2017
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary
Tennessee UnitedHealthcare Dual Complete (HMO SNP)
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Welcome

Welcome to the Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) 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 the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- **West Capitated Administrative Guide**, or go to uhcwest.com > Provider, click Library at the top of the screen. The Provider Administrative Guides link is on the left.
- A different Community Plan manual-go to UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in the manual using the following steps:

1. Press 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.

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 members.

**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.
Welcome

Welcome to UnitedHealthcare Community Plan, UnitedHealthcare Dual Complete (HMO SNP). We recognize that quality care providers are the key to delivering quality health care to members. To better assist you, UnitedHealthcare Dual Complete (HMO SNP) has provided this manual as a resource to answer questions regarding care for enrolled members. Our goal is to help you give members the highest-quality health care. This care provider manual explains the policies and procedures of the UnitedHealthcare Dual Complete (HMO SNP) network. We hope it provides you and your office staff with helpful information and guides you in making the best decisions for your patients.

Background

UnitedHealthcare Dual Complete (HMO SNP) is a Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Dual Complete (HMO SNP) Service Area. Members 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) members may be enrolled in UnitedHealthcare Community Plan.

Contacting UnitedHealthcare Community Plan Dual Complete (HMO SNP)

UnitedHealthcare Dual Complete (HMO SNP) manages a comprehensive care provider network of independent practitioners and facilities across Tennessee. The network includes health care professionals such as primary care providers (PCPs), specialist physicians, medical facilities, allied health professionals, and ancillary service providers. UnitedHealthcare offers several options to support care providers who require assistance.

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.

You can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice or review a member roster 24 hours a day, seven days a week.

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).

MediFAX (Emdeon)

MediFax is an integrated health care information system that provides transcription services.

Primary care providers (PCPs) who subscribe can log on to MediFax to determine the eligibility of members at emdeon.com.

UnitedHealthcare Dual Complete (HMO SNP) Roster

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

The PCP Panel Roster provides a list of our members currently assigned to the provider.

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 non-women’s health care issues discovered and treated in the course of receiving women’s health care services. This includes access to ancillary services ordered by women’s health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

We work with members and care providers to help ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, seven days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP’s nurse triage) which 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.
Chapter 1: Introduction

To print a monthly PCP Panel Roster, sign in to UHCprovider.com. Select the Link application. Then select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu. Complete additional fields as required. Click on the available report you want to view.

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 members obtain covered services.

Members using this UnitedHealthcare Dual Complete (HMO SNP) 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 the health care needs of members and arrange for medically necessary covered medical services. You may, at any time, advocate on behalf of the member without restriction to help ensure the best care possible for the member. In particular, you are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is your patient for:

A. The member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.
B. Any information the member needs to decide among all relevant treatment options.
C. The risks, benefits, and consequences of treatment or non-treatment.
D. The member’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, members 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 member care within the UnitedHealthcare Dual Complete (HMO SNP) care provider network. If possible, all members 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 member 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.

Participating Care Providers

Primary Care Providers

UnitedHealthcare Dual Complete (HMO SNP) contracts with certain PCPs members may choose to coordinate their health care needs. Except for member self-referral covered services (Chapter 2), the PCP provides or authorizes covered services for UnitedHealthcare Dual Complete (HMO SNP) members. 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 members 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 members. A PCP may refer a member to a specialist as medically necessary.

Addendum

This document is an addendum to the 2015 Tennessee UnitedHealthcare Dual Complete (HMO SNP) Administrative Guide. It provides additional information for Tennessee care providers only.
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.

CMS requires the SNP care provider to enter into an agreement with the State to provide or arrange for Medicaid benefits to its Dual Eligible enrollees. Hospitals in the UnitedHealthcare Dual Complete network must provide notification for observation stays within two business days of initiation of the observation stay. Inpatient admissions require both notification and prior authorization.

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 members.
- Payments for any Medicaid services covered solely by TennCare.
- Cost-sharing for a Part D prescription drug.

UPRV care providers are required to refer dual-eligible members who are QMB Plus or other FBDE recipients to the members’ TennCare managed care organization for the provision of TennCare benefits that are not covered by their SNP.

TennCare offers a broad array of long-term services and supports (LTSS) that help meet members’ 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.shtml](tn.gov/tenncare/providers.shtml)
- [tn.gov/tenncare/members.shtml](tn.gov/tenncare/members.shtml)
- [tn.gov/tenncare/longtermcare.shtml](tn.gov/tenncare/longtermcare.shtml)

Refer to the TennCare Bureau Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau website at [tn.gov](tn.gov) for claims submission requirements.
## Key Contact Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Behavioral Health</td>
<td></td>
<td>800-690-1606</td>
</tr>
<tr>
<td>Behavioral Health Crisis Services</td>
<td>Davidson County, call Mental Health Cooperative</td>
<td>615-726-0125</td>
</tr>
<tr>
<td></td>
<td>Tri-Cities region, call Frontier Health</td>
<td>877-928-9062</td>
</tr>
<tr>
<td></td>
<td>Greater Knoxville region, call Helen Ross McNabb Center</td>
<td>865-539-2409</td>
</tr>
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<td></td>
<td>For all other areas, call Youth Villages East Region</td>
<td>866-791-9224</td>
</tr>
<tr>
<td></td>
<td>South Middle Region</td>
<td>866-791-9222</td>
</tr>
<tr>
<td></td>
<td>Southeast Region</td>
<td>866-791-9225</td>
</tr>
<tr>
<td></td>
<td>Rural West Region</td>
<td>866-791-9227</td>
</tr>
<tr>
<td></td>
<td>North Middle Region</td>
<td>866-791-9221</td>
</tr>
<tr>
<td></td>
<td>Memphis Region</td>
<td>866-791-9226</td>
</tr>
<tr>
<td>Dental (UnitedHealthcare Dental)</td>
<td></td>
<td>844-275-8750</td>
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<tr>
<td>Family Assistance Service Center</td>
<td></td>
<td>866-311-4287</td>
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<tr>
<td>Foreign Language Line (all languages)</td>
<td></td>
<td>800-690-1606</td>
</tr>
<tr>
<td>Foreign Language Translation Services</td>
<td></td>
<td>800-758-1638</td>
</tr>
<tr>
<td>Medicaid (for Medicare crossover billing inquiries)</td>
<td></td>
<td>800-523-2863</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td>800-633-4227</td>
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<tr>
<td>Office of Inspector General (OIG)</td>
<td></td>
<td>800-433-3982</td>
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<tr>
<td>Optum NurseLine</td>
<td></td>
<td>800-690-1606</td>
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<tr>
<td>Pharmacy OptumRx</td>
<td></td>
<td>800-690-1606</td>
</tr>
<tr>
<td>Social Security Administration</td>
<td></td>
<td>800-772-1213</td>
</tr>
<tr>
<td>State Health Insurance Assistance Program (SHIP Help Line)</td>
<td></td>
<td>877-801-0044</td>
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<tr>
<td>Tennessee Community Services Agency (TennCare Advocacy Services provider)</td>
<td></td>
<td>800-758-1638</td>
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<tr>
<td>UnitedHealthcare Dual Complete (HMO SNP)</td>
<td></td>
<td>800-690-1606</td>
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<tr>
<td>Vision March Vision</td>
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<td>888-493-4070</td>
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For TennCare benefits, see your TennCare Provider Manual list of Key Contacts.
Chapter 2: Covered Services

Summary

The following table shows Medicare cost-shares for members enrolled in UnitedHealthcare Dual Complete (HMO SNP). Costs may vary based on the member’s type of Medicaid assistance.

<table>
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<th>If the Benefit is Covered by:</th>
<th>Then Medicare Cost-Sharing Paid by*</th>
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<tr>
<td></td>
<td>Medicare</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Qualified Medicare</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Beneficiary (QMB)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dual No premiums</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Non-QMB Dual*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>May pay Part B premium if not paid by the State Medicaid agency. Otherwise, no premiums.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
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</tbody>
</table>

Medicaid (Medicaid contractor) pays the Medicare cost-sharing (coinsurance, deductible, or copayments except 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 member 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 members of UnitedHealthcare Dual Complete 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 the contractor (Medicaid HMO) prohibits out-of-network referrals in the care provider contract, the care provider may be in violation of the contract. In this instance, the contractor (Medicaid HMO) has no cost-sharing obligation. The care provider who referred the member to an out-of-network care provider is obligated to pay any cost-sharing. The member does not pay the Medicare cost-sharing except as noted in the member section.

   However, if the Medicare HMO and the contractor (Medicaid HMO) have networks for the same service that have no overlapping care providers, and the contractor (Medicaid HMO) chooses not to have the service performed in its own network, the contractor (Medicaid HMO) pays the cost-sharing for that service. If the overlapping care providers have closed their panels, and the member goes to an out-of-network care provider, the contractor (Medicaid HMO) pays the cost-sharing.

2. **Member**
   If a member has been advised of the contractor’s (Medicaid HMO) network, and the member’s responsibility is delineated in the member handbook, and the member elects to go out of network, the member pays the Medicare cost-sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the contractor’s (Medicaid HMO) Member Handbook.

**Introduction to Summary of Benefits**

**Members 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 members pay.

- If you want to know more about the coverage and costs of Original Medicare, look in the current Medicare & You handbook. View it online at medicare.gov. You can also get a copy by calling 800-MEDICARE (800-633-4227) 24 hours a day, seven days a week. TTY users should call 486-2048.

**Sections in This Booklet**

- Things to Know About UnitedHealthcare Dual Complete (HMO SNP)
- Monthly Premium, Deductible, and Limits on How Much a Member Pays for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

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

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

**Things to Know About UnitedHealthcare Dual Complete (HMO SNP)**

**Hours of Operation**

You can call us seven days a week from 8 a.m. to 8 p.m. local time.

