-8750**. You can also access **UHCprovider.com** and register as a participating care provider. Once registered, you can conduct a claim history search by surfaced tooth, verify eligibility and check benefits. The full Dental Provider Manual and Dental Training are also available on the website.

Resource: **You want to:**	**Provider services line – dedicated service representatives.** **Phone: 1-844-275-8750** **Hours: 9 a.m.–6 p.m. Monday–Friday, ET**	**Online UHCproviders.com**	**Interactive Voice Response System** **Phone: 1-844-275-8750** **Hours: Any time**
Inquire about a claim	✔	✔	✔
Ask a benefit/plan question including prior authorization requirements	✔	✔	
Inquire about eligibility	✔	✔	✔
Request an EOB	✔	✔	
Request a fee schedule	✔	✔	
Request a copy of your contract	✔		
Ask a question about your contract	✔		
Inquire about the network	✔	✔	✔
Nominate a care provider for participation	✔		
Request a participation status change	✔		
Request an office visit (e.g., staff training)	✔		
Request documents	✔		
Request benefit information	✔	✔	

Chapter 9: Care provider performance standard and compliance obligation

Care provider evaluation

When evaluating your performance, UnitedHealthcare Dual Complete reviews at a minimum the following areas:

- **Quality of Care** – measured by clinical data related to the appropriateness of enrollee care and outcomes
- **Efficiency of Care** – measured by clinical and financial data related to an enrollee's health care costs
- **Enrollee Satisfaction** – measured by data collected at a provider level when an enrollee complains. All other enrollee satisfaction data is at the statewide level using CAHPS
- **Administrative Requirements** – measured by your methods and systems for keeping records and transmitting information
- **Participation in Clinical Standards** – measured by your involvement with panels used to monitor quality of care standards

Care provider compliance to standards of care

You must comply with all applicable laws and licensing requirements. In addition, you must furnish covered services in a manner that agrees with medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare Dual Complete 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 regarding the conduct of their profession
- UnitedHealthcare Dual Complete policies and procedures regarding the following:
  - Participation on committees and clinical task forces to improve the quality and cost of care
  - Prior authorization requirements and timeframes
  - Credentialing requirements
  - Referral policies
  - Case Management program referrals
  - Appropriate release of inpatient and outpatient utilization and outcomes information
  - Accessibility of enrollee medical record information to fulfill the business and clinical needs of UnitedHealthcare Dual Complete
  - Cooperating with efforts to assure appropriate levels of care
  - Maintaining a collegial and professional relationship with UnitedHealthcare Dual Complete personnel and fellow participating care providers
  - Providing equal access and treatment to all Medicare enrollees

Compliance process

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

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Dual Complete
- Failure to pre-notify UnitedHealthcare Dual Complete of admissions. Enrollee complaints/grievances determined against the care provider.
- Underutilization, overutilization or inappropriate referrals
- Inappropriate billing practices
- Non-supportive actions and/or attitude is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken.

Acting within the lawful scope of practice, you are encouraged to advise our enrollees about:

1. The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered). This includes enough information to help the enrollee decide among all relevant treatment options.
2. The risks, benefits and consequences of treatment or nontreatment
3. The opportunity to refuse treatment and to express preferences about future treatment decisions
4. The importance of preventive changes at no cost to the enrollee

Such actions are not considered non-supportive of UnitedHealthcare Dual Complete.

Laws regarding federal funds

Payments you receive for furnishing services to UnitedHealthcare Dual Complete enrollees are, in whole or part, from federal funds. That means you or your subcontractors must comply with certain laws applicable

to individuals and entities receiving federal funds. This includes but is 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.

Marketing

You may not develop and use any materials that market UnitedHealthcare Dual Complete without our approval in compliance with Medicare Advantage 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.

Sanctions under federal health programs and state law

You must help ensure you do not employ or subcontract 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.

You must disclose to UnitedHealthcare Dual Complete whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Tennessee, the federal government, or any public insurer. You must notify UnitedHealthcare Dual Complete immediately if any such sanction is imposed on you, a staff member or subcontractor.

Selection and retention of participating care providers

We arrange covered services provided to thousands of enrollees through a comprehensive care provider network of independent practitioners and facilities that contract with us. The network includes health care professionals such as PCPs, specialist physicians, medical facilities, allied health professionals and ancillary service providers.

Our network has been carefully developed to include those participating care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care and acceptance of our managed care principles and financial considerations.

We continuously review and evaluate participating care provider information and recredentials you every three years. The credentialing guidelines are subject to change based on industry requirements and our standards.

Termination of participating care provider privileges

Termination without cause

UnitedHealthcare Dual Complete and you must provide at least 60 days' written notice to each other before terminating a contract without cause.

Appeal process for care provider participation decisions

If UnitedHealthcare Dual Complete decides to suspend, terminate or non-renew your participation status, UnitedHealthcare Dual Complete must:

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

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare Dual Complete 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.

Subcontracted care provider groups must apply these procedures equally to care providers within those subcontracted groups.

Care provider education – sanction policy summary

The Practitioner Education/Sanction Policy helps ensure care provider compliance with utilization and quality management policies and procedures. Those not in compliance with standards of care or policies and procedures will be advised of the noncompliance and notified of their right to appeal.

The categories subject to sanctions include:

- Administrative
- Utilization
- Quality of practitioner service
- Quality of care
- Professional conduct

The chief medical officer and medical director have the authority to recommend monetary and non-monetary sanctions and/or to place a care provider on focused review. If they recommend terminating a care provider for conduct falling within the scope of this policy, they will send a sanction letter describing the occurrence notifying them of the sanction action and the consequences that may result from additional incidences. The care provider will also be notified in writing of any sanction issued to a mid-level care provider they supervise.

All care providers are notified in writing of their right to appeal a sanction through the Participating Practitioner Appeal Process for Sanctions. This includes having a discussion with the physician reviewer. The final decision for imposing sanctions rests with the CEO and chief medical officer or their designee. As necessary, sanction information may be referred to the Provider Advisory Committee between re-credentialing cycles. Care provider issues are considered when deciding on continued participation. Any issues warranting restricting privileges will be referred to the Credentialing Committee.

Following is a list of potential actions that may be used in the issuance of a sanction in any of the aforementioned categories. Appropriate education/sanction actions may include, but are not limited to, the following:

- Notification and education regarding the occurrence(s)
- Educational material from other care providers, or literature references
- A documented plan for improvement from the practitioner
- Focused review of the care provider practice
- Additional training and/or mandatory Category 1 CME. All expenses associated with training and CME will be the responsibility of the practitioner.
- External, professional review of relevant documentation
- Summary suspension
- Establishing a range of actions altering practitioner participation
- Initiation of the termination process
- Monetary sanction

When appropriate, sanctions will be reported to the appropriate regulatory or licensing agency as required.

Professional conduct sanctions

Professional misconduct will be handled on a case-by-case basis in collaboration with the chief medical officer, medical director, legal and other appropriate individuals. Suspension and/or termination may result.

Appeals of sanctions

If you appeal a sanction, you must notify the issuer of the sanction in writing within 30 days of the date of sanction notification. If the initial reviewer does not approve the appeal request, it will be presented to another reviewer of same or similar specialty for the decision. A decision will be made within 30 days of receipt of all information you submit. You will be notified in writing of the appeal decision.

Should you disagree with the appeal decision, you will have 60 days from the date of the decision on the appeal to request binding arbitration. The request should be submitted in writing to the issuer of the sanction. The health plan's legal department will send the care provider information regarding how to initiate arbitration with the American Arbitration Association (AAA). The practitioner's request for arbitration must be made to the AAA within 180 days of the decision on the appeal. The question before the arbitrator will be whether the decision being arbitrated should be set aside because the decision was arbitrary and capricious. Judgment upon the decision may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. Both parties will share expenses associated with the arbitration equally. Arbitration will be final and binding on all parties.

