



2026 Care Provider Manual

Physician, Care Provider, Facility, and Ancillary

UnitedHealthcare Community Plan of Massachusetts

UHC One Care (HMO D-SNP)

UHC Senior Care Options (HMO D-SNP)



**United
Healthcare[®]**
Community Plan

Welcome

Welcome to the UHC One Care and Senior Care Options care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. This manual also includes important phone numbers and websites on the **How to Contact Us** page. Find operational policy changes and other electronic transactions on our website at UHCprovider.com.

Click the following links to access different care provider manuals:

- **Administrative guide** – UHCprovider.com/guides
 - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – UHCprovider.com/guides
 - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**

View the [Medicaid glossary](#) for definitions of terms commonly used throughout the care provider manuals.

In this manual, we refer to UHC One Care and UHC Senior Care Options as “UnitedHealthcare Community Plan.”

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should utilize the Agreement instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations or state contracts, the latter will control.

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

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

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

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

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Chapter 1: Introduction

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

- Senior Care Options (SCO) is a fully integrated Medicare Advantage Special Needs plan serving members within the UnitedHealthcare SCO service area who are age 65 and older and are dually eligible for Medicare and Medicaid
- UHC One Care (One Care) serves adults with disabilities within the UnitedHealthcare Community Plan service area who are age 21 through 64 and are dually eligible for Medicare and Medicaid. Individuals who reach 65 years of age while enrolled in a One Care plan may remain enrolled in the One Care plan provided that those individuals continue to meet eligibility requirements.

If you have questions about the information in this care provider manual or about our policies, please visit [UHCprovider.com](https://uhcprovider.com) or call **Provider Services** for SCO at **1-888-867-5511** or One Care at **1-877-790-6543**, available Monday-Friday, 8 a.m.-6 p.m. ET.

How to join our network

UnitedHealthcare offers a streamlined process for providers, facilities, and hospitals to join our network and participate in delivering high-quality care. To begin, visit [UHCprovider.com/join](https://uhcprovider.com/join) and sign in with your One Healthcare ID or create one if you do not have it. Through Onboard Pro, you can select the appropriate credentialing path for hospitals and facilities and follow the interactive guide for step-by-step assistance. Credentialing requirements include current facility licensure, accreditation or approved alternative, malpractice and sanctions review, insurance coverage, and completion of the application and attestation.

Our credentialing team verifies all primary source data to ensure compliance with state and federal standards. For support if you need additional help, please connect with us 24/7 through the **UnitedHealthcare chat feature**. If you are specifically interested in joining the Long-Term Support Services (LTSS) network, email ma_cs_cc@uhc.com. By joining our network, you become part of a community committed to simplifying the health care experience and improving outcomes for everyone.

What you'll need to get started

- Provider Portal access using your One Healthcare ID.
 - Don't have a One Healthcare ID? [Register now](#).
- Entity details including TIN(s), legal name and contact information
- Council for Affordable Quality Healthcare (CAQH) registration (only required for some states and specialties)
 - If CAQH is required, make sure attestations and documentation are current

Select your entity type

- **Medical providers**
- **Hospitals and facilities**
- **Ancillary providers and centers**
- **Dental, vision, behavioral health and other**

Onboard Pro: Integrated credentialing and contracting platform

Onboard Pro is UnitedHealthcare's secure, self-service intake tool that streamlines care provider onboarding by combining credentialing and contracting into a single process. It allows care providers to submit network participation requests, upload required documentation, and track real-time status updates through a personal dashboard, with CAQH ProView® integration for faster credentialing. Supporting multiple lines of business and using rules-based decisioning to reduce manual reviews, Onboard Pro enhances efficiency and care provider satisfaction. Access the [platform](#) or view the [interactive guide](#).

UnitedHealthcare partners with HCBS care providers to deliver Long-Term Supports and Services that help members remain in their homes and communities. The contracting process includes credentialing, compliance verification, and execution of Provider Agreements in alignment with state and federal requirements.

Please note: HCBS contracting is handled outside of the Onboard Pro platform. Care providers interested in joining the HCBS network or with questions about contracting should email ma_cs_cc@uhc.com for assistance and next steps.

Benefits of Onboard Pro

- **Saves time:** Onboard Pro integrates with (CAQH) ProView®, in states that require it, so you don't need to re-enter the same information for UnitedHealthcare
- **Requires less back and forth:** The tool will let you know immediately if additional information is required
- **Sends immediate confirmation:** We'll email you a reference number shortly after your application is received
- **Allows you to check status 24/7:** Your personal dashboard will show the real-time status of every enrollment request you've submitted
- **Onboard Pro interactive guide:** Our comprehensive interactive [guide](#) provides information for individual health care professionals, group practices, hospitals and facilities.

Need help with your application status?

Sign in with your One Healthcare ID. This allows you to access self-service tools or connect with us through [chat](#) 24/7. Please have the care provider's full name, tax ID number (TIN) and National Provider Identifier (NPI) number available.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at UHCprovider.com/attestation.

Home- and Community- Based servicing (HCBS) care providers can submit their demographic updates directly to ma_cs_cc@uhc.com.

Care provider requirements for onboarding for Senior Care Options and One Care

Disclosure of ownership

All care providers joining the network must comply with federal requirements by completing a clean and valid disclosure of ownership form.