**UnitedHealthcare Dual Complete (HMO SNP)**

**Phone Numbers and Website**

- For existing plan members, call toll-free 800-690-1606
- If someone is not a member of this plan, call toll-free 888-834-3721.
- Our website: UHCCommunityPlan.com

**Who can Join?**

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

What Do We Cover?
Like all Medicare health plans, we cover everything that
Original Medicare covers — and more.
• Our plan members get all of the benefits covered by
  Original Medicare. For some of these benefits, you may pay
  more in our plan than you would in Original Medicare. For
  others, you may pay less.
• Our plan members also get more than what is covered by
  Original Medicare. Some of the extra benefits are outlined
  in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs
such as chemotherapy and some drugs administered by care
providers.
• You can see the complete plan formulary (list of Part D
  prescription drugs) and any restrictions on our website,
  UHCCommunityPlan.com.
• Or call us, and we will send you a copy of the formulary.

How Will the Member Determine Drug Costs?
The amount the member pays for drugs depends on the drug
they are taking and what stage of the benefit they have reached.
Later in this document we discuss the benefit stages that occur
after the member meets their deductible: Initial Coverage,
Coverage Gap, and Catastrophic Coverage.

Which Doctors, Hospitals, and Pharmacies
Can the Member Use?
UnitedHealthcare Dual Complete (HMO SNP) has a network
of doctors, hospitals, pharmacies, and other care providers. If
the member uses the care providers that are not in our network,
the plan may not pay for these services.

The member 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 (UHCCommunityPlan.com).

Or call us, and we will send you a copy of the care provider and
pharmacy directories.
## Summary of Benefits – for Enrolled Members Only

If you have any questions about this plan’s benefits or costs, please call UnitedHealthcare Community Plan at 1-800-690-1606. These are not benefits received by a care provider or facility.

### UnitedHealthcare Dual Complete™ (HMO SNP)

#### Monthly Premium, Deductible, and Limits on how Much the Member Pays for Covered Services

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is the monthly premium?</td>
<td>$0 per month.</td>
</tr>
<tr>
<td>How much is the deductible?</td>
<td>This plan does not have a deductible. This plan does not have a deductible for chemotherapy and other drugs administered in the doctor’s office (Part B drugs). This plan does not have a deductible for Part D prescription drugs.</td>
</tr>
<tr>
<td>Is there any limit on how much the member will pay for covered services?</td>
<td>Yes. Like all Medicare health plans, our plan protects the member by having yearly limits on out-of-pocket costs for medical and hospital care. In this plan, the member may pay nothing for Medicare-covered services, depending on the level of TennCare eligibility. Refer to the “Medicare &amp; You” handbook for Medicare-covered services. For TennCare covered services, refer to the Medicaid Coverage section in this document. The member’s yearly limit(s) in this plan is $6,700 for services they receive from in-network care providers. If the member reaches the limit on out-of-pocket costs, they keep getting covered hospital and medical services. We will pay the full cost for the rest of the year. Please note that the member will still need to pay the monthly premiums and cost-sharing for Part D prescription drugs.</td>
</tr>
<tr>
<td>Is there a limit on how much the plan will pay?</td>
<td>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</td>
</tr>
</tbody>
</table>

### Covered Medical and Hospital Benefits

**Note:**
- Services with a 1 may require prior authorization.
- Services with a 2 may require a referral from the member’s doctor.

#### Outpatient Care and Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture and Other Alternative Therapies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Ambulance</td>
<td>The member pays nothing.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Manipulation of the spine to correct a subluxation (when one or more of the bones of the spine move out of position): The member pays nothing.</td>
</tr>
</tbody>
</table>
# UnitedHealthcare Dual Complete™ (HMO SNP)

## Dental Services
Limited dental services (this includes preventive, fillings, some crowns and periodontal services, simple and surgical extractions): The member pays nothing.

Preventive dental services:
- Cleaning (for up to one every six months): The member pays nothing
- Dental x-ray(s) (for up to one): The member pays nothing
- Oral exam (for up to one every six months): The member pays nothing

Our plan pays up to $1,000 every year for covered dental services. Prior authorization is required for periodontal services and crowns.

## Diabetes Supplies and Services
Diabetes monitoring supplies: The member pays nothing.

Diabetes self-management training: The member pays nothing.

Therapeutic shoes or inserts: The member pays nothing.

The plan covers the following brands of blood glucose monitors and test strips: OneTouch® Ultra® 2, OneTouch® Verio™, OneTouch® UltraMini™, ACCU-CHEK® Aviva, ACCU-CHEK® Compact, ACCU-CHEK® SmartView

## Diagnostic Tests, Lab and Radiology Services, and X-rays
Diagnostic radiology services (such as MRIs, CT scans): The member pays nothing.

Diagnostic tests and procedures: The member pays nothing.

Lab services: The member pays nothing.

Outpatient x-rays: The member pays nothing.

Therapeutic radiology services (such as radiation treatment for cancer): The member pays nothing.

## Doctor’s Office Visits
PCP visit: The member pays nothing.

Specialist visit: The member pays nothing.

## Durable Medical Equipment (wheelchairs, oxygen, etc.)
The member pays nothing.

## Emergency Care
The member pays nothing.

## Foot Care (podiatry services)
Foot exams and treatment if the member has diabetes-related nerve damage and/or meet certain conditions. The member pays nothing.

Routine foot care (for up to four visit[(s)] every year): The member pays nothing.

## Hearing Services
Exam to diagnose and treat hearing and balance issues: The member pays nothing.

Routine hearing exam (for up to one every year): The member pays nothing.

Hearing aids: The member pays nothing up to $1,000 every two years.

## Home Health Care
The member pays nothing.
### Mental Health Care

Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

The copays for hospital and SNF benefits are based on benefit periods. A benefit period begins the day the member is admitted as an inpatient and ends when the member has not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If the member goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. The member must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 “lifetime reserve days.” These are “extra” days we cover. If the hospital stay is longer than 90 days, the member can use these extra days. But once the member has used up these extra 60 days, the inpatient hospital coverage will be limited to 90 days.

Outpatient group therapy visit: The member pays nothing.

Outpatient individual therapy visit: The member pays nothing.

### Non-Emergent Transportation

DNSP members may receive non-emergent transportation (NEMT) benefits. These benefits include:

- 36 one-way transportation trips (roundtrips are considered two trips) per calendar year
- Limited to ground transportation only
- Pick up to or from plan approved locations. Must be for approved medical, dental, vision, and/or hearing appointments or to a pharmacy
- Up to one companion per trip (companion must be at least 18 years of age)
- Curb to Curb service
- Wheelchair accessible vans upon request
- Each one-way trip must not exceed 50 miles
- Trip requests must be requested 72 hours prior to a scheduled appointment
- Stretcher transport for NEMT services is not covered

### Outpatient Rehabilitation

Cardiac (heart) rehab services (for a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks): The member pays nothing.

Occupational therapy visit: The member pays nothing.

Physical therapy and speech and language therapy visit: The member pays nothing

### Outpatient Substance Abuse

Group therapy visit: The member pays nothing.

Individual therapy visit: The member pays nothing.

### Outpatient Surgery

Ambulatory surgical center: The member pays nothing.

Outpatient hospital: The member pays nothing.

### Over-the-Counter Items

Please visit our website to see our list of covered over-the-counter items.
## UnitedHealthcare Dual Complete™ (HMO SNP)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Coverage Details</th>
</tr>
</thead>
</table>
| **Prosthetic Devices** (braces, artificial, limbs, etc.) | Prosthetic devices: The member pays nothing.  
Related medical supplies: The member pays nothing. |
| **Renal Dialysis**                     | The member pays nothing.                                                                          |
| **Transportation**                     | Not covered.                                                                                         |
| **Urgent Care**                        | The member pays nothing.                                                                            |
| **Vision Services**                    | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): The member pays nothing.  
Routine eye exam (for up to one every year): The members pays nothing.  
Contact lenses: The member pays nothing.  
Eyeglasses frames (for up to one every two years): The member pays nothing.  
Eyeglasses lenses (for up to one every two years): The member pays nothing.  
Eyeglasses or contact lenses after cataract surgery: The member pays nothing.  
Our plan pays up to $150 every two years for contact lenses, eyeglass lenses, and eyeglass frames. |
### UnitedHealthcare Dual Complete™ (HMO SNP)

#### Preventive Services

The member pays nothing.

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, Hepatitis B shots, Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly wellness visit. Any additional preventive services approved by Medicare during the contract year will be covered.
- Annual physical exam: The member pays nothing.

#### Hospice

The member pays nothing for hospice care from a Medicare-certified hospice. The member may have to pay part of the cost for drugs and respite care.
### UnitedHealthcare Dual Complete™ (HMO SNP)

#### Inpatient Care

<table>
<thead>
<tr>
<th>Inpatient Hospital Care</th>
<th>The copays for hospital and SNF benefits are based on benefit periods. A benefit period begins the day the member is admitted as an inpatient and ends when the member hasn’t received any inpatient care (or skilled care in a SNF) for 60 days in a row. If the member goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. The member must pay the inpatient hospital deductible for each benefit period. There’s no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 &quot;lifetime reserve days.&quot; These are &quot;extra&quot; days that we cover. If the hospital stay is longer than 90 days, the member can use these extra days. But once the member has used up these extra 60 days, the inpatient hospital coverage will be limited to 90 days. The member pays nothing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>Our plan covers up to 100 days in a SNF. The member pays nothing.</td>
</tr>
</tbody>
</table>

#### Prescription Drug Benefits

<table>
<thead>
<tr>
<th>How much do I pay?</th>
<th>For Part B drugs such as chemotherapy drugs: The member pays nothing. Other Part B drugs: The member pays nothing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Coverage</td>
<td>Our plan does not have a deductible for Part D prescription drugs. Depending on the member’s income and institutional status, the member pays the following: For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $3.30 copay For all other drugs, either: • $0 copay; or • $3.70 copay; or • $8.25 copay The member may get the drugs at network retail pharmacies and mail order pharmacies. If the member resides in a long-term care facility, they pay the same as at a retail pharmacy. The member may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. The member pays nothing.</td>
</tr>
</tbody>
</table>
Medicaid Benefits

Information for Members with Medicare and Medicaid

UnitedHealthcare Dual Complete (HMO SNP) is a Dual Eligible Special Needs Plan (D-SNP) for individuals that do not have any cost-sharing responsibility. If the member has both Medicare and Medicaid, their services are paid first by Medicare and then by Medicaid. The Medicaid coverage depends on the member’s income, resources and other factors. Some members get full Medicaid benefits.