Arbitration concerning recredentialing and termination will be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. If arbitration is used, the parties must waive their right to seek remedies in court, including their right to jury trial, except for enforcement of the decision of the arbitrator.

Denied payment authorization decisions

As a participating care provider, you have the right to submit more information following an initial payment authorization denial. You may also speak to the physician reviewer regarding medical necessity issues involved in the denied payment authorization. As the participating care provider, you make the final decision concerning admission, referrals and the continued medical care of your patients. The health plan makes the final determination concerning payment.

If the original decision is not reversed, you may then pursue the denied payment authorization through the appropriate appeal process. For denied services that have not been rendered, the enrollee may initiate an appeal by contacting the Customer Service Representative on the back of the

enrollee's ID card. You may assist enrollees in their appeal process. Appeals may be expedited when the enrollee's medical condition warrants and the treating care provider signs the enrollee's appeal request for expedited review.

Other care providers

UnitedHealthcare Dual Complete decisions subject to appeal includes decisions regarding reduction, suspension or termination of your participation resulting from quality deficiencies. UnitedHealthcare Dual Complete 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 will detail the limitations and inform you of your appeal rights.

Notifying enrollees of care provider termination

Provide as much advance notice as possible when preparing to terminate participation with the Personal Care Plus care provider network. CMS requires notifying enrollees affected by termination at least 30 days before the termination effective date.

Chapter 10: Medical records

Medical record review

A UnitedHealthcare Dual Complete (HMO SNP) representative may visit your office to review the medical records of UnitedHealthcare Dual Complete (HMO SNP) enrollees' medical records to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records. The Clinical Operations Subcommittee, the Provider Affairs Subcommittee and the Quality Management Committee will review the medical record results quarterly. The results will be used in the re-credentialing process.

Standards for medical records

You must have a system in place for maintaining medical records that conform to regulatory and UnitedHealthcare Dual Complete (HMO SNP) standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in the enrollee's medical chart. Each medical record chart must have documented at a minimum:

- Enrollee name
- Enrollee identification number
- Enrollee age
- Enrollee sex
- Enrollee 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 rational
- Name of participating care provider including signature and initials
- Instructions to enrollee
- Evidence of follow-up with indication that the PCP reviewed test results and discussed abnormal findings with enrollee/legal guardian
- Health risk assessment and preventive measures

Proper documentation and medical review

We perform medical reviews to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. We also do this to audit appropriateness, utilization and quality of the service provided.

In addition, you must document in the enrollee's current medical record whether they have executed an advance directive.

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of Tennessee 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 enrollee information

You must comply with all state and federal laws concerning confidentiality of health and other information about enrollees. You must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Enrollee record retention

You must retain the original or copies of enrollee medical records for at least 10 years after the last medical or health care service for all patients. You must comply with all state (A.R.S. 12-2297) and federal laws on record retention.

Medical records standards for (EPSDT) examinations

Please refer to the TennCare Provider Manual at **UHCprovider.com**.

Ambulatory record review standard guidelines

Your office medical records will be reviewed against the health plan, NCQA and regulatory guidelines relating to structure and content. We expect all medical records be in substantial (85%) compliance with these standards. Medical record standards for physical health care providers are located in this chapter.

Behavioral health treatment record documentation requirements

Based on the behavioral health clinician agreement, you must maintain high-quality medical, financial and administrative records related to any behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community and conform to all applicable statutes and regulations.

Behavioral health record content requirements

The health plan expects that all treatment records at a minimum include:

- Enrollee data on paper or in electronic format
- The enrollee's name or identification number on each page
- The enrollee's address, employer or school, home and work telephone numbers. This includes emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- Dated information
- The responsible clinician's name, professional degree, license and relevant identification number, if applicable
- Enrollee data in blue or black ink, legible to someone other than the writer, and maintained in a current, detailed, organized and comprehensive manner
- Uniform practices for modifications. Any error is to be lined through so that it can still be read, dated and initialed by the person making the change
- Medication allergies, adverse reactions and relevant medical conditions that are clearly documented and dated. If the enrollee has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted
- Presenting problems, relevant psychological and social conditions affecting the enrollee's medical and psychiatric status. The results of a mental status exam are documented and the source of such information should also be listed.
- Executed Declaration for Mental Health Treatment forms documented in a prominent place
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential prominently noted, documented and revised as appropriate. Also document the absence of such conditions.
- The medications prescribed, the dosage of each and the dates of initial prescription or refills. Informed consent for medication and the enrollee's understanding of the treatment plan should also be documented.
- A medical and psychiatric history, including previous treatment dates, clinician identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For enrollees 12 and older, documentation includes past and present use of cigarettes and alcohol as well as illicit, prescribed and over-the-counter drugs.
- DSM-V-TR diagnoses, including all five axes, and are consistent with the presenting problem(s), history, mental status examination and other assessment data. Priority enrollees should have comprehensive assessments of their physical and mental health status at the time of admission to services that include psychiatric assessment, medical assessment, substance abuse assessment, community functioning assessment and an assessment of enrollee strengths, current life status, personal goals and needs.
- Individualized treatment plans that are consistent with diagnoses and the comprehensive assessment have both objective, measurable goals and estimated time frames for problem resolution. The record should also include a preliminary discharge plan. There must be evidence that the treatment plans are developed and reviewed with the enrollee and/or parent or legal guardian.
- Continuity and coordination of care activities between the primary clinician, consultants, other behavioral health and medical clinicians and health care institutions. If the enrollee refuses to allow you to communicate with their other care clinicians, this must be documented. Referrals to other clinicians, services, community resources and/or wellness and prevention programs are documented when applicable.
- Progress notes that describe enrollee strengths and limitations in achieving treatment plan goals and objectives, and that reflect treatment interventions consistent with

those goals and objectives. Document dates for follow-up visits or complete termination summaries.

- Treatment involving the care of more than one enrollee of a family should have separate treatment records for each identified and diagnosed enrollee. Billing records should reflect the plan participant who was treated and the modality of care.

Guidelines for storing and accessing behavioral health treatment records

Following are additional guidelines for completing and maintaining enrollee treatment records:

- Practice sites must have an organized system of filing information in treatment records
- Treatment records must be stored in a secure area. The practice site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable statutes and regulations.
- The practice site must have a process that helps ensure records are available to qualified professionals if the treating professional is absent
- All records shall be maintained in accordance with the most stringent standards contained in HIPAA requirements
- Enrollees (for purposes of behavioral health records, an "enrollee" is 16 years or older) and their legally appointed representatives should be given access to the enrollee medical records. This is subject to reasonable charges (except as detailed).
- Provisions for helping ensure that, if a patient-care provider relationship with a UnitedHealthcare Dual Complete (HMO SNP) PCP ends, and the enrollee requests that medical records be sent to a second UnitedHealthcare Dual Complete (HMO SNP) care provider who will be the enrollee's PCP, the first care provider does not charge the enrollee or the second care provider for providing the medical records

Chapter 11: Reporting obligations

Cooperation in meeting the CMS requirements

UnitedHealthcare Dual Complete (HMO SNP) must provide CMS information necessary for CMS to administer and evaluate the Medicare Advantage program. This information is used to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on enrollee satisfaction and information on health outcomes. You must cooperate with UnitedHealthcare Dual Complete (HMO SNP) in its data reporting obligations by providing to UnitedHealthcare Dual Complete (HMO SNP) any information that it needs to meet its obligations.