Three-year reevaluation

Participating care providers are required to undergo a reevaluation process every 3 years to maintain compliance and network participation.

To learn more, visit UHCprovider.com/macommunityplan > [Provider Forms and References](#).

21st Century Cures Act Medicaid ID enrollment

All health care professionals and facilities participating in the UnitedHealthcare Community Plan of Massachusetts must obtain a Massachusetts Medicaid ID number within 120 days of joining the network.

You will receive a notification letter outlining the steps to enroll with MassHealth. To avoid billing delays and potential termination from the network.

If you do not yet have a Medicaid ID number, please download and complete the [Nonbilling Managed Care Entity Provider Contract Form](#).

Forms must be submitted electronically via the [MassHealth portal](#).

MassHealth will provide UnitedHealthcare with each provider's Medicaid ID, and UnitedHealthcare will then issue a notification letter to the provider confirming their corresponding Medicaid ID.

Our approach to health care

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

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

Care model

Upon joining the UnitedHealthcare Community Plan program, every member is screened and stratified into a level of acuity and assigned a care coordinator or care manager.

Each new member then receives a face-to-face initial assessment to confirm the appropriate level of acuity has been assigned, to help ensure appropriate services are in place, and to develop an individualized care plan (ICP) in conjunction with the member's Interdisciplinary Care Team (ICT). Subsequent assessments are conducted on a scheduled basis and also ad hoc whenever a member experiences a significant change in condition. The care coordinator/care manager documents all orientation findings, health assessments, reassessments, and ICP in the member's centralized enrollee record (CER).

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

Members in long-term care facilities, the facility staff and the UnitedHealthcare Community Plan case manager convene a primary care team meeting to determine the most appropriate services that support the member's goals of care.

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

Interdisciplinary care team

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

Primary care team members work together to develop and update an integrated ICP, which includes treatment goals (medical, behavioral, social and long-term care) and measures progress and success in meeting those goals.

With the collective input from primary care team members, the team promotes independent functioning of the member and provides services in the most appropriate, least restrictive setting. The member's primary care team works to help ensure effective coordination and delivery of covered services. The team provides ongoing direction for member care, creating consensus and facilitating an interdisciplinary team approach to provide comprehensive care management.

During regular and ad hoc meetings, primary care team members review results of initial and ongoing assessments, discuss changes in member status and create new goals, when appropriate.

Covered interdisciplinary care team activities

UnitedHealthcare Community Plan of Massachusetts SCO and One Care will pay qualified care providers for certain ICT-related activities if they are medically necessary and properly recorded:

- Taking part in multidisciplinary clinical rounds for high-risk members

Billing Codes

Care providers can submit claims for ICT participation with these HCPCS/CPT codes when appropriate:

- **CPT 99358** – Extra evaluation and management services carried out before or after direct patient care (limited to 1 unit a day)
- **CPT 99359** – Every extra 30 minutes of prolonged non-face-to-face evaluation and management (can be billed as an add-on to CPT 99358)

The member must be recognized as high-risk, and the activity has to be relevant to their care plan.

Limitations and Exclusions

Payment depends on member eligibility and their benefit coverage.

Care manager and primary care provider collaboration

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

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a cultural competency program. Linguistic and cultural barriers can negatively affect access to health care participation. You must support UnitedHealthcare Community Plan's Cultural competency program.

For more information, go to [UHCprovider.com/resourcelibrary](https://uhcprovider.com/resourcelibrary) > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education:** Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

- **Coverage of medical interpreter services:** You must provide language services and auxiliary aide and services, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

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

Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record. Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability. If you provide virtual visits, these services must be accessible to individuals with disabilities. Post your virtual visits procedures for members who are deaf or hard of hearing so they receive them prior to the virtual visit.

- **Care for members who are deaf or hard of hearing:** You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing virtual visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides:

- **Language interpretation line**
 - We provide interpreter services Monday–Friday, 8 a.m.–8 p.m. ET
 - To arrange for interpreter services, please call **1-877-842-3210, TTY 711**
- **I Speak language assistance card:** This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**

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.

For more information, go to uhc.com > **Language Assistance**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations. Please refer to the **UnitedHealthcare clinical guidelines**.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the **digital solutions comparison guide**.

Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow.

Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit UHCprovider.com/api.

Electronic data interchange

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

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

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
 - Claims (837),
 - Eligibility and benefits (270/271),
 - Claims status (276/277),
 - Referrals and authorizations (278),
 - Hospital admission notifications (278N), and
 - Electronic remittance advice (ERA/835).

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

Getting started

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

Read our [Clearinghouse Options](#) page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically.

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

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow [these steps](#) to register

Here are the most frequently used tools on the UnitedHealthcare Provider Portal:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
- **Prior authorizations and notifications** – Submit notification and prior authorization requests. For more information, go to UHCprovider.com/priorauth.
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable drugs. Go to UHCprovider.com/pharmacy for more information.

- **My Practice Profile** – View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mypracticeprofile.
- **Document Library** – Access claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to UHCprovider.com/documentlibrary.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

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

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

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**.

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

Privileges

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

Provider Services

The provider call center is the primary point of contact for care providers seeking assistance. The center is staffed with representatives specifically trained to support UnitedHealthcare Community Plan providers.

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Protection Act (TCPA) Opt Out form**. The Provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and it will be processed within 10 business days and your phone number will be removed from the do not call registry.