The following people can enroll in UnitedHealthcare Dual Complete (HMO SNP):

- **Qualified Medicare Beneficiary (QMB).** The member gets Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays Part A and Part B premiums, deductibles, coinsurance amounts and copayments only.

- **Qualified Medicare Beneficiary Plus (QMB+).** The member gets Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays Part A and Part B premiums, deductibles, coinsurance and copayment amounts.

**If the Member Is a QMB or QMB+ Beneficiary:**

The member has 0% cost-share, except for Part D prescription drug copays.

If the member’s category of Medicaid eligibility changes, their cost-share may also increase or decrease. The member must recertify their Medicaid enrollment to continue receiving Medicare coverage.

**How to Read the Medicaid Benefit Chart:**

Medicaid covers the following benefits. Medicare covers the benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits. For each benefit listed, you can see what TennCare covers and what our plan covers. If a benefit is used up or not covered by Medicare, Medicaid may provide coverage. This depends on the type of Medicaid coverage.
## Chapter 2: Covered Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicaid</th>
<th>UnitedHealthcare Dual Complete (HMO SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Residential Treatment Services</td>
<td>$0 copay</td>
<td>No coverage</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICF/IID)</td>
<td>$0 copay</td>
<td>No coverage beyond Original Medicare</td>
</tr>
</tbody>
</table>

### Medicare-covered Services

**Ambulance**

- Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount.
- For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts:
  - $0 copay for TennCare services

**Chiropractic Care**

- Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount.
- For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts:
  - $0 copay for TennCare services for QMB beneficiaries and beneficiaries younger than 21 years.
  - Not covered for non-QMB beneficiaries 21 years and older.

**Dental Services**

- Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount.
- For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts:
  - $0 copay for TennCare services for QMB beneficiaries and beneficiaries younger than 21 years.
  - Not covered for non-QMB beneficiaries 21 years and older.
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<tr>
<td>Diabetes Supplies and Services</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Diagnostic Tests, Lab and Radiology Services, and X-rays</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
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<tr>
<td>Doctor’s Office Visits</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
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### Chapter 2: Covered Services

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<tr>
<td><strong>Foot Care</strong> (podiatry services)</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services for QMB beneficiaries and beneficiaries younger than 21. Not covered for non-QMB beneficiaries 21 years and older.</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services TennCare may cover additional Home Health Care Services based on medical necessity. For adults, TennCare has limits on home health. See Care with Limits in the TennCare Member Handbook.</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
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## Chapter 2: Covered Services

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<th>Benefit</th>
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<tbody>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Prosthetic Devices (braces, artificial, limbs, etc.)</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medicaid</td>
<td>UnitedHealthcare Dual Complete (HMO SNP)</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services for QMB beneficiaries and beneficiaries younger than 21 years. • Not covered for non-QMB beneficiaries 21 years and older.</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Hospice</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services • TennCare also covers hospice room and board when Medicare hospice is provided in a nursing facility.</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
</tbody>
</table>
### Chapter 2: Covered Services

<table>
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<tr>
<th>Benefit</th>
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<td>Inpatient Hospital Care</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
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<td>Inpatient Mental Health Care</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Depending on the member’s level of TennCare eligibility, TennCare may pay the Medicare cost-sharing amount. For services not covered by Medicare or if the benefit is exhausted, TennCare may provide additional coverage subject to the following cost-share amounts: • $0 copay for TennCare services TennCare covers Medicaid Nursing Facility services beyond the Medicare 100-day limit for those members on TennCare CHOICES for members who meet nursing facility level of care.</td>
<td>Covered. See Section 2 for applicable cost-sharing amount.</td>
</tr>
</tbody>
</table>

#### Additional Services Available through UnitedHealthcare Dual Complete (HMO SNP)

| Additional Dental Services | TennCare adults 21 and older do not have access to routine dental services. TennCare children younger than 21 years are provided comprehensive dental services. $0 copay for all preventative care. $0 copay for TennCare children younger than 21 years for medical/surgical/dental services. | Covered. See Section 2 for applicable cost-sharing amount. |
## Chapter 2: Covered Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicaid</th>
<th>UnitedHealthcare Dual Complete (HMO SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Foot Care</strong></td>
<td>Must be medically necessary and be provided by a participating care provider. Copays are only required of TennCare. Standard children with incomes above poverty for these services.</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Additional Hearing Services</strong></td>
<td>TennCare adults 21 and older do not have access to routine hearing services. TennCare children younger than 21 years are provided hearing services. $0 copay for all preventative care.</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Over-the-Counter Items</strong></td>
<td>No coverage.</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Transportation (routine)</strong></td>
<td>$0 copay. Transportation is available to covered services when the member does not have access to transportation services; transportation must be provided by approved and contracted transportation providers.</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
<tr>
<td><strong>Additional Vision Services</strong></td>
<td>TennCare adults 21 and older do not have access to routine vision services. Medical eye care is covered. The first pair of glasses or lenses after cataract surgery is covered. TennCare children younger than 21 years are provided vision services and glasses as needed. $0 copay for all preventative care. $0 copay for eyeglasses.</td>
<td><strong>Covered.</strong> See Section 2 for applicable cost-sharing amount.</td>
</tr>
</tbody>
</table>
Multi-language Interpreter Services

UnitedHealthcare Dual Complete (HMO SNP) offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services anytime to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Dual Complete (HMO SNP) member needs Interpreter Services, we prefer care providers use a professional interpreter.
  - To access a professional interpreter during regular business hours, contact the Provider Call Center.

- **Cultural member materials:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-834-3721. Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-834-3721. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-834-3721。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-834-3721。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katunangan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuhang tagasaling-wika, tawagan lamang kami sa 1-888-834-3721. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d’interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d’assurance-médicaments. Pour accéder au service d’interprétation, il vous suffit de nous appeler au 1-888-834-3721. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình bảo hiểm sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-834-3721 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-834-3721. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-834-3721번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.
Chapter 2: Covered Services

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 888-834-3721. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إذا كنت بحاجة إلى خدمات الترجمة المجانية للإجابة على أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا، يمكنك الاتصال بنا على 888-343-721. سوف نقدم شخصًا يعرف اللغة العربية فورًا للرد على أسئلتك. هذه الخدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 888-834-3721. Un nostro incaricato che parla Italiano vi fornirà l’assistenza necessaria. È un servizio gratuito.

Portuguese: Disponemos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicamento. Para obter um intérprete, contacte-nos através do número 888-834-3721. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 888-834-3721. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 888-834-3721. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके कस्तन-कस्तन प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। एक दुभाषिया परापर परापर करने के लिए, बस हमें 888-834-3721 पर फोन करें। कोई दुभाषिया जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、 888-834-3721にお電話 ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。
Prior Authorization

Services requiring prior authorization are included in the Appendix. 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: 800-690-1606
- Online: TennCloud.com > My Dashboard > Patient Eligibility & Benefits application
- Ability to add attachments using the TennCloud Application
- Medical Fax: 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) member’s 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 members and see that members 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 members who self-refer for their well-woman exam.

Write referrals on the same form you use for UnitedHealthcare Community Plan Medicaid members. 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 member, or call the Health Plan at 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 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 member’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 member’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 a member’s prescribed psychotropic medication.
- Coordination allows for better management of treatment and follow-up for members with both behavioral and medical disorders.
- Continuity of care across all levels of care and between behavioral and medical treatment modalities is enhanced.
- Members 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 members may not allow for release of his 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 at communicating with other behavioral health clinicians and any medical care professionals treating the plan participant.

Emergency and Urgent Care

- Members are encouraged to receive emergency services from their PCP or a participating hospital or facility.
- Behavioral Health Crisis Services are available 24 hours a day/seven days a week. For adults, 18 years and older, crisis services can be accessed by calling 855-CRISIS1 (855-274-7471). For children younger than 18 years, the toll-free numbers are:

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

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

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

  **For all other areas call Youth Villages:**
  East Region: 866-791-9224
  South Middle Region: 866-791-9222
  Southeast Region: 866-791-9225
  Rural West Region: 866-791-9227
  North Middle Region: 866-791-9221
  Memphis Region: 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; or
- 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; and
- Needed to evaluate or stabilize an emergency medical condition.

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

The health plan covers necessary emergent services to stabilize members, 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 member’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 privileges to stabilize, treat and transfer the member. 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 member, the health plan must be notified no later than the end of the next working day. Once the member’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 a member’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.

- Under Medicare guidelines, outpatient observation is limited to 48 hours for physical health observation.
- When a member is admitted after an outpatient observation, the health plan considers the date the member entered outpatient observation as the first day of the inpatient admission.
- Billing guidelines
  a. Use observation revenue codes of 760, 761, or 762
  b. Place number of hours in observation in the unit field.
    (1 hour = 1 unit)

Bill for observation, even if the member is later admitted. You may bill observation and inpatient on the same claim. Observation day(s) will be considered the first day(s) of the inpatient admission. The observation day(s) will be part of the inpatient reimbursement.

Post-stabilization Care Services

Services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition, or to improve or resolve the member’s 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 member’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 member’s PCP or the health plan directs the member to the emergency room, emergency screening services and other medically necessary emergency services will be reimbursed, whether or not the member’s condition meets the prudent layperson definition of an emergency medical condition.