Certification of diagnostic data

UnitedHealthcare Dual Complete (HMO SNP) must submit to CMS data necessary to characterize the context and purposes of each encounter between an enrollee and a care provider, supplier, physician or other practitioner (encounter data). Participating care providers that furnish diagnostic data to assist UnitedHealthcare Dual Complete (HMO SNP) in meeting its reporting obligations to CMS must certify (based on best knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

Risk adjustment data

Comprehensively code all enrollees' diagnoses to the highest level of specificity possible. Submit all enrollee medical encounters to us.

Chapter 12: Initial decisions, appeals and grievances

Initial decisions

The "initial decision" is the first decision UnitedHealthcare Dual Complete (HMO SNP) makes regarding coverage or payment for care. In some instances, you, acting on behalf of UnitedHealthcare Dual Complete (HMO SNP) may make an initial decision regarding whether a service will be covered.

- If an enrollee asks us to pay for medical care the enrollee has already received, this is a request for an "initial decision" about payment for care
- If an enrollee or you, acting on their behalf, asks for preauthorization for treatment, this is a request for an "initial decision" about whether the treatment is covered by UnitedHealthcare Dual Complete (HMO SNP)
- If an enrollee asks you for a specific type of medical treatment, this is a request for an "initial decision" about whether we cover the treatment

UnitedHealthcare Dual Complete (HMO SNP) will generally make decisions regarding payment for care that enrollees have already received within 30 days.

A decision about whether UnitedHealthcare Dual Complete (HMO SNP) will cover medical care can be a "standard initial decision" made within the standard time frame (typically within 14 days), or it can be an expedited initial decision (typically within 72 hours).

An enrollee can ask for an expedited initial decision only if they or any care provider believes waiting for a standard initial decision could seriously harm the enrollee's health or ability to function. The enrollee or you can request an expedited initial decision. If you request an expedited initial decision or support an enrollee in asking for one, and you indicate that waiting for a standard initial decision could seriously harm the enrollee's health or ability to function, UnitedHealthcare Dual Complete (HMO SNP) will automatically provide an expedited initial decision.

At each patient encounter with a UnitedHealthcare Dual Complete (HMO SNP) enrollee, you must notify the enrollee of their right to receive, upon request, a detailed written notice from UnitedHealthcare Dual Complete (HMO SNP) regarding the enrollee's services. Your notification must provide them with the information necessary to contact UnitedHealthcare Dual Complete (HMO SNP) and must comply with any other CMS requirements. If an enrollee requests UnitedHealthcare Dual Complete (HMO SNP) provide a detailed notice of your decision to deny a service in whole or part, UnitedHealthcare Dual Complete (HMO SNP) must give them a written notice of the initial determination.

If UnitedHealthcare Dual Complete (HMO SNP) does not make a decision within the time frame nor notify the enrollee regarding why the time frame must be extended, the enrollee can treat the failure to respond as a denial and may appeal, as set forth as follows.

Appeals and grievances

Enrollees have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two types of complaints they can make. You must cooperate in the Medicare appeals and grievances process.

- An appeal is the type of complaint an enrollee makes when the enrollee wants UnitedHealthcare Dual Complete (HMO SNP) to reconsider and change an initial decision (by UnitedHealthcare Dual Complete [HMO SNP] or you) about what services are necessary or covered or what UnitedHealthcare Dual Complete (HMO SNP) will pay for a service
- A grievance is the type of complaint an enrollee makes regarding any other type of problem with UnitedHealthcare Dual Complete (HMO SNP) or you. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of your facilities are grievances. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (this would be an appeal).

Resolving appeals

An enrollee may appeal an adverse initial decision by UnitedHealthcare Dual Complete (HMO SNP) or you concerning authorization for, or termination of, coverage of a health care service. They may also appeal an adverse initial decision by UnitedHealthcare Dual Complete (HMO SNP) concerning payment for a health care service. UnitedHealthcare Dual Complete (HMO SNP) must resolve an enrollee's appeal of an initial decision about authorizing health care or terminating coverage of a service within 30 calendar days or sooner if their health condition requires. We must resolve an appeal concerning payment within 60 calendar days.

You must also cooperate with UnitedHealthcare Dual Complete (HMO SNP) and enrollees in providing necessary information to resolve the appeals within the required time

frames. You must provide the pertinent medical records and any other relevant information to UnitedHealthcare Dual Complete (HMO SNP). In some instances, you must provide the records and information to allow UnitedHealthcare Dual Complete (HMO SNP) to make an expedited decision.

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

Special types

A special type of appeal applies only to hospital discharges. If the enrollee thinks UnitedHealthcare Dual Complete (HMO SNP) coverage of a hospital stay is ending too soon, the enrollee can appeal directly and immediately to the Quality Improvement Professional Research Organization (QIPRO). In Tennessee, that organization is the Health Services Advisory Group (HSAG).

HSAG can be located at hsag.com.

However, such an appeal must be requested no later than noon on the first working day after the day the enrollee gets notice that UnitedHealthcare Dual Complete (HMO SNP) coverage of the stay is ending. If the enrollee misses this deadline, the enrollee can request an expedited appeal from UnitedHealthcare Dual Complete (HMO SNP).

Another special type of appeal applies only to an enrollee dispute regarding when coverage will end for SNF, home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs provide enrollees with a written notice at least two days before their services are scheduled to end. If the enrollee thinks their coverage is ending too soon, they appeal directly and immediately to the QIPRO.

The QIPRO in Tennessee is HSAG.

If the enrollee gets the notice two days before coverage ends, they must request an appeal to QIPRO no later than noon of the day after they get the notice. If the enrollee gets the notice more than two days before coverage ends, the enrollee must make the request no later than noon the day before the date that coverage ends. If the enrollee misses the deadline for appealing to QIPRO, they can request an expedited appeal from UnitedHealthcare Dual Complete (HMO SNP).

Resolving grievances

If an enrollee has a grievance about UnitedHealthcare, a provider or any other issue, tell them to contact Customer Service by:

Fax: 1-888-285-2885

Call: **1-800-690-1606** (Customer Service)
TTY/TDD: **1-800-884-4327**

Mail:
UnitedHealthcare Community Plan
Appeals, Grievances and Disputes
CA124-0187
P.O. Box 6103
Cypress, CA 90630-0016

We will respond to grievances in the following manner:

- Grievances submitted in writing will be responded to in writing
- Grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response
- Grievances related to quality of care, regardless of how the grievances are filed, will be responded to in writing

A final decision will be made as quickly as the case requires based on the enrollee's health status, but no later than 30 calendar days after receiving the complaint. We may extend the time frame by up to 14 calendar days if an extension is requested or if we justify a need for additional information and the delay is in the enrollee's best interest. Our enrollees may ask for an expedited grievance upon initial request. We will respond to an expedited grievance request within 24 hours.

Further appeal rights

If UnitedHealthcare Dual Complete (HMO SNP) denies the enrollee's appeal in whole or part, except for Part D claims, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not a part of UnitedHealthcare Dual Complete (HMO SNP). 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 and the amount at issue meets a specified dollar threshold, the enrollee may appeal to an administrative law judge (ALJ). If the enrollee is not satisfied with the ALJ's decision, the enrollee may request review by the Department Appeal Board (DAB). If the DAB refuses to hear the case or issues an adverse decision, the enrollee may appeal to a district court of the United States.