For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit UHCprovider.com/contactus.

How to contact us

Topic	Contact	Information
Behavioral, mental health & substance use/misuse	Optum® providerexpress.com Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	UHCprovider.com/benefits Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711	Confirm a member's benefits or prior authorization.
Cardiology prior authorization	UHCprovider.com/cardiology > Sign In 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code lists, and more information.
Care Model (care management/disease management)	MAcaremanagement@uhc.com Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractic care	myoptumhealthphysicalhealth.com 1-800-873-4575	We provide SCO members with up to 20 visits per calendar year without prior authorization.
Claims	UHCprovider.com/claims Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711 Mailing address: UnitedHealthcare Community Plan P.O. Box 31350 Salt Lake City, UT 84131-0350 For FedEx (use for large packages/more than 500 pages): UnitedHealthcare Community Plan 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claim overpayments	Sign in to the Provider Portal at UHCprovider.com/claims Senior Care Options: 1-888-867-5511, TTY 711 One Care: 1-877-790-6543, TTY 711 Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Dental	uhcdental.com Senior Care Options: 1-888-867-5511, TTY 711 One Care: 1-800-980-2968, TTY 711	Review dental plan information, check member eligibility, manage dental claims and learn about joining the UnitedHealthcare Dental Provider Network.
Electronic Data Intake (EDI) issues	EDI Transaction Support Form UHCprovider.com/edi ac_edi_ops@uhc.com 1-800-210-8315	Contact EDI Support for issues.
Eligibility	UHCprovider.com/eligibility Senior Care Options: 1-888-867-5511, TTY 711 One Care: 1-877-790-6543, TTY 711	Confirm member eligibility.
Enterprise Voice Portal	Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal.	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment integrity information: UHCprovider.com/MAcommunityplan > Integrity of Claims, Reports, and Representations to the Government Reporting: uhc.com/fraud 1-844-359-7736 (FWA hotline) or 1-877-401-9430 (vendor fraud hotline)	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Hearing services (UnitedHealthcare Hearing)	UHChearing.com 1-855-523-9355	Ask about hearing aid services.
Laboratory services	UHCprovider.com/findprovider > Preferred Lab Network	The Preferred Lab Network webpage provides a full listing of eligible labs.

Topic	Contact	Information
MassHealth (Medicaid)	Medicaid.gov 1-800-841-2900	Contact Medicaid directly.
Medical claim, reconsideration and appeal	UHCprovider.com/claims Phone options allow accessibility for SCO and One Care providers who do not have the capability to submit electronically. Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711 Care providers have the ability to submit reconsiderations and appeals electronically within UHCprovider.com/claims . For further information on reconsiderations and appeals see the Reconsiderations and Appeals interactive guide .	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member handbook	UHCCommunityPlan.com/MA Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-866-633-4454 , TTY 711	See section on member rights and responsibilities.
Member Services	myuhc.com Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-866-633-4454 , TTY 711	Assist members with issues or concerns. Available 8 a.m.–8 p.m. ET, 7 days a week.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	1-800-493-4647 , TTY 711	Available Monday-Friday, 8 a.m.–6 p.m. ET, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management support	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at UHCprovider.com/chat . For HCBS and LTSS: mahp_hcbspra@uhc.com Ask about contracting for HCBS at: ma_cs_cc@uhc.com	Self-service functionality to update or check credentialing information.
NurseLine	1-866-385-6728	Available 24 hours a day, 7 days a week.

Topic	Contact	Information
Obstetrics/pregnancy and baby care (One Care members)	Healthy First Steps® Pregnancy Notification Form at UHCprovider.com , then Sign In for the UnitedHealthcare Provider Portal. 1-800-599-5985 UHChealthyfirststeps.com	For pregnant One Care members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to UHChealthyfirststeps.com to sign up for Healthy First Steps Rewards.
Oncology prior authorization	UHCprovider.com/oncology 1-888-397-8129 Monday–Friday, 7 a.m.–7 p.m. CT.	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at UHCprovider.com/chat .	Contact if you have issues with your ID. Monday–Friday, 6 a.m.–10 p.m. CT; Saturday and Sunday, 6 a.m.–6 p.m. CT.
Pharmacy services	professionals.optumrx.com 1-877-889-6510	OptumRx® oversees and manages our network pharmacies.
Prior authorization/notification for pharmacy	UHCprovider.com/pharmacy 1-800-711-4555	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript® tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • UHCprovider.com/priorauth • Call Care Coordination at the number on the member’s UCard (self-service available after hours) and select “Care Notifications” or call Provider Services Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-866-633-4454 , TTY 711	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/prior authorization lists. UHCprovider.com/MAcommunityplan > Prior Authorization and Notification

Topic	Contact	Information
Provider Services	UHCprovider.com/MAcommunityplan Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711	Available Monday-Friday, 8 a.m.–6 p.m. ET.
Radiology prior authorization	UHCprovider.com/radiology 1-866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Reimbursement policy	UHCprovider.com/MAcommunityplan > Policies and Protocols	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates. Note: UnitedHealthcare Community Plan of Massachusetts ensures that nonpayment of Serious Reportable Events (SREs), Serious Reportable Adverse Events (SRAEs) and Provider Preventable Conditions (PPCs) will not prevent access to care and continued service for our members.
Technical support	For chat options and contact information, visit UHCprovider.com/contactus . 1-866-209-9320 (Optum support)	Call if you have issues logging in to the Provider Portal, you cannot submit a form.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	SafeRide saferidehealth.com 1-844-714-2217, TTY 711	To arrange non-emergent transportation, please contact SafeRide at least 2 business days in advance.
Utilization management	Senior Care Options: 1-888-867-5511 , TTY 711 One Care: 1-877-790-6543 , TTY 711	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to UHCprovider.com/protocols . Request a copy of our UM guidelines or information about the program.