Members 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 member is temporarily absent from the UnitedHealthcare Dual Complete (HMO SNP) service area, and
- When such services are medically necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) members 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 member 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

A member may obtain medically necessary dialysis services from any qualified care provider the member selects when he/she is 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, a member may voluntarily 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 the member use a qualified dialysis provider.
Preventive Services

Members 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.

Members 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 Members (DSNP). 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 members 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). The following list shows about these exclusions and limitations. It describes services not covered under any conditions and some that are covered only under specific conditions.

If members 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.

Services UnitedHealthcare Dual Complete (HMO SNP) Does Not Cover

- Services not covered under Original Medicare, unless such services are specifically listed as covered.
- Services members receive from non-plan care providers. The exceptions are care for a medical emergency and urgently needed care, renal (kidney) dialysis services received when temporarily outside the plan's service area, and care from non-plan care providers arranged or approved by a plan care provider.
- Services members receive without prior authorization, when prior authorization is required for getting those services.
- Services not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UnitedHealthcare Dual Complete (HMO SNP) and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
- Private room in a hospital, unless medically necessary.
- Private-duty nurses.
- Personal convenience items, such as a telephone or television in your room at a hospital or SNF.
- Nursing care on a full-time basis in your home.
- Custodial care is not covered by UnitedHealthcare Dual Complete (HMO SNP) unless provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with the activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services.
- Charges imposed by immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
- Cosmetic surgery or procedures unless needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
- Chiropractic care is generally not covered under the plan (except for manual manipulation of the spine) and is limited according to Medicare guidelines.
- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
- Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet. Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Hearing aids and routine hearing examinations.
- Radial keratotomy, LASIK surgery, vision therapy and other low-vision aids and services.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyorgasmia.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
- Acupuncture.
• Naturopath services.
• Services provided to veterans in Veteran’s Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under UnitedHealthcare Dual Complete (HMO SNP), we will reimburse veterans for the difference. Members are still responsible for the UnitedHealthcare Dual Complete (HMO SNP) cost-sharing amount.

We regularly review new procedures, devices and drugs to determine whether they are safe and efficacious for members. 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 member 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 individual member, one of our medical directors makes a medical necessity determination based on individual member 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 a member who is your patient for the following:

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

The member’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 the enrollment and assignment of the member 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 member enrollment and assignment may result in claim denial.
- Rendering covered services to UnitedHealthcare Dual Complete (HMO SNP) members in an appropriate, timely, and cost-effective manner and in accordance with their specific contract and CMS requirements.
- 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 members diagnosed as being infected with the human immunodeficiency virus (HIV) or having acquired immune deficiency syndrome (AIDS) in the same manner and to the same extent as other members and under the compensation terms set forth in their contract.
- Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities. They may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.
- Making a concerted effort to educate and instruct members about the proper utilization of the practitioner’s office in lieu of hospital emergency rooms. Do not refer or direct members to hospital emergency rooms for non-emergent medical services.
- Abiding by the UnitedHealthcare Dual Complete (HMO SNP) referral and prior authorization guidelines.
- Admitting members 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 member’s condition is emergent, and the use of a contracted hospital is not medically feasible. You will provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
- Using participating hospitals, specialists, and ancillary care providers. A member 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 800-690-1606 for questions related to profiles, member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc.
- Providing all EPSDT services to UnitedHealthcare Dual Complete (HMO SNP) members up to 21 years.
- Screening UnitedHealthcare Dual Complete (HMO SNP) members for behavioral health problems, using the Screening Tool for Chemical Dependence (a.k.a. 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 member in making an appointment. No formal referral form is required.
- Being available to members by phone 24 hours a day, seven days a week. 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 member showing signs of end-stage renal disease.
• Admitting UnitedHealthcare Dual Complete (HMO SNP) members to the hospital when necessary and coordinating the medical care of the member while hospitalized.
• Reporting all services provided to UnitedHealthcare Dual Complete (HMO SNP) members 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 member’s medical records must be provided to members upon request at no charge.
• Allowing timely access to UnitedHealthcare Dual Complete (HMO SNP) member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
• 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 members 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 800-560-5767. You can also view their website at: tn.gov/mental/legalCounsel/olc.html.

Care Provider Privileges

To help our members 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 but is not limited to 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 assure that:

• 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 a member 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 fee 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.

1. Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates, receives, maintains and transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Help ensure compliance with the Security Regulations by the covered entity’s workforce. UnitedHealthcare 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 receiving payment for any services rendered to UnitedHealthcare Dual Complete (HMO SNP) members, 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 imbedded intelligence
- A HIPAA standard
- Mandated for use in ALL standard electronic transactions across the industry (claims, enrollment, remittance, claim status request and response, auth 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 auth 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 & 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: 800-465-3203 or TTY 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 877-842-3210 or your provider relations consultant at 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 member 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 members, 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 member for copies of medical records provided for claims payment or medical management. You may charge the member for records provided at the member’s request.

You may not charge the health plan or the member for records provided when a member moves from one primary care provider 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 member’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 member without the physician’s written consent.

**Organization and Responsibility** – The development and continued improvement of the UM Program 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 medical care of the patient. 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) members 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.

- Notification pertaining to such services received by the health plan must be directed 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 member’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 emergency room 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 member’s condition prevents transfer to a participating hospital. Transfers should occur within 48 hours of determination of the member’s transferability.

**Medical Hospital Utilization Management**

Admissions are reviewed within one business day of received clinical using Medicare guidelines and MCG (formerly Milliman 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 member 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 member request according to applicable state laws.

The ultimate decision regarding medical management of a member 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 occurs 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 members directly face-to-face or by phone.
You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. 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 MCG (formally Milliman 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, but not limited to, 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 member.

**Admission to Skilled Nursing Units**

**Inpatient hospitalization is not required for a member 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 members 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 on 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 is 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 a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage SNF, HHA, and CORF providers to work with 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 member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by phone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice. The call must be documented, and the notice must be mailed to the representative.

Expedited Review Process
If the 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.

A member may contact the QIO (QSource) at 901-682-0381 or 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. You should cooperate with our requests for assistance in getting needed information. 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 member’s benefit is exhausted;
2. Denial of an admission to an SNF, HHA or CORF;
3. Denial of non-Medicare covered services; or
4. A reduction or termination of services that do not end the skilled stay.

When a Detailed Explanation of Non-Coverage (DENC) Will Be Issued
We will issue a DENC explaining why services are no longer medically necessary to the member. 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 member 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 UHCCommunityPlan.com.

More Information
Further information on this process, including the required notices and related CMS instructions, can be found 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. Members 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.

Member Eligibility and Enrollment
Medicare and (Medicaid) beneficiaries who elect to become members of UnitedHealthcare Dual Complete (HMO SNP) must meet the following qualifications.

- Members must be entitled to Medicare Part A and be enrolled in Medicare Part B.
- Members must be entitled and enrolled in TennCare (Medicaid) benefits.
- Members must reside in the Dual Complete (HMO SNP) service area.
- A member must maintain a permanent residence within the service area. They must not reside outside the service area for more than six months.
- Members of all ages who 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) member will receive a UnitedHealthcare Dual Complete (HMO SNP) identification (ID) card containing the member’s name, member 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) members are assigned a Dual Complete (HMO SNP) specialist to act as advocates.

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

**Assignment to PCP Panel Roster**

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at [UHCProvider.com](http://UHCProvider.com). The portal requires a unique user name and password combination to gain access.

Sign in to [UHCProvider.com](http://UHCProvider.com). Select the Link application on Link. Select Reports from the Tools & Resources. From the Report Search page, Select the Report Type (PCP Panel Roster) from the pull-down menu. Complete additional fields as required. Click on the available report you want to view.

**Verifying Member Enrollment**

Once a member has been assigned to a PCP, UnitedHealthcare Dual Complete (HMO SNP) documents the assignment and provides each PCP a roster indicating the members assigned to them. Rosters can be viewed electronically on [UHCProvider.com](http://UHCProvider.com). PCPs should verify eligibility by using their rosters in conjunction with:

- [AmeriChoice.com](http://AmeriChoice.com)
- UnitedHealthcare Dual Complete (HMO SNP): 800-690-1606
- MedIFAX
- TennCare (Medicaid) web-based eligibility verification system
- [TennCloud.com](http://TennCloud.com) > My Dashboard > Patient Eligibility & Benefit Application

At each office visit, your office staff should:

- Ask for the member’s ID card and have a copy of both sides in the member’s office file.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- Refer to the member’s ID card for the appropriate 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 member’s PCP. If the member’s name is not listed, your office staff should contact UnitedHealthcare Dual Complete (HMO SNP) Customer Service to verify PCP selection before the member is seen by the participating care provider.

Verify member eligibility prior to providing services.

**PCP Member Assignment**

UnitedHealthcare Dual Complete (HMO SNP) manages the member’s care on the date they are enrolled with the plan and until the member is disenrolled from UnitedHealthcare Dual Complete (HMO SNP). Each enrolled member can choose a PCP within our Provider Directory. Members 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 member elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Dual Complete (HMO SNP) to change their PCP at any other time, the change will be made effective on the date of the request.
Coordinating 24-Hour Coverage

PCPs are expected to provide coverage for UnitedHealthcare Dual Complete (HMO SNP) members 24 hours per day, seven days per week. When a PCP is unavailable to provide services, the PCP must help ensure they have coverage from another participating care provider. Hospital emergency rooms 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

In the event of a medical emergency, a member should seek care from the nearest doctor or hospital. Crisis services are available for members with behavioral health emergencies. Behavioral Health Crisis Services for adults (18 years and older) can be accessed by calling 855-CRISIS-1 (or 1-855-274-7471).