Chapter 13: Enrollees rights and responsibilities

UnitedHealthcare Dual Complete (HMO SNP) enrollees have the right to timely, high-quality care and treatment with dignity and respect. You must respect the rights of all UnitedHealthcare Dual Complete (HMO SNP) enrollees. Specifically, UnitedHealthcare Dual Complete (HMO SNP) enrollees have been informed that they have the following rights:

Timely quality care

- Choice of a qualified contracting PCP and contracting hospital
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their PCP and referrals and recommendations to specialists when medically necessary
- To receive emergency services when the enrollee, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists
- To actively participate in decisions regarding their health and treatment options
- To receive urgently needed services when traveling outside UnitedHealthcare Dual Complete's (HMO SNP) service area or in UnitedHealthcare Dual Complete's (HMO SNP) service area when unusual or extenuating circumstances prevent the enrollee from obtaining care from a participating care provider
- To request the number of grievances and appeals and dispositions in aggregate
- To request information regarding care provider compensation
- To request information regarding the financial condition of UnitedHealthcare Dual Complete (HMO SNP)

Treatment with dignity and respect

- To be treated with dignity and respect and to have their right to privacy recognized
- To exercise these rights regardless of the enrollee's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for care
- To confidential treatment of all communications and records pertaining to the enrollee's care
- To access, copy and/or request amendment to the enrollee's medical records consistent with the terms of HIPAA
- To extend their rights to any person who may have legal responsibility to make decisions on the enrollee's behalf regarding the enrollee's medical care
- To refuse treatment or leave a medical facility, even against the advice of care providers (providing the enrollee accepts the responsibility and consequences of the decision)
- To complete an advance directive, living will or other directive to the enrollee's medical care providers

Enrollee satisfaction

UnitedHealthcare Dual Complete (HMO SNP) periodically surveys enrollees to measure overall customer satisfaction as well as satisfaction with the care you provide. UnitedHealthcare Dual Complete (HMO SNP) reviews survey information and shares the results with you.

CMS conducts annual enrollee surveys to measure their overall customer satisfaction as well as satisfaction with the care received from you. Survey results are available upon request.

Enrollee responsibilities

Enrollee responsibilities include:

- Reading and following the Evidence of Coverage (EOC)
- Treating all UnitedHealthcare Dual Complete (HMO SNP) staff and health care providers with respect and dignity
- Protecting their health plan or TennCare ID card and showing it before obtaining services
- Knowing the name of their PCP
- Seeing their PCP for their health care needs
- Using the ER for life-threatening care only and going to their PCP or urgent care center 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 until the child is 18 years old

- Making an appointment before they visit their PCP or any other UnitedHealthcare Dual Complete (HMO SNP) health care provider
- Arriving on time for appointments
- Calling the office at least one day in advance if they must cancel an appointment
- Being honest and direct with their PCP, including giving the PCP the enrollee's health history as well as their child's
- Telling their UnitedHealthcare Dual Complete (HMO SNP) and their Department of Intellectual and Developmental Disabilities support coordinator if they have changes in address, family size or eligibility for enrollment
- Tell us if they have other insurance
- Give a copy of their living will to their PCP

Services Provided in a Culturally Competent Manner

UnitedHealthcare Dual Complete (HMO SNP) is obligated to help ensure services are provided in a culturally competent manner to all enrollees. This includes people with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. You must cooperate with UnitedHealthcare Dual Complete (HMO SNP) in meeting this obligation.

Enrollee Complaints/ Grievances

UnitedHealthcare Dual Complete (HMO SNP) tracks all complaints and grievances to identify its areas of improvement. This information is reviewed in the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UnitedHealthcare Dual Complete (HMO SNP) board of directors. Please refer to **Chapter 11** for enrollee appeal and grievances rights.

Chapter 14: Access to care/ appointment availability

Enrollee access to health care guidelines

UnitedHealthcare Dual Complete (HMO SNP) actively monitors the adequacy of appointment processes and helps ensure an enrollee's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the care provider is unavailable due to an emergency. For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. You must help ensure that the following appointment standards are met:

PCPs

- Emergency appointments – same day of request
- Urgent care appointments – with 2 days of request
- Routine care appointments – within 21 days of request
- Waiting time – 45 minutes or less

Primary care obstetricians (PCO)

For maternity care, the contractors provide initial prenatal care appointments for enrolled pregnant enrollees as follows:

- First trimester – within 14 days of request
- Second trimester – within 7 days of request
- Third trimester – within 3 days of request
- High-risk pregnancies – within 3 days of identification of high risk by the contractor or maternity care provider, or immediately if an emergency exists
- Waiting time – 45 minutes or less

Specialists

For specialty referrals, the contractor should be able to provide:

- Emergency appointments – within 24 hours of referral
- Urgent care appointments – within 3 days of referral
- Routine care appointments – within 45 days of referral
- Waiting time – 45 minutes or less

Dentists

For dental appointments, the contractor should be able to provide:

- Emergency appointments – within 24 hours of request
- Urgent care appointments – within 3 days of request
- Routine care appointments – within 45 days of request
- Waiting time – 45 minutes or less

Adherence to enrollee access guidelines is monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination.

Variations from the policy are reviewed by network management for educational and/or counseling opportunities and tracked for participating care provider re-credentialing.

All participating care providers and hospitals must treat all UnitedHealthcare Dual Complete (HMO SNP) enrollees with equal dignity and consideration as their non-UnitedHealthcare Dual Complete (HMO SNP) patients.

Care provider availability

PCPs will provide anytime coverage. When a PCP cannot provide services, they must help ensure another participating care provider is available.

The enrollee should normally be seen within 45 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 is 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.

Care provider office confidentiality statement

UnitedHealthcare Dual Complete (HMO SNP) enrollees have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage Program. Participating care providers and each staff member sign an employee confidentiality statement to be placed in the staff member's personnel file.

Enrollee transfer and termination participating care provider's panel

UnitedHealthcare Dual Complete (HMO SNP) determines reasonable cause for a transfer based on written documentation you submit. You may not transfer an enrollee to another participating care provider due to the costs associated with the enrollee's covered services. You may request termination of an enrollee due to fraud, disruption of medical services or repeated failure to make the required reimbursements for services.

Closing of care provider panel

When closing a practice to new UnitedHealthcare Dual Complete (HMO SNP) enrollees or other new patients, you are expected to:

- Give UnitedHealthcare Dual Complete (HMO SNP) prior written notice that the practice will be closing to new enrollees as of the specified date
- Keep the practice open to UnitedHealthcare Dual Complete (HMO SNP) enrollees who were enrollees before the practice closed
- Uniformly close the practice to all new patients including private payers, commercial or governmental insurers
- Give UnitedHealthcare Dual Complete (HMO SNP) prior written notice of the reopening of the practice, including a specified effective date

Prohibition against discrimination

Neither UnitedHealthcare Dual Complete (HMO SNP) nor participating care providers may deny, limit or condition the coverage or furnishing of services to enrollees based on any factor related to health status. This includes the following:

- Medical condition including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability including conditions arising out of acts of domestic violence
- Disability

Network pharmacies

With a few exceptions, our enrollees must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is where enrollees can get their outpatient prescription drugs through their prescription drug coverage. We call them "network pharmacies" because they contract with our plan. In most cases, prescriptions are covered only if they are filled at one of our network pharmacies. Once an enrollee goes to one, they are not required to continue going to the same pharmacy to fill their prescription; they can go to any of our network pharmacies.

Covered Drugs are all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the Prescription Drug List (PDL).

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Following 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 Dual Complete (HMO SNP) Member Services to see if a network pharmacy is available.

- We cover prescriptions filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, enrollees have to pay the full cost (rather than paying just the copayment) when they fill their prescription. Our enrollees can ask us for reimbursement for their share of the cost by submitting a paper claim form.
- If our enrollee is traveling within the U.S. but outside of the plan's service area and becomes ill, loses or runs out of their prescription drugs, we cover prescriptions filled at an out-of-network pharmacy. In this situation, the enrollee pays the full cost (rather than paying just their copayment) when they fill their prescription. The enrollee can ask us to reimburse them for our share of the cost by submitting a claim form. Prior to filling a prescription at an out-of-network pharmacy, call UnitedHealthcare Dual Complete (HMO SNP) Member Services to find out if there is a network pharmacy in the enrollee's area where they are traveling. If there are no network pharmacies in that area, Member Services may be able to make arrangements for the enrollee to get their prescriptions from an out-of-network pharmacy.
- If our enrollee can't get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If an enrollee is trying to fill a covered prescription drug not regularly stocked at an eligible network retail store (these drugs include orphan drugs or other specialty pharmaceuticals).