Topic	Contact	Information
Vision services	One Care MARCH Vision Care marchvisioncare.com 1-844-576-2724	Contact MARCH Vision Care’s provider relations department for information on benefits, lab order submissions and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers and federal TINs. Attend a training session on eyeSynergy. This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.
	Senior Care Options UnitedHealthcare Vision® spectera.com 1-800-638-3120	
Website for Massachusetts Community Plan	UHCprovider.com/MAcommunityplan	Access your state-specific Community Plan information on this website.

Chapter 2: UHC One Care (HMO D-SNP)

Member eligibility

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

Members include adults who:

- Have physical disabilities
- Live with intellectual or developmental disabilities (ID/D)
- Experience serious mental illness (SMI)
- Have substance use disorders (SUD)
- Manage multiple chronic conditions or have functional/cognitive limitations
- Are homeless and living with disabilities
- Identify as gender diverse
- Speak languages other than English
- Are deaf, hard of hearing, or deaf-blind

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

Individuals who turn 65 while enrolled in a One Care Plan may remain enrolled as long as they continue to meet all other eligibility requirements.

Enrollment for One Care is handled by the Massachusetts Community Plan Enrollment Team.

Verify member enrollment

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

- Check Eligibility and Benefits on the **UnitedHealthcare Provider Portal**, then select Eligibility and Benefits
- Call One Care Provider Services at **1-877-790-6543**, TTY **711**

Member UCard

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

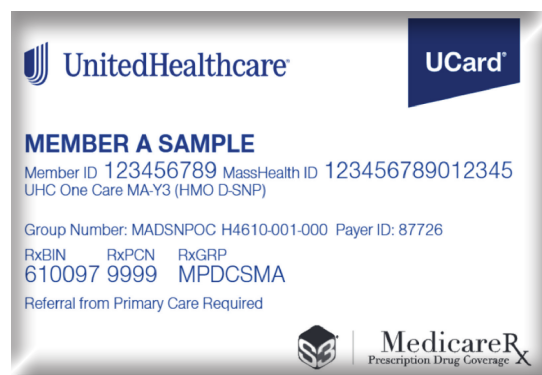
The member's UCard does not show the PCP assignment on the front of the card. Members must choose a PCP to provide and manage their care. Our plan's PCPs are affiliated with medical groups. When a member chooses their PCP, they're also choosing their affiliated medical group.

If a member does not bring their card, call **Provider Services** at **1-877-790-6543**, TTY **711** and document the call in the member's chart.

Member identification number

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

Sample member UCard



Covered services

The UHC One Care plan offers the following services:

- Acupuncture treatment
- Ambulatory surgery/outpatient hospital care
- Audiologist
- Behavioral health inpatient services
- Behavioral health outpatient services
- Breast pumps
- Chiropractic services
- Community health center services
- Continuous skilled nursing
- Dental services
- Diabetes self-management training
- Dialysis services
- Durable medical equipment and medical/surgical supplies
- Medical/surgical supplies
- Emergency services
- Family planning
- Hearing aid services
- Homeless medical respite
- Hospice
- Infertility
- Inpatient hospital services
- Laboratory
- Medical nutritional therapy
- Orthotics
- Oxygen and respiratory therapy equipment
- Pharmacy
- Physician (primary and specialty)
- Prosthetics services and devices
- Remote patient monitoring (RPM)
- Radiology and diagnostic tests
- Skilled nursing facility/nursing facility services
- Therapy
- Tobacco cessation services
- Transitional living
- Transportation (emergency medical transportation and non-emergency medical transportation [NEMT])
- Urgent care clinic services
- Vaccine counseling services
- Vision care

Referrals

Starting Jan. 1, 2026, most members enrolled in One Care plans will be required to obtain a referral from their primary care provider (PCP) before accessing certain specialist services in outpatient, office or home settings.

Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit.

Members don't need a referral to use certain specialists, such as women's health specialists.

Submitting referrals

Submit referrals electronically, prior to the service being rendered, using:

- **API:** Visit the API Marketplace for more details on referral submissions and follow the Get Started prompts to schedule a meeting with an API consultant to learn more
- **EDI:** Use the EDI 278 transaction. Go to UHCprovider.com/edi278 for more information.
- **Online:** UHCprovider.com > Sign In > Referrals
- **Delegated entity's website** listed on the member's UCard

You can choose a start date of up to 5 calendar days prior to the entry date.

Referrals are effective immediately upon submission. UnitedHealthcare does not approve or deny referrals; they are accepted as entered by the PCP.

For more information on how to submit referrals on our provider portal, please review our [Referrals Interactive Guide](#).