For children younger than 18 years, the toll-free numbers are:

- Tri-Cities Region, for Frontier Health: 877-928-9062
- Frontier Health Greater Knoxville Region, call: Helen Ross McNabb, 865-539-2409
- Davidson County, Mental Health Cooperative: 615-726-0125

All other areas, call Youth Villages:

- East Region: 866-791-9224
- Southeast Region: 866-791-9225
- North Middle Region: 866-791-9221
- South Middle Region: 866-791-9222
- Rural West Region: 866-791-9227
- Memphis Region: 866-791-9226

If the member has questions or needs medical advice, they may contact Optum NurseLine.

Optum® NurseLine Services

Optum® NurseLine is a service that gives medical facts and access to health information.

Optum® NurseLine can be accessed 24 hours a day by calling 866-263-9168 and TDD (Hearing-Impaired) 800-855-2880.

Optum® NurseLine can:

- Help avoid unnecessary emergency room visits
- Provide 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 877-842-3210 and provide 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 to 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 a member; (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.

Public Release of Care Provider/Clinician Specific Information
We do not release any clinician-specific utilization management information to entities outside the health plan except as permitted or required by law.

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:
Chapter 5: Credentialing

• Accreditation certificate/letter
• State license
• Certificate of professional liability insurance
• Laboratory certification
• Information regarding any license sanctions and/or insurance denials
• A listing 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.
UnitedHealthcare Community Plan care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare for Medicare and Medicaid benefits, may take advantage of single-claim submission. Claims submitted to UnitedHealthcare Community Plan for dual-enrolled members 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 member.

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 UHCCommunityPlan.com. 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 UHCCommunityPlan.com. To enroll, call e-business unit at 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

Claims Format

All claims for medical or hospital services must be submitted using the standard CMS1500 (formerly known as HCFA 1500), UB-04, or respective HIPAA-compliant format. The health plan recommends the use of black ink when completing a CMS 1500. This allows for optimal scanning into the claims processing system.

No matter which format you use, help ensure all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

Claim Processing Time

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is 10 business days, measured from date of receipt.

Claims Submission Rules

The following claims MUST be submitted on paper due to required attachments:

- Timely filing reconsideration requests
- CCI edit reconsideration
- Unlisted procedure codes if sufficient information is not sent in the notes field
- See TennCare Provider Manual for rules regarding Sterilization/Abortion/Hysterectomies.

Please do not send claims on paper or with attachments unless requested by the health plan.

The following claims may be submitted electronically without 59 Modifier rules.

Claims Billing Procedures

Paper claim specific rules include:

- Corrected claims may be submitted electronically. However, the words “corrected claims” must be in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Unlisted procedure codes may be submitted with a sufficient description in the notes field. Your software vendor can instruct you on correct placement of all notes. If sufficient information cannot be submitted in the notes field, paper must be submitted. X-ray, lab and drug claims with unlisted procedure codes should be submitted electronically with notes.
- OT/ST/PT/MHSA/Dialysis claims require the date of service by line item. The health plan does not accept span dates for these types of claims.
- Secondary COB claims may be submitted if the following “required” fields are included on the electronic submission:
  - Institutional: Payer Prior Payment, Medicare Total Paid Amount, Total Non Covered Amount, Total Denied Amount
  - Professional
  - Dental: Payer Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (Amount that the payer paid to the member, not the care provider)
Chapter 6: Claims Process/Coordination of Benefits/Claims

- Injectable drugs provided in an office/clinic setting: We reimburse injectable drugs obtained in an office/clinic setting and to care providers providing both home infusion services and the drugs and biologics. We require all professional claims contain NDC (National Drug Code) 11-digit number and unit information to be paid for home infusion and J codes. The NDC number must be entered in the 24D field of the CMS-1500 Form.

You must submit standard transactions using your National Provider Identifier (NPI). Claims will not be accepted for payment without an NPI.

TCI processes claims on our behalf for NEMT services only. NEMT providers should not submit claims to us for its members. Any NEMT claims submitted to us will receive a denial reason code saying “Tennessee Carriers is responsible for service.” Those claims should be submitted to TCI following its designated process. If you have questions about TCI’s process, call 866-405-0238. Submit claims for Emergency Transport Services to us. All claim rules, including timely filing rules, apply. You must file your claim within 120 days from the date of service.

To help ensure proper claims adjudication, please use the ID that best represents the health care professional that performed the service. If you have any questions about IDs, please contact your local office or EDI Customer Service at 800-210-8315 or ac_edi_ops@uhc.com.

**Care Provider Responsibilities with Member Cost-Sharing**

You may submit Medicare and Medicaid claims before collecting copayments, coinsurances, deductibles, and non-covered services. Reasonable efforts to collect should include, but are not limited to, referral to a collection agency and, where appropriate, court action. Documentation of the collection efforts must be maintained and made available to us upon request.

**Cost-Sharing for Dual Eligible Members**

Do not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Dual Complete Preferred member who is eligible for both Medicare and Medicaid, or their representative, or the UnitedHealthcare organization for Medicare Part A and B cost-sharing (e.g., copays, deductibles, coinsurance) when the state is responsible for paying such amounts. Either: (a) accept payment made by or on behalf of the UnitedHealthcare organization as payment in full or (b) bill the appropriate state source for such cost-sharing amount.

**Span Dates**

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

**Effective Date / Termination Date**

Coverage will be effective on the date the member is effective with the health plan. Coverage will terminate on the date the member’s benefit plan terminates with the health plan. If a portion of the services or confinement take place prior to the effective date, or after the termination date, we require an itemized split bill. Effective dates for members can change, as individual members enroll and disenroll with the Centers for Medicare & Medicaid Services (CMS). Verify eligibility at each visit to assure coverage for services.

**Overpayments**

Handle a potential overpayment by calling Provider Services at 800-690-1606 or submitting a Recoupment Request Form.

**Subrogation**

We will not override timely filing denials based on decisions received from third-party carriers on subrogation claims. At the time of service, please submit all claims to the health plan for processing. Through recovery efforts, we will work to recoup dollars related to subrogation. In addition, if your office receives a third-party payment, notify Provider Services. The overpayment will be recouped.

**Balance Billing**

The balance billing amount is the difference between Medicare’s allowed charge and the care provider’s actual charge to the patient. Our members cannot be billed for covered services in accordance with the federal law prohibition found at 42 U.S.C.A. § 1395cc and 42 U.S.C.A § 1396a(p).
Services to members cannot be denied for failure to pay copayments. If a member requests a service not covered by UnitedHealthcare Dual Complete (HMO SNP), have the member sign a release form indicating understanding that the service is not covered by UnitedHealthcare Dual Complete (HMO SNP). The member is financially responsible for all applicable charges.

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

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

**Timely Filing and Late Bill Criteria**

Timely filing improves cash flow for your office. It enables the health plan to settle fund accounts accurately and to intervene earlier in cases requiring case management to improve patient outcomes. Claims for services must be submitted by 180 days from the date of service. Otherwise, the claim will be denied for timely filing. Should a member have primary coverage, the 180-day period begins on the date of the primary EOB.

If the health plan receives a claim and returns it to you for additional information, resubmit the claim within 180 days of the date services were rendered. If the health plan is the secondary insurance carrier, claims must be submitted and received within 180 days from the date on the primary insurance carrier’s EOB and/or EOMB. Secondary claim submissions can be submitted electronically or with a copy of the primary health payer’s remittance. See the COB section for rules regarding secondary claims submission.

If you first submitted a claim to a different payer, you have 180 days from receipt of the denial from that payer to submit the claim to the health plan for payment. A copy of the denial must be included with the claim submission if more than 180 days has elapsed from the date of service. In the event the contracted or plan care provider determines the health plan was incorrectly billed or that the health plan paid incorrectly, they must rebill within 180 days of the date of service or the date of the health plan payment, whichever is later.

Claims submitted after the 180-day limit will be denied as not allowed — do not bill the patient.

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- EOB or EOMB from primary health payer dated within 180 days of claim submission to the health plan.
- Confirmation of denial from believed health payer within 180 days of claim submission to the health plan.
- Copy of billing statement to patient showing dates of bills or provision of patient’s health plan insurance information.
- Documentation proving the health plan contributed to the filing delay.
- Electronic report stating the health plan has accepted the claim.
- Electronic reports stating vendor or clearinghouse has accepted the claim.

The following are not acceptable forms of documentation for timely filing payment reconsideration:

- Screen prints showing dates of a claim previously submitted to the health plan.
- Screen prints from the health plan’s website.
- CMS or UB form with “print” date located in Box 31 or Box 86, respectively.
- Screen prints from the health plan’s website.

**Care Provider Complaints and Claims Payment Disputes**

We have a procedure for resolving disputes between the health plan and participating care providers involving either partially or totally denied claims that result in written requests for reconsideration. A claim dispute must be in writing and include any documentation that supports the request for reconsideration (i.e., claim, remit, medical records, correspondence). The care provider dispute form must also be submitted.

The dispute form can be found at UHCCommunityPlan.com.

Refer to your provider agreement to determine the time limit for submitting requests for reconsideration.

The dispute resolution process for the Medicare Special Needs Plan (SNP) is outlined in your care provider contract. The health plan is the first point of contact for a care provider dispute.

**Note the following to avoid delays in processing disputes:**

- Incomplete dispute submissions will be returned unprocessed.
- A separate care provider dispute form is required for each claim dispute (i.e., one form per claim).
- Applicable filing limit standards apply.
- Corrected claims should NOT be submitted as disputes. See Claim Submission Guidelines.
- Include applicable supporting documentation.
Mail dispute form and supporting documentation to:

UnitedHealthcare Community Plan
Attn: Provider Disputes
PO Box 5220
Kingston, NY 12402-5220

If you have questions relating to claims payments, please contact Customer Service at 800-690-1606. A representative will assist you.

Complaints for other issues are handled through Customer Service. Please call the health plan at 800-690-1606 to initiate any requests for resolution of complaints.

The Correct Coding Initiative
The health plan performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.

The edits fall into one of two categories:

1. Comprehensive and Component Codes.

   Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:
   • Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently. They should not be reported when they are an integral part of a more comprehensive procedure.
   • Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
   • With/without services. Do not report code combinations where one code includes and the other excludes certain other services.
   • Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
   • Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.
   • Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes.