Paper claim submission

When our enrollees go to a network pharmacy, that pharmacy automatically submits that claim to us. However, if they go to an out-of-network pharmacy for one of the reasons listed, the pharmacy may not be able to submit the claim directly to us. When that happens, enrollees will have to pay the full cost of their prescription. Call UnitedHealthcare Dual Complete (HMO SNP) Member Services at **1-800-690-1606** (TTY/TDD users should call **711**). for a direct enrollee reimbursement claim form and instructions on how to obtain reimbursement for covered prescriptions.

Mail the claim form and receipts to:

Optum Rx Claims Department
P.O. Box 29045
Hot Springs, AR 71903

Prescription drug list (PDL)

A PDL is a list of all the drugs we cover. We cover the drugs listed in our PDL 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.

We select the drugs on the PDL 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. Both brand-name drugs and generic drugs are included in the PDL. 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 in the PDL. 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 PDL during the year. If we change the PDL, we will notify you at least 60 days before the effective date of change. If we do not notify you in advance, the enrollee will get a 60 day supply of the drug when they request a refill. However, if a drug is removed from our PDL because the drug has been recalled from the market, we

will NOT give a 60-day notice before removing the drug from the PDL. Instead, we will remove the drug from our PDL immediately and notify enrollees about the change as soon as possible.

To find out what drugs are on the PDL or to request a copy of our PDL, call UnitedHealthcare Dual Complete (HMO SNP) Member Services at **1-800-690-1606**. (TTY/TDD **711**). You can also get updated information about covered drugs by visiting **UHCprovider.com**.

Exception request

You can ask us to make an exception to our coverage rules. There are several types of exceptions you can ask us to make.

A. You can ask us to cover your drug even if it is not on our PDL

B. You can ask us to waive coverage restrictions or limits on your drugs. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

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

Please call our UnitedHealthcare Dual Complete (HMO SNP) Member Services at **1-800-690-1606** (TTY/TDD **711**,) to request a PDL exception.

If we approve your exception request, our approval is valid for the remainder of the plan year, as long as you continue to prescribe the drug, and it continues to be safe and effective for treating the patient's condition.

All new Dual Complete (HMO SNP) (Medicare) enrollees may receive a 30-day transition supply of a non-PDL/noncovered drug when a prescription is presented to a network pharmacy. The pharmacist will fill the script and a letter will be automatically generated to you and the enrollee. It will advise that either a PDL alternative should be chosen or a request for exception should be submitted.

You may request an exception for coverage (or continuation of coverage post-transition fill) of a non-formulary drug, or you may ask to waive quantity limits or restrictions. Exception requests require you to provide documentation that the patient has unsuccessfully tried a regimen of a PDL medication or that such medication would not be as effective as the non-formulary alternative. Exception requests will be evaluated based on the information you provide. Please call **1-800-711-4555** to start the exception process.

Drug management programs (utilization management)

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

1. **Prior Authorization**: We require our enrollees to get prior authorization for certain drugs. This means that a participating care provider or pharmacist will need to get approval from us before an enrollee fills their prescription. If they do not get approval, we may not cover the drug.
2. **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 90 tablets per prescription for ALTOPREV. This quantity limit may be in addition to a standard 30-day supply limit.
3. **Step Therapy**: In some cases, we require enrollees 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 your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
4. **Generic Substitution**: When there is a generic version of a brand-name drug available, our network pharmacies automatically give the enrollee the generic version, unless their doctor has told us that they must take the brand-name drug

Find medical policies and coverage determination guidelines at **UHCprovider.com**.

Chapter 16: Healthy First Steps

Healthy First Steps (HFS) is a program we developed for pregnancy management. The program is available for all pregnant enrollees. Enrollment is voluntary, but enrollees are encouraged to participate.

Enrollees may be identified by plan data or you, community or self referrals. All enrollees identified receive initial outreach to educate on the HFS program and obtain consent for HFS enrollment. If initial telephone outreach is unsuccessful, the enrollee will be mailed program information and requested to contact staff.

Enrollees initially identified at risk, or if problems are identified during the pregnancy, are referred for clinical evaluation. Clinical assessments are done by a care manager who is a registered nurse with extensive maternity management experience.

All enrollees enrolled in the program are evaluated for additional medical problems, behavioral health needs and social support services throughout their pregnancy and the postpartum period.

Integration of medical, behavioral and social services provides an efficient and comprehensive approach for enrollees enrolled in this program.

Notify the health plan of pregnant enrollees. Referral information for Healthy First Steps can be accessed at **UHCprovider.com**. Request more information about the Healthy First Steps Program by calling Customer Service at **1-800-690-1606**.

Chapter 17: Behavioral health utilization management specifics

Certification of benefits for inpatient services – behavioral health

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists. All inpatient and sub-acute level of care admissions must be pre-certified by a behavioral health care manager unless the admission is an emergency. When requesting certification for an acute or sub-acute level of care, be prepared to discuss the clinical presentation of the plan participant, including the severity of their symptoms. When making a recommendation about the level of care, consider the enrollee's level of functional impairment and risk factors. UnitedHealthcare Community Plan uses the following Level of Care Guidelines (LOCGs) to conduct medical necessity reviews of requests for services as they apply to available behavioral health benefits. ASAM (American Society of Addiction Medicine) criteria (Third Edition) are currently used for all substance abuse services. ASAM criteria are proprietary and cannot be given to you or enrollees unless a denial of service(s) is rendered, at which time a copy of the criteria in question can be obtained upon request.

To access these criteria independently, you may purchase them at asam.org. (The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition) Guidelines currently used for other levels of care can be found at **UHCprovider.com**.

Services provided to enrollees in an inpatient psychiatric or substance abuse unit are reviewed initially and then concurrently by licensed clinicians based on clinical appropriateness. These reviews provide information about the enrollee's status and need for continued inpatient care. Inpatient peer reviews are conducted directly with the attending psychiatrist whenever possible.

The health plan reserves the right to require a direct conversation with the attending psychiatrist before authorizing coverage for any inpatient stay. In the event benefits are not certified, the health plan will support clinicians or hospital staff to maximize benefits. Adverse benefit determinations may occur for three reasons:

1. The requested services are not covered under the benefit plan
2. The enrollee's available coverage for inpatient behavioral health services has been exhausted
3. There has been a determination that the inpatient admission does not meet clinical guidelines for the patient's level of acuity, or does not adhere to standards of best practice

Again, when certification for coverage is not granted, the behavioral health care manager works with the clinician or facility to develop an alternative treatment intervention for the enrollee. Whenever a certification for coverage of inpatient services is not granted, the health plan notifies the enrollee or, in the case of minors or enrollees under custodial care, the health plan notifies the appropriate custodian. In addition, notification is made directly to the hospital regarding the adverse determination for continued coverage. The facility is expected to inform the enrollee or appropriate custodian immediately of any adverse benefit determination as well as the status of the appeal process requirements.

During an emergency admission, notify the health plan as soon as possible, no later than the next business day. Conditions that warrant an emergency admission are those in which there is a clear and immediate risk to the safety of the enrollee or another person as a direct result of mental illness or substance abuse. Requests for initiation of inpatient rehabilitative substance abuse treatment are not considered to be emergencies and are evaluated during the next business day. If appropriate, the health plan retrospectively certifies coverage of admissions for emergency services provided; however, depending on the specific circumstances of each individual case, the health plan reserves the right to deny coverage for all or part of an admission. All requests for retrospective reviews must be received by the health plan within 90 days of the date the services were provided to the enrollee, unless state law mandates otherwise.