Services not subject to prior authorization

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

- Any emergency medical services, including behavioral health emergencies
- Urgent care outside of the service area
- Urgent care under unusual or extraordinary circumstances in the service area when the contracted care provider is unavailable or inaccessible

- The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand or generic formulations
- Family planning services
- Renal dialysis services outside of service area
- Inpatient SUD services if medically necessary
- Acute treatment services (ATS) for SUD if medically necessary
 - You must notify us within 48 hours of a member's admission
- Clinical support services (CSS) for SUD
 - You must notify us within 48 hours of a member's admission
- Outpatient services for covered SUD treatment services
- Day treatment: Structured Outpatient Addiction Program (SOAP)
- Intensive outpatient program (IOP)
- Partial hospitalization for American Society of Addiction Medicine (ASAM) level 2.5, with short-term day or evening mental health programming
- Transitional support services (TSS) for SUDs
- Residential rehabilitation services (not required for the first 90 days of treatment)

Dental

UnitedHealthcare Community Plan covers dental checkups and preventive dental services. Refer to the Dental Provider Manual for applicable exclusions, limitations and covered services. Standard ADA coding guidelines apply to all claims. For more details, go to uhcdental.com. To find a dental provider, go to UHCprovider.com/findprovider > Dental.

Family planning

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

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

The following services are included:

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

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

Non-covered items include:

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

Voluntary sterilization

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the EOHHS Regulations for more information on sterilization.

Hysterectomies

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

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form.

The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility. Find the form on [mass.gov](https://www.mass.gov).

Exception: Massachusetts EOHHS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

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

Sterilization and hysterectomy procedures

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

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

Sterilization informed consent

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

Sterilization consent form

Use the consent form for sterilization:

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

Find the form on [mass.gov](https://www.mass.gov).

Have 3 copies of the consent form:

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

Home- and Community-Based Services

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

They help members with routine daily activities such as bathing, dressing, preparing meals and taking medications. Benefits include the following, but not limited to:

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

Community-based organizations

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

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

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

Visit these websites for more information about:

- ASAPs: [Mass.gov](https://www.mass.gov) > Aging Services Access Points (ASAP)
- RLCs: [Mass.gov](https://www.mass.gov)

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

Maternity/pregnancy/well-child care

Pregnancy Notification Risk Screening

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

Call Healthy First Steps at **1-800-599-5985**.

Healthy First Steps strives to:

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

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

Pregnancy/maternity

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

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



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

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

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

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

Pregnancy termination services

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

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

Maternity admissions

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



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

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

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

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

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

Newborn/infant care is not covered by One Care

MassHealth requires care providers to assist in enrolling newborns into an alternative MassHealth program. The care provider delivering the newborn must download and complete a [Notification of Birth \(NOB\) form](#) and fax it to MassHealth's NOB unit at 1-617-887-8777. Submit the NOB form as soon as possible after birth and no later than 10 days after birth whenever possible. Newborns will be retroactively enrolled in the MassHealth program effective on date of birth.

Vision

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

Additional services

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

Podiatry services

We pay for the following services:

- Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)
- Routine foot care for members with conditions affecting the legs, such as diabetes

Prior authorization may be needed.

HouseCalls

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

NurseLine

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



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

Quit for Life smoking cessation program

Members get coaching and support to quit tobacco and nicotine, at no additional cost.

Quit For Life® has helped 5.9 million members quit for good with judgment-free support and personalized guidance.

Members can get started at [uhc.com](https://www.uhc.com).

Telehealth

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

UHC Latino



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

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

Member eligibility

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

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

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

- Be 65 years or older, or turning 65 in the month enrollment becomes effective
- Reside in Massachusetts
- Be enrolled in Medicare Parts A & B and eligible for Part D
- Be enrolled in MassHealth Standard
- Have no other comprehensive health insurance
- Not have presumptive eligibility
- Not be subject to a 6-month deductible period under 130 CMR 520.028
- Not be a refugee as defined in 130 CMR 522.002
- Not be enrolled in a Home- and Community-Based Services waiver, except the Frail Elder Waiver (if other requirements are met)

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

Verify member enrollment

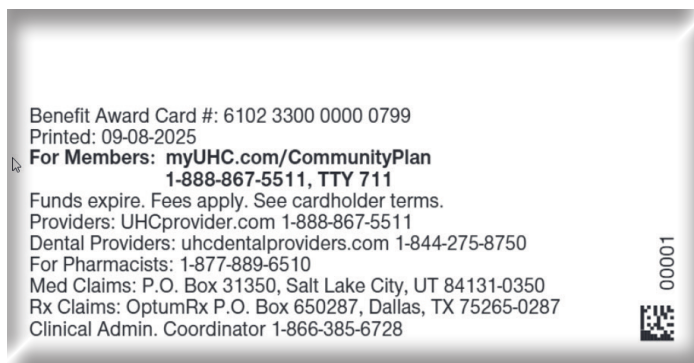
Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Check Eligibility and Benefits on the **UnitedHealthcare Provider Portal**, then select Eligibility and Benefits
- Call Provider Services
- Go to MassHealth at mass.gov > Check member eligibility

Member UCard

Each UnitedHealthcare Community Plan SCO member receives an UCard with their name, member number, and benefit details. The card is for identification only and does not guarantee eligibility.

Sample member UCard



Covered services

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

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

Referrals

Starting Jan. 1, 2026, most members will be required to obtain a referral from their primary care provider (PCP) before accessing certain specialist services in outpatient, office or home settings.

Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit.

Members don't need a referral to use certain specialists, such as women's health specialists.