   These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same care provider. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

   CCI guidelines are available in paper form and in software packages that will edit your claims prior to submission. Your CPT and ICD-10 vendor probably offers a version of the CCI manual. Many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS’s authorized distributor of CCI information is the U.S. Department of Commerce’s National Technology Information Service, or NTIS. They can be reached at 800-363-2068 or on www.ntis.gov.

Member Cost-Sharing Responsibilities
Members are dual eligible for both Medicaid and Medicare services. Claims for dual-eligible members will be paid according to the Medicare Cost-Sharing Policy. Depending on their Medicaid benefit, they may not have to pay out-of-pocket costs for premiums, deductibles, copayments and coinsurances. These costs may be covered by Medicaid as long as they qualify for Medicaid benefits. The only exception is that members are responsible for Part D prescription drug copayments and their Medicaid copayments, if applicable.

Coordination of Benefits
Coordination of Benefits (COB) helps avoid duplicate payment for covered services. COB is applied whenever the member covered by the health plan is also eligible for other health insurance benefits. If a member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by UnitedHealthcare Dual Complete (HMO SNP) will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies. The health plan recommends the copayment not be collected until the second payer has paid the claim to prevent a possible overpayment.

You will cooperate with the health plan toward the effective implementation of COB procedures, including identifying services and individuals for which there may be a financially responsible party other than the health plan. You will also help coordinate payments with those parties.

How to file:
   • When the health plan is primary, submit directly to us.
   • When the health plan is secondary, submit to primary carrier first. Then submit the EOB with the claim to the health plan for consideration. EOBs can be submitted to the health plan electronically. Refer to “Claims Submission Rules” in this manual.
• As the Tennessee state Medicaid plan, TennCareSM is always the payer of last resort.

Claims Submission for UnitedHealthcare Dual Complete Preferred Members
Submit claims to UnitedHealthcare Dual Complete Preferred at the claims mailing address:

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

We will process the claim accordingly and send the remittance to you. Then you will then submit the secondary coverage claim with our EOB to the Tennessee Medicaid claims address:

TennCare Crossover Unit
PO BOX 460
Nashville, TN 37202

Electronic Claims Submission and Billing
The River Valley Entities follow CMS guidelines and placement for NPI. NPI is required on all claims both paper and electronic. You may continue to submit your Legacy Provider Numbers that were assigned by us in Box 33b HCFA 1500 Professional Format and Form Locator 50 UB04 Institutional Format.

Please call 800-690-1606 or email ac_edi_ops@uhc.com to obtain your River Valley Entities’ Electronic Provider Identification number.

If you have any questions concerning the placement of your NPI or legacy provider number, please contact us at 800-690-1606, email us at ac_edi_ops@uhc.com or refer to Section 2 of our Companion Documents for ANSI X12 4010A1 837.

Importance and Usage of EDI Acknowledgment/Status Reports
Software vendor reports only show that the claim left your office and either was accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by the health plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claim(s) have reached the health plan for payment or if claim(s) have been rejected for an error or additional information. You MUST review your reports, clearinghouse acknowledgement reports and the health plan’s status reports to eliminate processing delays and timely filing penalties for claims that have not reached the health plan.

How Do I Get These Reports?
Your software vendor is responsible for establishing your connectivity to ENS and will instruct you how your office will receive Clearinghouse Acknowledgment Reports.

How Do I Correct Errors?
If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. Review clearinghouse reports and work them after each transmission. These reports should be kept if you need documentation for timely filing later.

What Will Each Report Provide?
Usually two or three acknowledgment reports will be received as follows:

1. Software vendor report
   You will receive a status report from your software vendor, stating how many claims you are transmitting and number of claims forwarded on to the clearinghouse. This report does NOT MEAN claims have been accepted by payer for payment consideration. This report only verifies you transmitted claims and may state “claim forwarded to the health plan” or “claim forwarded for further processing.”

2. ENS Clearinghouse Report
   ENS will return to you our claims status report. If you had connection to us through Emdeon, you do not have to make any changes, unless you choose to. Emdeon will forward all claims to ENS. Emdeon combines our acknowledgment reports into their standard reports so our rejections will show on Emdeon’s unprocessed claims report.

If a claim is rejected and corrections are not received by the health plan within 120 days from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED. It will be denied as not allowed for timely filing.

Common Error Messages
MESSAGE: Insured’s Social Security number/employee number not found on carrier files.

MEANING: The Social Security number / Member ID number submitted could not be located in our enrollment files.

MESSAGE: Rendering ID for care provider is invalid or missing.

MEANING: Your electronic care provider number is not being received at the clearinghouse. You need to contact your software support representative to have programming corrected.

Specific questions about report frequency, report transmission methods and data definitions should be directed to your EDI Software Vendor.
EDI Companion Documents
The health plan’s Companion Guides help convey information within the framework of the ASC X12N Implementation Guides (IG) adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted.

The Companion Documents are located on our website at: UHCCommunityPlan.com.

The health plan uses the companion guides to:
- Clarify data content that meets the needs of the health plan’s business purposes when the IG allows multiple choices.
- Outline which situational elements the health plan requires.
- Provide values that the health plan will return in outbound transactions.

Section 1 provides general information.

Section 2 provides specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

As the health plan makes information available on various transactions, we will identify our requirements for those transactions in Section 2 of the Companion Guide. Additional comments may also be added to Section 1 as needed. Changes will be included in the Change Summary located in each section of the Companion Document. Please routinely visit our website to help ensure you have the most recent information.

e-Business Support
For technical assistance or information on how to enroll for electronic claims, remittance, or other transactions, contact Provider Services or visit UHCCommunityPlan.com.

Phone: 866-509-1593
Email: ac_edi_ops@uhc.com

Contact your software vendor and/or clearinghouse prior to contacting the health plan.

UHCprovider.com is an innovative suite of online health care management tools. Offering online features is just another way the health plan is working to strengthen our relationships with you. Go to UHCprovider.com and register so you may use these tools.

For questions, call Customer Service at 800-690-1606.
UnitedHealthcare Dual Complete (HMO SNP) seeks to improve the quality of care provided to its members. 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 member 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 are allowed to use your performance data to conduct quality activities.

**Referrals and Prior Authorization**

You are required to coordinate member care within the UnitedHealthcare Dual Complete (HMO SNP) care provider network. If possible, all UnitedHealthcare Dual Complete (HMO SNP) members 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) members 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 used by UnitedHealthcare Dual Complete (HMO SNP) to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other care providers are required to comply with UnitedHealthcare 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 a member, 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 where nurses and medical directors are available any time.

**How to obtain a Prior Authorization:**
- **Phone:** 800-690-1606
- **Online:** TennCloud.com > My Dashboard > Patient Eligibility & Benefit application
- **Ability to add attachments using the TennCloud Application**
- **Medical Fax:** 800-743-6829

**PCP Referral Responsibilities**

If a member self-refers, or the PCP coordinates with the member 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:
- Member’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 members 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 members 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.

Notification of Members 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 notification of members 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 members and their families by analyzing all options available to them within the health care delivery system, promoting self-management and helping the member coordinate their health care.

Care managers use motivational interviewing techniques to interact with members by phone or in person. Their goal is to empower members to better manage their chronic conditions and improve their use of clinical, caregiver/family and community resources to improve their health outcome. They support the care prescribed for the member 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 through Friday from 8 a.m. to 8 p.m. Central Time.

For questions regarding the medical review process, contact your provider relations consultant at 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:**

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 through Friday from 7 a.m. to 5 p.m. Central Time. The health plan staff is available for behavioral health inpatient and urgent care authorizations 24 hours a day, seven days a week. For questions regarding the behavioral health review process, contact your provider relations consultant at 800-690-1606.
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 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.

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<tr>
<th>Resource: You want to:</th>
<th>Provider services line – dedicated service representatives.</th>
<th>Online uhcproviders.com</th>
<th>Interactive Voice Response System</th>
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<tbody>
<tr>
<td></td>
<td>Phone: 844-275-8750 Hours: 9 a.m. – 6 p.m. Monday – Friday, Eastern time</td>
<td></td>
<td>Phone: 844-275-8750 Hours: 24 Hours a Day, Seven Days a week</td>
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<tr>
<td>Inquire about a claim</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Ask a benefit/plan question including prior authorization requirements</td>
<td>✓</td>
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<tr>
<td>Inquire about eligibility</td>
<td>✓</td>
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<tr>
<td>Request an EOB</td>
<td>✓</td>
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<tr>
<td>Request a fee schedule</td>
<td>✓</td>
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<tr>
<td>Request a copy of your contract</td>
<td>✓</td>
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<tr>
<td>Ask a question about your contract</td>
<td>✓</td>
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<tr>
<td>Inquire about the network</td>
<td>✓</td>
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<tr>
<td>Nominate a care provider for participation</td>
<td>✓</td>
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<tr>
<td>Request a participation status change</td>
<td>✓</td>
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<tr>
<td>Request an office visit (e.g., staff training)</td>
<td>✓</td>
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<tr>
<td>Request documents</td>
<td>✓</td>
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<tr>
<td>Request benefit information</td>
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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 member care and outcomes.
- **Efficiency of Care** – measured by clinical and financial data related to a member’s health care costs.
- **Member Satisfaction** – measured by data collected at a provider level when there is a member complaint. All other member 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 member 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 members.

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.
- Member 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 members 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 member decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
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 member.

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

Laws Regarding Federal Funds

Payments you receive for furnishing services to UnitedHealthcare Dual Complete members 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 members 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 credentials 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 member may initiate an appeal by contacting Customer Service number on the back of the member’s ID card. You may assist members in their appeal process. Appeals may be expedited when the member’s medical condition warrants, and the treating care provider signs the member’s appeal request for expedited review.
Other Care Providers
UnitedHealthcare Dual Complete decisions subject to appeal include 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 to you will detail the limitations and inform you of your appeal rights.