Retrospective review process – behavioral health

A retrospective review occurs only on those rare occasions when an initial request for certification is made after services have already been delivered. For all retrospective reviews, the health plan issues a determination within 30 calendar days of receipt of the request. Any retrospective review requests received outside the established time frame are processed by the health plan.

Pilot projects affecting certification requirements – behavioral health

The health plan may launch pilot projects that alter precertification requirements. We will advise clinicians of any initiatives affecting certification requirements in a separate mailing. Unless you have received a health plan communication that notifies you of your participation in a pilot project, you are expected to follow the pre-certification requirements described.

Psychological testing – behavioral health

All psychological testing must be precertified for both outpatient and inpatient services. Psychological testing is considered after a standard evaluation including clinical interview, observation and collateral information (as indicated), has been completed or gathered and one of the following circumstances exists:

- Significant diagnostic questions remain that can only be clarified through testing.
- Questions about appropriate treatment course to standard treatment remain with no clear explanation. Testing would have a timely effect on the treatment plan.
- Based on the initial assessment, the presence of cognitive or intellectual deficits may exist that affect functioning or interfere with the enrollee's ability to participate in or benefit from treatment. Testing will verify the presence or absence of such deficits.
- The presence of neuropsychological dysfunction may exist that adversely affects functioning or interferes with the enrollee's ability to participate in or benefit from treatment. Testing can clarify the presence or absence of such dysfunction.

Generally, psychological testing for school evaluations, learning disabilities, developmental delays, admission to organizations and for judicial reasons are not covered behavioral health services. Requests for neurological assessments typically will be channeled through a neurologist for initial evaluation. This service is typically covered under the enrollee's medical benefit plan so is not considered a behavioral health service.

Testing is not generally certified when it is:

- Done routinely as part of an assessment
- Excluded as a covered benefit by the plan
- Used to determine the extent of neurological damage
- Used purely to meet a court order, educational requirement, or other administrative orders or requirements

Generally, certification of benefits is only for the time involved in direct contact with the patient or family and not for scoring, interpreting or report writing.

Learn more about coverage for psychological testing at the health plan website. You can also call the health plan at **1-800-690-1606**.

Managing expectations through education – behavioral health

Educate enrollees about what to expect when they present for treatment. Enrollees will benefit from clear explanations about their diagnosis, prognosis, treatment plan, the potential benefits of medication (if medication is indicated) and the projected length and course of treatment. You can assist enrollees in managing their expectations about treatment by explaining that treatment will be focused on their current presenting problems/symptoms and that not all of the therapeutic work to be done will occur in the office. Discussing therapeutic homework, community support and ancillary interventions early in the therapeutic process helps establish realistic expectations about treatment. It may also set the stage for greater compliance with recommended treatment over time.

Discuss with all enrollees their treatment options, and the associated risk and benefits, regardless of whether the treatment is covered under their benefit plan. Nothing in this manual is intended to interfere with your relationship with enrollees as patients.

Discharge and treatment planning (behavioral health)

Effective discharge planning addresses how an enrollee's needs will be met as they move from one level of care to another or to a different treating clinician. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective planning is a key indicator of the ongoing health and well-being of a enrollee following acute care. Care managers work with you to begin the discharge or treatment planning process for enrollees at the time that services are initiated.

As appropriate, the discharge or treatment planning process will involve a behavioral health care manager, the current clinician, the enrollee, their family, the clinician at the next level of care and/or relevant community resources. Discharge planning involves assessment of the enrollee's needs and the clinician's ability to address those needs. It also involves the best and most effective means by which these needs can be met. To help enrollees keep their therapeutic gains, educate them about the importance of enlisting community support services, communicating treatment recommendations to all involved treating professionals and adhering follow-up care throughout the discharge and treatment planning process. Enrollees have the right to decline the release of information but should be informed about the risks and benefits of this decision.

Continuation of services after care provider termination (behavioral health)

Network clinicians who wish to withdraw from the behavioral health network are required to notify the health plan, in writing, 90 days prior to the withdrawal date. Network clinicians who withdraw from the behavioral health network are obligated to provide treatment for all enrollees under their care at the date of the contract termination for a maximum of 90 days or until the existing certification of care has been exhausted, whichever is shorter. If the enrollee's care can be completed in this 90-day period, or you can successfully transfer them to another contracted behavioral health clinician, please work closely with the Behavioral Health Care Management Department.

The behavioral health care manager can issue certifications for treatment during this 90-day post-termination period at the behavioral health contract rate. In some cases, you and the behavioral health care manager may determine if the enrollee should extend care beyond this time frame. The health plan will arrange to continue certification for such care at the behavioral health contracted rate of reimbursement. Clinicians may continue to collect copays and deductible amounts. Enrollees should not be balance billed. The health plan notifies enrollees of a clinician's anticipated change in network status prior to the contract termination in accordance with contract requirements.

Communication with PCPs and other health care professionals – behavioral health

To appropriately coordinate and manage care between behavioral health care clinicians and medical professionals, the health plan asks that clinicians attempt to obtain the enrollee's consent to exchange treatment information with medical care professionals (i.e., PCPs, medical specialists) and/or other behavioral health care clinicians (psychiatrists, therapists). Coordination and communication should take place at the time of intake, during treatment, the time of discharge or termination of care and between levels of care.

The coordination of care between behavioral health care clinicians and medical care professionals improves the quality of care to our plan participants in several ways:

- Communication can confirm for a PCP that their patient followed through on a referral to a behavioral health professional
- Coordination minimizes potential adverse medication interactions for an enrollee's prescribed psychotropic medication
- Coordination allows for better management of treatment and follow up for enrollees with coexisting behavioral and medical disorders
- Continuity of care across all levels of care and between behavioral and medical treatment modalities is enhanced
- For enrollees with substance abuse disorders, coordination can reduce the risk of relapse

The following guidelines are intended to facilitate effective communication. During the diagnostic assessment session, request the patient's written consent to exchange information with all appropriate treatment professionals.

Following the initial assessment, provide other treating professionals with the following information within two weeks:

- Summary of patient's evaluation
- Diagnosis
- Treatment plan summary (including any medications prescribed)
- Primary clinician treating the patient
- Update other behavioral health clinicians and/or primary or referring care providers when the patient's condition or medications change

At the completion of the treatment, send a copy of the termination summary to the other treating professionals.

- Obtain all relevant clinical information other treating professionals may have about the patient's mental health or substance abuse problems. Some enrollees may refuse to allow for release of this information, which must be noted in the clinical record. Both accreditation bodies and the health plan expect all clinicians to make a "good faith" effort to communicate with other behavioral health clinicians and any medical care professionals who are treating the plan participant.

Chapter 18: Population health management

We have developed several Population Health Management programs, which include a coordinated system of health care interventions and communications. These programs help our enrollees better understand their conditions, provide self-care tips and give updates on new information about certain conditions and preventive care. You provide input into our health management programs to help ensure they are based on current medical practices.

Clinicians, community health workers and health coaches manage the programs and work with enrollees by providing health coaching, patient-specific education, educational mailings, newsletters and reminder cards. You also receive information about their patients and the services they are receiving, such as patient specific plans of care or participation in specialty programs such as weight management. Participation in Population Health Management is voluntary and at no cost to our enrollees.

Participation in Population Health Management is voluntary and at no cost to our enrollees.

Population Health Management programs include:

- Maternity Management (Healthy First Steps)
- Behavioral Health Care Management
- Complex and Chronic Care Management
- Transitional Care Management
- Specialty Health Coaching (weight management, smoking cessation and diabetes)
- Total Population Wellness Reminders

Information regarding these programs and care provider rights and responsibilities is available on **UHCprovider.com**. You may also call us at **1-800-690-1606** for more information or to give feedback.