Submitting referrals

Submit referrals electronically, prior to the service being rendered, using:

- **API:** Visit the API Marketplace for more details on referral submissions and follow the Get Started prompts to schedule a meeting with an API consultant to learn more
- **EDI:** Use the EDI 278 transaction. Go to [UHCprovider.com/edi278](https://uhcprovider.com/edi278) for more information.
- **Online:** [UHCprovider.com](https://uhcprovider.com) > Sign In > Referrals
- **Delegated entity's website** listed on the member's ID card

You can choose a start date of up to 5 calendar days prior to the entry date.

Referrals are effective immediately upon submission. UnitedHealthcare does not approve or deny referrals; they are accepted as entered by the PCP.

For more information on how to submit referrals on our provider portal, please review our [Referrals Interactive Guide](#).

Aging services access points

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

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

For more information about ASAPs, go to [Mass.gov](https://mass.gov) > Aging Services Access Points (ASAP) or email your HCBS provider relations advocate at mahp_hcbpra@uhc.com.

Dental services

A dental care provider manual is available for detailed coverage information.

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

Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims. For more details, go to: uhcdental.com.

To find a dental provider, go to [UHCprovider.com/findprovider](https://uhcprovider.com/findprovider) > Dental.

Long-Term Support Services

Overview

Long-Term Support Services (LTSS) are Home- and Community-Based Services (HCBS) that provide health care and supportive services to members with functional limitations or chronic illnesses, allowing them to remain safely in their homes and community settings.

Services include:

- Adult day health
- Adult foster care
- Companion care
- Day habilitation
- Group adult foster care
- Frail elder waiver (SCO)
- Housekeeping, laundry, chore
- Home health (skilled and non-skilled)
- Meal preparation
- Home delivered meals
- Grocery shopping
- Personal emergency response system
- Personal care services (e.g., bowel and bladder care, bathing, grooming, paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired
- Self-consumer directed care (SCO)
 - Members can self-direct care by selecting, hiring, supervising, training, and terminating caregivers

Eligibility

- Enrolled in Senior Care Options or One Care Plans (disabled or blind)
- Massachusetts resident physically residing in the United States
- Meet Medicaid recipient eligibility criteria (income and asset limits)

Clinical eligibility

- Reside in the community (not in acute care hospitals, long-term care facilities, or licensed community care facilities)

Referral

Anyone can initiate an LTSS application on behalf of a member. Adult members are encouraged to self-refer by contacting their UnitedHealthcare Community Plan care manager. In most cases, members require a referral from their PCP before using other providers.

Assessment and Approval

The member's care manager will assess LTSS services according to state guidelines. Members will be notified if services are approved or denied.

Vision

Vision services are covered by UnitedHealthcare Vision®.

Phone: 1-800-638-3120

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

Online: spectera.com

Additional services

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

Adult pain management/chiropractic services

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

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

Use the following steps to access the fee schedules online:

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

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

Fitness program

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

Foot care (routine)

6 routine foot care visits and all medically necessary visits. You may need to obtain prior authorization for services.

HouseCalls

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

Over the counter + healthy food

A \$125 monthly credit is loaded to the SCO member's UCard every month to help pay for over the counter (OTC) products and wellness support, plus healthy food and utilities if the member qualifies. For non-qualifying members, a \$125 credit is loaded to the SCO member's UCard every month to help pay for OTC products.

Telehealth

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

Skilled nursing facility

Nursing facility role and responsibilities

Nursing facilities provide overall care for all members including but not limited to the following: room and board, interdisciplinary healthcare needs, and access to hospice services.

Following are additional responsibilities:

- Participation with our clinical teams
- Coordinate care with the member's assigned PCP
- Observe necessary notifications to us, including admission and change in member status or condition
- Determine eligibility and securing necessary authorizations prior to service delivery

Each nursing facility is assigned a dedicated Provider Engagement Representative (PER). The PER serves as the primary liaison between UnitedHealthcare Community Plan and the facility, ensuring strong collaboration and effective communication.

Their responsibilities encompass the full spectrum of provider relations and service interactions, including:

- Claims support: Managing end-to-end care provider claim inquiries and resolution.
- Education & training: Developing and delivering external provider education programs to enhance understanding of policies, processes, and best practices.
- Relationship management: Designing and implementing initiatives that foster positive, productive relationships between the health plan, care providers, and nursing facilities.

By combining operational support with strategic engagement, PERs play a critical role in improving provider satisfaction and ensuring high-quality care delivery.

Chapter 4: Care provider standards and policies

General care provider responsibilities

Accessibility

UnitedHealthcare Community Plan supplies policies and procedures via the Provider Portal as it relates to the Americans with Disabilities Act (ADA) compliance, accessibility, and accommodations requirements. This includes, but is not limited to, ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities or with diverse ethnic and cultural backgrounds from obtaining care.

It is vital that the provider network adheres to compliance of the ADA as well as the flexibility to meet members' unique and individual accommodation needs (e.g. flexible scheduling, interpreter services, compatible formats of written material, accessible equipment: scales, exam tables). Announced and unannounced site visits may be conducted annually to ensure compliance with ADA requirements.

Non-discrimination

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

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

Providers cannot refuse services to a member because the member has an outstanding debt with the provider from before the member joined the One Care plan.

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

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

Provide official notice

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

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

Visit UHCprovider.com/attestation to view ways to update and verify your provider demographic data.