Notification of Members 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 the notification of members affected by termination a minimum of 30-days’ notice 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) members’ 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 member’s medical chart. Each medical record chart must have documented at a minimum:

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

Proper Documentation and Medical Review
We perform medical review 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 member’s current medical record whether the member has 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 Member Information
You must comply with all state and federal laws concerning confidentiality of health and other information about members. You must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Member Record Retention
You must retain the original or copies of patient’s medical records as follows:

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

In accordance with 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:

• Member data on paper or in electronic format.
• The member’s name or identification number on each page.
• The member’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.
• Member 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, then 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 member 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 member’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 member’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 members 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 includes psychiatric assessment, medical assessment, substance abuse assessment, community functioning assessment and an assessment of member 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 member 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 member 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 member 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 member of a family should have separate treatment records for each identified and diagnosed member. 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 treatment records for members:

- 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.
- Members (for purposes of behavioral health records, member includes an individual who is 16 years or older) and their legally appointed representatives should be given access to the member medical records. This is subject to reasonable charges (except as detailed).
- Provisions for helping ensure that, in the event a patient care provider relationship with a UnitedHealthcare Dual Complete (HMO SNP) PCP ends, and the member requests that medical records be sent to a second UnitedHealthcare Dual Complete (HMO SNP) care provider who will be the member’s PCP, the first care provider does not charge the member or the second care provider for providing the medical records.
Chapter 11: Reporting Obligations

Cooperation in Meeting the Centers for Medicaid and Medicare Services (CMS) Requirements

UnitedHealthcare Dual Complete (HMO SNP) must provide to 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 members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on member 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 a member 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 members diagnoses to the highest level of specificity possible. All member medical encounters must be submitted 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 a member asks us to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.
- If a member or you, acting on behalf of a member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by UnitedHealthcare Dual Complete (HMO SNP).
- If a member 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 members 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).

A member 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 member’s health or ability to function. The member or you can request an expedited initial decision. If you request an expedited initial decision, or support a member in asking for one, and you indicate that waiting for a standard initial decision could seriously harm the member’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) member, you must notify the member of their right to receive, upon request, a detailed written notice from UnitedHealthcare Dual Complete (HMO SNP) regarding the member’s services. Your notification must provide the member with the information necessary to contact UnitedHealthcare Dual Complete (HMO SNP) and must comply with any other CMS requirements. If a member 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 the member 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 member regarding why the time frame must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth as follows.

Appeals and Grievances

Members 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 a member makes when the member 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 a member 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

A member 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. A member 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 a member’s appeal of an initial decision about authorizing health care or terminating coverage of a service within 30 calendar days or sooner, if the member’s 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 members in providing necessary information to resolve the appeals within the required time frames. You must provide the pertinent medical records and any other relevant information to UnitedHealthcare Dual Complete (HMO SNP). In some instances, you must provide the records and information quickly 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 member’s health or ability to function, the member or the member’s care provider can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time period. If you request the expedited appeal and indicate that the normal time period for an appeal could result in serious harm to the member’s health or ability to function, we will automatically expedite the appeal.

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

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

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

Resolving Grievances
If a member has a grievance about us, a care provider or any other issue, tell them to contact Customer Service by:

Fax: 888-285-2885
Call: 800-690-1606 (Customer Service)
TTY/TDD: 800-884-4327

Write:
UnitedHealthcare Dual Complete Preferred
Attn: Grievances & Appeal Dept.
2035 Lakeside Centre Way, Suite 200
Knoxville, TN 37922

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 is filed, will be responded to in writing.

A final decision will be made as quickly as the case requires based on the member’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 member’s best interest. Our members 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 member’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 member may appeal to an administrative law judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Department Appeal Board (DAB). If the DAB refuses to hear the case or issues an adverse decision, the member may be able to appeal to a district court of the United States.
Chapter 13: Member Rights and Responsibilities

UnitedHealthcare Dual Complete (HMO SNP) members 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) members. Specifically, UnitedHealthcare Dual Complete (HMO SNP) members have been informed that they have the following rights:

Timely Quality Care

- Choice of a qualified participating 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 member, 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 member 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).

Member Satisfaction

UnitedHealthcare Dual Complete (HMO SNP) periodically surveys members 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 member surveys to measure their overall satisfaction as well as satisfaction with the care received from you. Survey results are available upon request.

Member Responsibilities

Member 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 emergency room 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 member’s health history as well as their child’s.

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 member’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 member’s care.
- To access, copy and/or request amendment to the member’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 member’s behalf regarding the member’s medical care.
- To refuse treatment or leave a medical facility, even against the advice of care providers (providing the member accepts the responsibility and consequences of the decision).
- To complete an advance directive, living will or other directive to the member’s medical care providers.
• Telling 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.

• Telling us if they have other insurance.

• Giving 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 members, including those 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.

**Member 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 member appeal and grievances rights.
Chapter 14: Access to Care/Appointment Availability

Member Access to Health Care Guidelines

UnitedHealthcare Dual Complete (HMO SNP) actively monitors the adequacy of appointment processes and helps ensure a member’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 two 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 members as follows:
- First trimester – within 14 days of request.
- Second trimester – within seven days of request.
- Third trimester – within three days of request.
- High-risk pregnancies – within three 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 three 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 three days of request.
- Routine care appointments – within 45 days of request.
- Waiting time – 45 minutes or less.

Adherence to member 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) members with equal dignity and consideration as their non-UnitedHealthcare Dual Complete (HMO SNP) patients.

Care Provider Availability

PCPs will provide coverage 24 hours a day, seven days a week. When a PCP cannot provide services, they must help ensure another participating care provider is available.

The member 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) members 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.

Transfer and Termination of Members from 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 a member to another participating care provider due to the costs associated with the member’s covered services. You may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements for services.
Closing of Care Provider Panel

When closing a practice to new UnitedHealthcare Dual Complete (HMO SNP) members 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 members as of the specified date.
- Keep the practice open to UnitedHealthcare Dual Complete (HMO SNP) members who were members 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) or participating care providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status. This includes but is not limited to 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; or
- Disability
Chapter 15: Prescription Benefits

Network Pharmacies

With a few exceptions, our members must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is where members 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 a member 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, members have to pay the full cost (rather than paying just the copayment) when they fill their prescription. Our members can ask us for reimbursement for their share of the cost by submitting a paper claim form.

- If our member is traveling within the United States but outside the plan’s service area and becomes ill, loses or runs out of their prescriptions, we cover prescriptions filled at an out-of-network pharmacy. In this situation, the member pays the full cost (rather than paying just their copayment) when they fill their prescription. The member can ask us to reimburse them for their share of the cost by submitting a claim form. Prior to filing 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 member’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 member to get their prescriptions from an out-of-network pharmacy.

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

- If a member 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 members 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, members will have to pay the full cost of their prescription. Call UnitedHealthcare Dual Complete (HMO SNP) Member Services at 800-690-1606 (TTY/TDD users should call 711.) for a direct member reimbursement claim form and instructions on how to obtain reimbursement for covered prescriptions.

Mail the claim form and receipts to:

OptumRx 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 on 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 on 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 member will get 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 members 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 800-690-1606. (TTY/TDD users should call 711.) You can also get updated information about covered drugs by visiting UHCCommunityPlan.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 on the plan’s PDL would not be as effective in treating the member’s condition and/or would cause them to have adverse medical effects.

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) members 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 member. 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 800-711-4555 to initiate 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 members 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 to provide quality coverage to our members. Examples of utilization management tools are:

1. Prior Authorization: We require our members to get prior authorization for certain drugs. This means that a participating care provider or pharmacist will need to get approval from us before a member 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 members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat 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 member 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 UHCCommunityPlan.com > For Health Care Professionals > Tennessee > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.
Chapter 16: Healthy First Steps

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

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

Members 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 members 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 members enrolled in this program.

Notify the health plan of pregnant members. Referral information for Healthy First Steps can be accessed at UHCCommunityPlan.com. Additional information related to the Healthy First Steps Program may be requested by calling Customer Service at 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 member’s level of functional impairment and risk factors. UnitedHealthcare Community Plan currently 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 members unless a denial of service(s) is rendered, at which time a copy of the criteria in question can be obtained upon request.

Care providers wishing to access these criteria independently 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 UHCCommunityPlan.com.

Services provided to members 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 plan participant’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 that are available. Adverse benefit determinations may occur for three reasons:

1. The requested services are not covered under the benefit plan;
2. The member’s available coverage for inpatient behavioral health services has been exhausted; or
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 member. Whenever a certification for coverage of inpatient services is not granted, the health plan notifies the member or, in the case of minors or members 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 member or appropriate custodian immediately of any adverse benefit determination as well as the status of the appeal process requirements.

In the event of an emergency admission, clinicians should notify the health plan as soon as possible or at the latest, 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 member 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 member, 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 occasionally launch pilot projects that alter pre-certification 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:

- There are significant diagnostic questions remaining that can only be clarified through testing.
- There are questions about appropriate treatment course to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan.
- There is reason to suspect, based on the initial assessment, the presence of cognitive or intellectual deficits that may affect functioning or interfere with the patient’s ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits.
- There is reason to suspect the presence of neuropsychological dysfunction that may adversely affect functioning or interfere with the patient’s ability to participate in or benefit from treatment, and 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 member’s medical benefit plan and is not considered a behavioral health service.

Testing is not generally certified when:

- It is done routinely as part of an assessment.
- It is excluded as a covered benefit by the plan.
- It is to determine the extent of neurological damage.
- It is 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.

Managing Expectations Through Education – Behavioral Health

Educate members about what to expect when they present for treatment. Members 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 members 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 health plan participants 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 members as patients.