Chapter 19: Preventive health and clinical practices

Preventive health care standards

Our goal is to partner with you to help ensure enrollees receive preventive care. We endorse and monitor the practice of preventive health standards recommended by recognized medical and professional organizations.

Agency for Healthcare Research and Quality and the U.S. Preventive Services Task Force's Recommendations:

- ahrq.gov or access directly at uspreventiveservicestaskforce.org

Department of Health and Human Services – Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule.

Department of Health and Human Services – Centers for Disease Control and Prevention. Recommended Immunization Schedule for Persons Aged 0–18 Years.

Preventive health care standards and guidelines are available at **UHCprovider.com**.

UnitedHealthcare Dual Complete (HMO SNP) monitors the provision of these services through chart reviews. We also do so through a care provider profiling system highly dependent on the accuracy of the PCP's submissions of claims and encounters. Well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening and cervical and breast cancer screening are included. The profile is risk adjusted for the enrollee's comorbidities to profile on hospital, ER, specialist and pharmacy utilization.

Clinical practice guidelines

UnitedHealthcare Dual Complete (HMO SNP) strongly supports evidence-based medicine. As a result, we have identified sources that have received national recognition both from the government and the health care community. We have vetted these sources within UnitedHealth Group and our own network advisory committees. Visit the following websites for clinical practice guidelines. They are an important resource to support and guide your clinical decision making. Clinical Practice Guidelines are available at ahrq.gov or can be viewed on **UHCprovider.com**.

Communicable disease monitoring

The Department of Health requires all licensed Medicaid managed health care plans to actively monitor and provide oversight for reporting communicable and other designated reportable diseases by its participating care providers.

Chapter 20: Fraud, waste and abuse

We are committed to preventing fraud, waste, and abuse in Medicare benefit programs. Fraud, waste, and abuse by providers, enrollees, contractors, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our enrollees.

If any such actions, activities or behaviors come to your attention, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made in several ways:

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

Call the UnitedHealthcare Special Investigation Unit Fraud Hotline at **1-800-690-1606**, 8 a.m.–8 p.m. local time, 7 days a week.

Mail the information listed below to:

UnitedHealthcare Community Plan
Special Investigations Unit
8 Cadillac Drive, Suite 100
Brentwood, TN 37027

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

- Name, address and phone number of provider
- Medicaid number of the care provider
- Type of care provider (physician, physical therapist, pharmacist)
- Names and phone numbers of others who can aid in the investigation
- Specific details about the suspected fraud or abuse
- The enrollee's name, date of birth, Social Security number, ID number
- The enrollee's address
- Specific details about the suspected fraud or abuse

This hotline allows you to report cases anonymously and confidentially. All information provided to UnitedHealthcare Dual Complete regarding potential fraud or abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions of UnitedHealthcare Community Plan Dual Complete's Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns you may have regarding confidentiality should be addressed to the attention of the UnitedHealthcare Dual Complete Compliance Officer.

Our enrollees are instructed through the Member Handbook to safeguard their Member ID cards as they would any other private and personal identification information such as a driver's license or checkbook. If you have any concerns about a patient's enrollment when they present for non-emergent or non-urgent services:

- Ask for another form of identification, preferably one with a photograph
- Use **UHCprovider.com** or the IVR phone line to confirm enrollment
- Contact Member Services for verification

Examples of fraud and abuse include:

- Misrepresenting Services Provided
  - Billing for services or supplies not rendered
  - Misrepresentation of services/supplies
  - Billing for higher level of services than performed
- Falsifying Claims/Encounters
  - Alteration of a claim
  - Incorrect coding
  - Double billing
  - False data submitted
- Administrative or Financial
  - Kickbacks
  - Falsifying credentials
  - Fraudulent enrollment practices
  - Fraudulent third-party liability reporting
- Enrollee Fraud or Abuse issues
  - Fraudulent altered prescriptions
  - Card loaning/selling
  - Eligibility fraud
  - Failure to report third-party liability/other insurance

This hotline allows you to report cases anonymously and confidentially. All information provided to UnitedHealthcare Dual Complete regarding potential fraud or abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions

of UnitedHealthcare Community Plan Dual Complete's Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns you may have regarding confidentiality should be addressed to the attention of the UnitedHealthcare Dual Complete Compliance Officer.

Federal False Claims Act

The Federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor. Civil penalties can be imposed on any person or entity that violates the Federal False Claims Act, including monetary penalties of $5,500 to $11,000 as well as damages of up to three (3) times the federal government's damages for each false claim.

Federal fraud civil remedies

The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid Programs.

State False Claims acts

Several states, including Tennessee, have enacted broad false claims laws modeled after the Federal False Claims Act or have legislation pending that is similar to the Federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

Whistleblower and whistleblower protections

The Federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The Federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action. You must establish an effective training program for all staff on the following aspects of the Federal False Claims Act provisions:

- The administrative remedies for false claims and statements
- Any state laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws

All training must be appropriately documented and may be requested at any time by UnitedHealthcare Dual Complete.

Appendix A

Services that require prior authorization for UnitedHealthcare Community plan acute and dual complete programs

Important Information:

- All services rendered by a non-participating care provider require authorization and must have supporting documentation to support the out-of-network request
- All out-of-state services require authorization with medical documentation to support the out-of-state request
- Any service which may be considered experimental or investigational is not a covered benefit

The following directives apply to all prior authorizations:

- The enrollee must be eligible at the time the covered service is rendered
- Only one service may be requested per prior authorization request form
- Authorization is not a guarantee of payment. Billing guidelines must be met
- All rendering care providers/facilities/vendors must be actively registered

Important reminders:

- All services may be submitted through our web portal or by phone or fax
- Find instructions for submitting prior authorization requests online at **UHCprovider.com**

How to obtain a Prior Authorization:

- Phone: **1-800-690-1606**
- Online: **tenncloud.com** > My Dashboard > Patient Eligibility and Benefit application
- Ability to add attachments using the TennCloud Application

For information regarding the Medicare Advantage Advance Notification/Prior Authorization Requirements please contact Customer Service at **1-800-690-1606** or go online **UHCprovider.com**.

Abuse

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

Appeal

Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee is entitled to receive or any amounts that the enrollee must pay for a covered service. These procedures include reconsiderations by UnitedHealthcare Dual Complete (HMO SNP), an independent review entity, hearings before an ALJ, review by the Medicare Appeals Council and judicial review.

Basic benefits

All health and medical services that are covered under Medicare Part A and Part B, except hospice services and additional benefits. All UnitedHealthcare Dual Complete (HMO SNP) enrollees receive all basic benefits.

CMS

The Centers for Medicare and Medicaid Services, the federal agency responsible for administering Medicare, Medicaid and Children's Health Insurance Plan (CHIP) programs.

Concurrent review

A review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care and ongoing ambulatory care.

Cost-sharing

Refers to our obligation for payment of applicable Medicare coinsurance, deductible and copayment amounts for Medicare Parts A and B covered services.

Cost-sharing obligations

Medicare deductibles, premiums, copayments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's and other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child younger than 21 or an SSI beneficiary. No plan can impose cost-sharing obligations on its enrollees which would be greater than those that would be imposed on the enrollee if they were not an enrollee.

Covered services

Those benefits, services or supplies which are:

- Provided participating care providers or authorized by UnitedHealthcare Dual Complete (HMO SNP) or its participating care providers
- Emergency services and urgently needed services that may be provided by non-participating care providers
- Renal dialysis services provided while the enrollee is temporarily outside the service area
- Basic and supplemental benefits

Dual eligible

As used in Tennessee, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this contract, dual eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus and other full benefit dual eligible (FBDE).