Provide notice of care provider panel closing

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

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

Transition member care following termination of your participation

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

Arrange substitute coverage

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

Panel disenrollment/reassignment requests must be submitted to the UnitedHealthcare Community Plan Provider Services at **1-888-867-5511** for SCO members and **1-877-790-6543** for One Care members.



For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com/findprovider.

Medicaid ID requirement for integrated D-SNP

All healthcare professionals and facilities participating in UnitedHealthcare Community Plan of Massachusetts must obtain a Massachusetts Medicaid ID within 120 days of joining the network, per federal 21st Century Cures Act requirements.

All providers are required to enroll with MassHealth and have a Medicaid ID number, even if you do not submit claims and receive payment directly from MassHealth.

Notification & enrollment

You will receive a letter from UnitedHealthcare with steps to enroll with MassHealth. Complete enrollment promptly to avoid network termination or billing delays.

Forms must be submitted electronically via the [MassHealth portal](#).

After enrollment

MassHealth will validate your provider information and share confirmation with UnitedHealthcare.

UnitedHealthcare will send you a letter with your PIDSL/Medicaid ID Number.

If MassHealth cannot validate your information, they will ask UnitedHealthcare for correction.

Change an existing TIN or add a health care provider

Visit UHCprovider.com/attestation to view ways to update and verify your provider demographic data.

Update your practice or facility information

You can update your practice information through the [UnitedHealthcare Provider Portal](#).

Go to UHCprovider.com/mypracticeprofile. Or submit your change by:

- Visiting UHCprovider.com/attestation to view ways to update and verify your provider demographic data electronically
- Connecting with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#)

After-hours care

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

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

Participate in quality initiatives

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

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

Provide access to your records

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

Performance data

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

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's protocols, including those contained in this manual. You may view protocols at UHCprovider.com/protocols.

Office hours

You must provide the same office hours of operations for all services to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

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

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

Follow medical record standards

Please reference **Chapter 8** for Medical Record Standards.

Inform members of advance directives

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

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

Notification of Medicare Non-Coverage

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

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

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

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

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

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

The Massachusetts QIO is MassPro:

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

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



For more information about instructions, notification requirements and to download the NOMNC form, see Chapter 11 of the **Care Provider Administrative Guide for Commercial and Medicare Advantage** or visit [cms.gov](https://www.cms.gov) > Medicare.

Appeal process for care provider participation decisions

Participating care providers

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

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

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

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

- Appeal procedures apply equally to care providers within those subcontracted groups

- Subcontracted groups must adhere to all UnitedHealthcare Community Plan, federal and state requirements

Other care providers

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

We will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body as required by law. Written communication to you will detail the limitations and inform you of your appeal rights.

Member notification of care provider termination

When a contract termination involves a PCP, UnitedHealthcare Community Plan will notify members who are patients of that PCP of the termination. For all other care providers, we will make a good faith effort to provide written or verbal termination notice of a participating care provider to all members who are patients seen on a regular basis by that care provider at least 30 calendar days before the termination effective date, regardless of the termination reason. Members may call Member Services to change their PCP. Otherwise, we will assign one.

Administrative terminations for inactivity

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

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

CMS and state of Massachusetts reporting requirements

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

Your Agreement

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

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

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

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

Mutual obligations-UnitedHealthcare and provider professional conduct

Professional conduct

When we conduct business together, you will work with us to ensure that your employees, agents, and any personnel operating in our facilities or yours comply with the following:

- **Collaborate for member outcomes:** Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism:** At all times, treat other providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.
- **Prohibit threats and harassment:** Create a safe and respectful environment. Any form of threats, harassment, or intimidation is strictly prohibited, including verbal, physical, and written forms.
- **Prohibit violence:** Prohibit acts of violence against other providers, UnitedHealthcare members, and UnitedHealthcare and your employees.
- **Protect confidential employee information:** Not publicly disclose any confidential personal information about UnitedHealth Group's or your employees, including home address, personal telephone numbers, personal and professional email addresses, medical, or employment-related details, to any third party without express written consent from the other party, unless legally required to do so.
- **Inaccurate statements:** Not make any misleading, inaccurate or untrue statements, whether oral or written, that disparage or intentionally harm the reputation or safety of the other party, its affiliates, or its employees. This includes statements made on social media, in public forums, or any other medium of communication.

If the requirements above are not met, we will collaborate and fully cooperate to address the matters.

If you fail to fully cooperate with UnitedHealthcare to address any violation of these requirements, such conduct is a material breach under the Agreement. UnitedHealthcare may:

- Refuse to interact with any individual engaging in such conduct;
- Terminate any professional's participation in UnitedHealthcare's network, without terminating the Agreement between the parties;
- Terminate the Agreement between the parties upon 30 days' prior written notice; and
- Any other remedies available to the parties under the participation agreement or at law.

Any threat, attempted violence, or acts of violence will be reported to the appropriate authorities including, but not limited to, UnitedHealth Group Corporate Security, appropriate provider security, law enforcement, state and federal regulatory bodies.