Discharge and Treatment Planning (Behavioral Health)

Effective discharge planning addresses how a member’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 member following acute care. Care managers work with you to begin the discharge or treatment planning process for health plan participants 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 member, the member’s family, the clinician at the next level of care, and/or relevant community resources. Discharge planning involves assessment of the member’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 members keep their therapeutic gains, educate them about the importance of enlisting community support services, communicating treatment recommendations to all involved treating professionals, and adhering to follow-up care throughout the discharge and treatment planning process. Members have the right to decline the release of information but should be informed about the risks and benefits of this decision.
Chapter 17: Behavioral Health Utilization Management Specifics

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 health plan participants 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 member’s care can be completed in this 90-day period, or you can successfully transfer the member 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 member 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. Members should not be balance billed. The health plan notifies members 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 member’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 a member’s prescribed psychotropic medication.
- Coordination allows for better management of treatment and follow up for members with coexisting behavioral and medical disorders.
- Continuity of care across all levels of care and between behavioral and medical treatment modalities is enhanced.
- For members 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 members 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 at communicating 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 members 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 members 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 members.

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

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 UHCCommunityPlan.com. You may also call us at 800-690-1606 for more information or to give feedback.
Chapter 19: Preventive Health & Clinical Practices

Preventive Health Care Standards

Our goal is to partner with you to help ensure members 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

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 important resources to support and guide your clinical decision-making. Clinical Practice Guidelines are available at ahrq.gov or can be viewed on UHCCommunityPlan.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.

Preventive health care standards and guidelines are available at UHCCommunityPlan.com.
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, members, 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 members.

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 UHCCommunityPlan.com and select “Contact Us” to report information relating to suspected fraud or abuse.

Call the UnitedHealthcare Special Investigation Unit Fraud Hotline at 800-690-1606, 8 a.m. to 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 member’s name, date of birth, Social Security number, ID number
• The member’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 members are instructed through the member handbook to safeguard their member ID cards as they would any other private and personal identification information as a driver license or checkbook. If you have any concerns about a member’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, or
• Contact the Member Services Department 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

Member 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 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.
Chapter 21: Appendix

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 member 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.
  - Instructions for submitting prior authorization requests online can be found at UHCCommunityPlan.com.

How to obtain a Prior Authorization:

- Phone: 800-690-1606
- Online: TennCloud.com > My Dashboard > Patient Eligibility & Benefit application
- Ability to add attachments using the TennCloud Application
- Medical Fax: 800-743-6829

For information regarding the Medicare Advantage Advance Notification/Prior Authorization Requirements please contact Customer Service at 800-690-1606 or go online UHCprovider.com.
## Additional Services That Require Prior Authorization

<table>
<thead>
<tr>
<th>Service Needed</th>
<th>MIDDLE Tennessee Service Areas</th>
<th>WEST Tennessee Service Areas</th>
<th>EAST Tennessee Service Areas</th>
<th>MEDICARE Special Needs Plan</th>
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<tbody>
<tr>
<td>Behavioral Health and Substance Abuse – Ambulatory</td>
<td>Call: 800-690-1606 Fax: 888-735-1434</td>
<td>Call: 800-690-1606 Fax: 866-359-3770</td>
<td>Call: 800-690-1606 Fax: 877-614-7141</td>
<td>Call 800-690-1606</td>
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<tr>
<td>• Outpatient Detoxification and Rehabilitation</td>
<td>In case of an emergency, call the local Mobile Crisis Line</td>
<td>In case of an emergency, call the local Mobile Crisis Line</td>
<td>In case of an emergency, call the local Mobile Crisis Line</td>
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<tr>
<td>• Psychological Testing</td>
<td>Adults – Older Than 18 Years: 855-CRISIS-1 (or 855-274-7471)</td>
<td>Adults – Older Than 18 Years: 855-CRISIS-1 (or 855-274-7471)</td>
<td>Adults – Over 18 Years: 855-CRISIS-1 (or 855-274-7471)</td>
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<tr>
<td>• Electro Convulsive Therapy</td>
<td>Younger Than 18 Years: For Davidson County, call Mental Health Cooperative at 615-726-0125</td>
<td>Younger Than 18 Years: For South Middle Region, call Youth Villages at 866-791-9222</td>
<td>Younger Than 18 Years: For Tri-Cities Region, call Frontier Health at 877-928-9062; or the Greater Knoxville Region, call Helen Ross McNabb at 865-539-2409</td>
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<td>Mental Health and Substance Abuse Ambulatory (OP) Services</td>
<td>For North Middle Region call Youth Villages at 866-791-9221</td>
<td>For Memphis Region, call Youth Villages at 866-791-9226</td>
<td>For Southeast Region, call Youth Villages at 866-791-9225</td>
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<td>• Mental Health Case Management – Level I Team Only (CTT/CCFT/PACT)</td>
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<td>For East Region, call Youth Villages at 866-791-9224</td>
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<td>• Intensive Outpatient (IOP)**</td>
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<td>• Suboxone</td>
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<td>• Psychological Testing</td>
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<td>• Applied Behavioral Analysis (ABA)</td>
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<td>• Electro Convulsive Therapy (ECT)</td>
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<td>Behavioral and Substance Abuse</td>
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<td>Call 800-690-1606 or fax requests to 877-614-7141</td>
<td>Call 800-690-1606</td>
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<td>• Inpatient</td>
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<td>Middle TN Fax: 888-735-1434</td>
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<td>• Detoxification</td>
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<td>East TN Fax: 877-614-7141</td>
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<td>Inpatient and Residential Services for Mental Health and Substance Abuse</td>
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<td>West TN Fax: 866-359-3770</td>
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<td>• Inpatient (Detoxification)</td>
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<td>• Substance Abuse Residential Detoxification</td>
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Footnotes

1. Chiropractic
   • Not a covered benefit for members ≥ 21 years of age.

2. Eye Care/Optometry
   • Locate a care provider through UHCCommunityPlan.com
   • Or Call 800-481-2779

3. Genetic Testing
   • Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Routine, non-genetic testing for other medical conditions (e.g., renal disease, hepatic disease) that may be associated with an underlying genetic condition is covered when medically necessary. Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly. Genetic testing is not a covered service for purposes of determining current or future family planning. Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases. Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

4. Emergency Services in Hospital/ Inpatient Services
   • Emergency services do not require prior authorization. However, hospitals must notify us if the member is stabilized and admitted to full inpatient status.
   • Inpatient admissions are limited to 25 days per fiscal year for members ≥ 21 years old. This does not apply to Medicare QMB enrolled members.
   • Observation services DO NOT require authorization. Observation stay ≥ 24 hours will be counted as 1 bed day and will be included in the 25 days per year benefits for ≥ 21 years old.

5. PROSTHETICS - L5856, L5857, L5858 and L5973
   • Microprocessor-controlled lower limbs and microprocessor-controlled joints for lower limbs are not a covered benefit.

6. ORTHOTICS - L0001 - L4999
   • Orthotics are generally items in codes L0001-L4999 with some exceptions. (There are some supplies which are also listed in this range of orthotic codes. Those supplies are a benefit.)
   Equipment maintenance and repair of component parts are covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.
   (See Policy Manual, Attachment 300-3 A for listed exceptions)

7. Podiatry Services
   • Services rendered by a podiatrist or podiatrist surgeon are not a covered service for Medicaid members older than 21 years.
   • Routine foot care services are a covered service for members older than 21 years when provided by a PCP.

8. Radiology Services
   • Refer to UHCCommunityPlan.com
   • Prior Authorization request form can be found on the link.

9. Emergency Transportation
   • Emergency transportation does not require prior authorization.
   • Facility-to-facility transport by ambulance does not require authorization.
   • Non-emergent ambulance transportation must meet medical criteria to be a covered benefit.

10. Additional Benefit Exclusions for Members 21 Years and older:
    • INSULIN PUMPS – E0784
      Hardware not covered. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.
    • PERCUSSIVE VESTS – E0483
      Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided when seeking prior authorization.
• **BONE-ANCHORED HEARING AIDS – L8690, L8692**
  Hardware not covered. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided when seeking prior authorization.

• **COCHLEAR IMPLANTS – L8614**
  Hardware not covered. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided when seeking prior authorization.

• **EMERGENCY DENTAL SERVICE**
  Emergency adult dental services eliminated. In accordance with federal law and state plan, will cover medical and surgical services furnished by a dentist only to the extent that such services may be performed under state law either by a physician or by a dentist. Such services would be considered a physician service if furnished by a physician. The services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g., dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.

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**Other Important Phone Numbers**

<table>
<thead>
<tr>
<th>Member Services</th>
<th>800-690-1606</th>
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<tr>
<td>8 a.m. – 8 p.m.</td>
<td>TTY-711</td>
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</tbody>
</table>
Waiver of Liability Statement

Medicare/HIC Number

Enrollee's Name

Care Provider Dated of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature Date
Glossary of Terms

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 cost 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 a member is entitled to receive or any amounts that the member 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 members of the UnitedHealthcare Dual Complete (HMO SNP) receive all basic benefits.

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

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 members which would be greater than those that would be imposed on the member if they were not a member of the plan.

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 member 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 contact, dual eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and other full benefit dual eligible (FBDE).

Dual- Eligible Member
An enrollee who is Dual Eligible and is enrolled in a plan.

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; and
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.
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 him/her self 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 members 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 member’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; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the member, 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.
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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 members 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, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, they may buy the coverage from Social Security if members 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 a member’s Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services whether members 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.

Member
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.

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) members.

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) members 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) members.

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) members.

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

Primary Care Provider (PCP)
The participating care provider who a member chooses to coordinate their health care. The PCP provides covered services for UnitedHealthcare Dual Complete (HMO SNP) members 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.
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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.

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

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

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.

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, and 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 members. In the case of the TennCare Program the special class of members 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 MCO
A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits

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

TennCare
The medical assistance program administered 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.
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:

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<th>County</th>
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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 24 hours a day, seven days a week at 800-690-1606.
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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:

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Submitted by:

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