Emergency medical condition

A medical condition with serious, acute symptoms (including severe pain) such a prudent layperson, with an average knowledge of health and medicine, would know that not getting immediate medical attention would result in 1) Serious jeopardy to the person's health or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency services

Covered inpatient or outpatient services:

1. Furnished by a qualified care provider
2. Needed to evaluate or stabilize an emergency medical condition

Encounter data

In the context of the Medicare Advantage Agreement, data elements from an encounter service event for a fee-for-service claim or capitated services proxy claim.

Enrollee

The Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the UnitedHealthcare Dual Complete (HMO SNP) and whose enrollment has been confirmed by CMS.

Experimental procedures and items

Items and procedures determined by UnitedHealthcare Dual Complete (HMO SNP) and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, UnitedHealthcare Dual Complete (HMO SNP) will follow CMS guidance (through the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Fee-for-service medicare

A payment system by which doctors, hospitals and other care providers are paid for each service performed (also known as traditional and/or Original Medicare).

Fraud

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

Full benefit dual eligible (FBDE)

An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits, including those who are categorically eligible and those who qualify as medically needy under the State Plan.

Grievance

Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeals process are: waiting times in physician offices; and rudeness or unresponsiveness of customer service staff.

Home health agency

A Medicare-certified agency that provides intermittent skilled nursing care and other therapeutic services in your home when medically necessary when enrollees are confined to their home and when authorized by their PCP.

Hospice

An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospitals

A Medicare-certified institution licensed in Tennessee, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Hospitalist

A hospitalist is a member of a medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this medical specialty, hospitalists must complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the enrollee’s PCP.

Independent Physicians Association (IPA)

A group of physicians who function as a contracting medical care provider/group yet work out of their own independent medical offices.

Marketing

As defined by 45 CFR § 164.501, the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare

Medically necessary

Medical services or hospital services determined by UnitedHealthcare Dual Complete (HMO SNP) to be:

- Rendered for the diagnosis or treatment of an injury or illness
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards
- Not furnished primarily for the convenience of the enrollee, the attending participating care provider or other provider of service

UnitedHealthcare Dual Complete (HMO SNP) will make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by UnitedHealthcare Dual Complete (HMO SNP).

Medicare

The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium

Medicare Part A is financed by the Social Security payroll withholding tax paid by workers and their employers, and the self-employment tax paid by self-employed persons. If enrollees are entitled to benefits under either the Social Security or railroad retirement systems or worked long enough in federal, island or local government employment to be insured, enrollees do not have to pay a monthly premium. If enrollees do not qualify for premium-free Part A benefits, they may buy the coverage from Social Security if enrollees are at least 65 years old and meet certain other requirements.

Medicare Part B

Supplemental, optional medical insurance that requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B premium

A monthly premium paid to Medicare (usually deducted from an enrollee's Social Security check) to cover Part B services. Enrollees must continue to pay this premium to Medicare to receive covered services whether enrollees are covered by an MA Plan or by Original Medicare.

Medicare Advantage (MA) plan

A policy or benefit package offered by a Medicare Advantage Organization (MAO) under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UnitedHealthcare Dual Complete (HMO SNP). An MAO may offer more than one benefit plan in the same service area. UnitedHealthcare Dual Complete (HMO SNP) is an MA plan.

Non-participating medical care provider or facility

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by Tennessee or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver covered services to UnitedHealthcare Dual Complete (HMO SNP) enrollees.

Non-QMB dual

An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB benefits.

Participating care provider

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by Tennessee or Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to UnitedHealthcare Dual Complete (HMO SNP) enrollees pursuant to the terms of the agreement.

Participating hospital

A hospital that has a contract to provide services and/or supplies to UnitedHealthcare Dual Complete (HMO SNP) enrollees.

Participating medical group

Care providers organized as a legal entity for the purpose of providing medical care. The medical group has an agreement to provide medical services to UnitedHealthcare Dual Complete (HMO SNP) enrollees.

Participating pharmacy

A pharmacy that has an agreement to provide UnitedHealthcare Dual Complete (HMO SNP) enrollees with medication(s) prescribed by the enrollees' participating care providers in accordance with UnitedHealthcare Dual Complete (HMO SNP).

Primary care provider (PCP)

The participating care provider whom an enrollee chooses to coordinate their health care. The PCP provides covered services for UnitedHealthcare Dual Complete (HMO SNP) enrollees and coordinating referrals to specialists. PCPs are generally participating care providers of internal medicine, family practice or general practice.

Qualified medicare beneficiary (QMB)

An individual entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance and Copayments (except for Medicare Part D). Collectively, these benefits [services] are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by the contract are as follows:

QMB only

QMBs who are not otherwise eligible for full Medicaid.

QMB plus

QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients.

Qualified medicare beneficiary (QMB) dual

An individual who is eligible for QMB benefits as well as Medicaid benefits.

Review types

The health plan has adopted the ERISA and NCQA service definitions.

Post service

Assessing appropriateness of medical services on a case-by-case or aggregate basis after services have been provided.

Preservice review

A case or service that the organization must approve, in whole or in part, in advance of an enrollee obtaining medical care or services. Preauthorization and precertification are preservice claims.

Specified low-income medicare beneficiary (SLMB) plus

An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, whose resources do not exceed twice the SSI limit and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

Specified needs plan (SNP) or plan

A type of Medicare Advantage plan that also incorporates services designed for a certain class of enrollees. In the case of the TennCare Program the special class of enrollees is persons who are both Medicare and Medicaid Dual eligible. These plans must be approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

TennCare

The medical assistance program administrated by Tennessee Department of Finance and Administration, Bureau of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare MCO

A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits

TennCloud

A tool used to verify enrollment, eligibility, assignments and benefits.

Service Area

A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The geographic area for UnitedHealthcare Dual Complete (HMO SNP) includes the counties of:

Anderson	Crockett	Hamilton	Lauderdale	Morgan	Stewart
Bedford	Cumberland	Hancock	Lawrence	Obion	Sullivan
Benton	Davidson	Hardeman	Lewis	Overton	Sumner
Bledsoe	Decatur	Hardin	Lincoln	Perry	Tipton
Blount	DeKalb	Hawkins	Loudon	Pickett	Trousdale
Bradley	Dickson	Haywood	Macon	Polk	Unicoi
Campbell	Dyer	Henderson	Madison	Putnam	Union
Cannon	Fayette	Henry	Marion	Rhea	Van Buren
Carroll	Fentress	Hickman	Marshall	Roane	Warren
Carter	Franklin	Houston	Maury	Robertson	Washington
Cheatham	Gibson	Humphreys	McMinn	Rutherford	Wayne
Chester	Giles	Jackson	McNairy	Scott	Weakley
Claiborne	Grainger	Jefferson	Meigs	Sequatchie	White
Clay	Greene	Johnson	Monroe	Sevier	Williamson
Cocke	Grundy	Knox	Montgomery	Shelby	Wilson
Coffee	Hamblen	Lake	Moore	Smith	

Please contact UnitedHealthcare Dual Complete (HMO SNP) if you have any questions regarding the definitions listed or any other information listed in this manual. Our representatives are available at any time at **1-800-690-1606**.

Comments

UnitedHealthcare Dual Complete (HMO SNP) welcomes your comments and suggestions about this care provider manual. Please complete this form if you would like to see more information, or expansions on topics, if you find inaccurate information. Please mail this form to:

UnitedHealthcare Dual Complete (HMO SNP)
Attn: Vice President of Network Programs
8 Cadillac Drive, Suite 100
Brentwood, TN 37027

Comments and Suggestions:

Submitted by:

Name: _____

Address: _____

Phone: _____