Access to care and appointment availability standards

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

Primary care

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

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

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

- **Emergency care:** Immediately or referred to an emergency facility (24 hours a day, 7 days a week)
- **Urgent care:** within 48 hours
- **Non-symptomatic office visits:** within 45 calendar days
- **Non-urgent symptomatic care:** within 10 calendar days
- **Individuals with disabilities:** Physical and phone access required. You must make reasonable accommodations to ensure physical or communication barriers do not inhibit access to care.
- **All other care:** within 14 calendar days

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

Specialty care

Specialty care availability:

- **Urgent care:** within 48 hours
- **Non-urgent symptomatic care:** within 30 calendar days
- **Non-symptomatic care:** within 60 calendar days

Prenatal care

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

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

Virtual visits

Care providers can use telehealth options to offer access and availability where applicable.

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

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

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

Provider directory

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

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

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you.

If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our care provider directory after 10 business days.

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

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

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

For delegated care providers: Your designated submission pathway

For non-delegated care providers: Visit [UHCprovider.com/attestation](https://uhcprovider.com/attestation) to view ways to update and verify your provider demographic data.

Online care provider directory

Find the medical, dental and mental health care provider directory at [UHCprovider.com/findprovider](https://uhcprovider.com/findprovider).

Care provider attestation

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

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

Requirements for primary care provider and specialists serving in primary care provider role

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

These relationships help coordinate care and provide the member a “medical home.”

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

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

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

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

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

We ask members who don’t select a PCP during enrollment to select one.

UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP’s nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services.

Recorded messages are not acceptable.

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

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

Responsibilities of primary care providers and specialists serving in primary care provider role

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

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

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

- Maintain licenses, certifications, permits or other prerequisites as required by law, regulation and policy to provide covered services. Submit evidence that each is current and in good standing upon our request.

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services**
- Check the member's UCard at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

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

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

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
 - Preventive (wellness) health services from a care provider, PA, NP or social worker
 - Mental health services
 - Immunizations (shots)
 - Home nurse visits
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments

In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCP may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

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

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

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

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

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

Prenatal care provider responsibilities

Pregnant UHC One Care members should only receive care from UnitedHealthcare Community Plan One Care participating providers.

Call Healthy First Steps at **1-800-599-5985**.

Ancillary care provider responsibilities

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

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

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services**.
- Check the member's UCard at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth**.
- Identify and bill other insurance carriers when appropriate

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com** then Sign In. Each month, we monitor PCP panel sizes via PCP-to-member ratio reports.

When a PCP's panel nears the max limit, we remove it from auto-assignment.

1. Go to UHCprovider.com.
2. Select Sign In on the top right.
3. Log in.
4. Select Clinical & Pharmacy tab.
5. Select UnitedHealthcare Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS® measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use Document Library for member contact information in a PDF at the individual practitioner level.

You may also use [Report Center](#) for member contact information in a PDF at the individual practitioner level.

View the [Report Center Interactive User Guide](#) to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

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

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

Deductibles/copayments

Deductibles and copayments are waived for covered services for SCO and One Care members

Medicare deeming period

Effective January 1, 2026, for SCO and One Care enrollees who lose MassHealth Medicaid eligibility, UnitedHealthcare will disenroll members at the end of the month in which they lose Medicaid eligibility and will only cover Medicare benefits during the plan's Medicare deeming period for 60 days.

Medicaid-covered services are not reimbursed during this time.

Verify eligibility before services

Use the available UnitedHealthcare tools: [Provider Portal](#) and [GPS Enrollment Tool](#).

If Medicaid shows inactive with an end date, member may be in deeming period.

Do not bill Medicaid-only services as they will not be reimbursed.

Examples: Home delivered meals, PCA services, day habilitation, chore/homemaker, laundry, consumer directed care, personal emergency response, skilled nursing (Medicare covers skilled care; custodial care and room & board are not reimbursed).

Cost sharing

Providers must not charge coinsurance, copayments, or deductibles to members who are actively enrolled in MassHealth Standard on the date of service.

If a member loses MassHealth Standard eligibility but remains enrolled in SCO or One Care during the 60-day deeming period, they may be responsible for cost sharing.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

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

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

Primary care provider - initiated transfers

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

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

Mailing address:

UnitedHealthcare Community Plan

Attn: Health Services

950 Winter Street, Suite 3800

Waltham, MA 02451

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new UCard will be sent to the member with the new PCP information. We will determine reasonable cause for a transfer based on your submitted written documentation. You may not transfer a member to another participating care provider due to the member's covered services costs.

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

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to uhc.com/medicaid/dsnps.

For information about D-SNP, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at [UHCprovider.com/guides](https://uhcprovider.com/guides). For state-specific information, go to [UHCprovider.com/ma](https://uhcprovider.com/ma) > Medicare > **Dual Complete Special Needs Plans**.

Interacting with capitated/delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare (“capitated organization”). If your patient is assigned to one of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

Capitation is a payment model in which care providers receive a fixed per-member, per-period payment, regardless of services rendered. Common capitated entities include Independent Practice Associations (IPAs), medical groups, and occasionally hospital systems or ancillary care providers.

What is delegation?

Delegation is the transfer of authority to perform specific functions on our behalf.

We may delegate:

- Medical management
- Credentialing
- Utilization management
- Claims processing and payment
- Complex case management
- Other clinical and administrative functions

When responsibilities are delegated to a care provider, they become a “delegated entity” or “delegate.”

UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other care providers, but those agreements must follow UnitedHealthcare’s product-specific regulations. To obtain and maintain delegation, care providers must comply with our standards and best practices. Non-compliance may result in revocation of delegated responsibilities.

Capitated organizations are often also delegated entities, making them responsible for both delivering care and administering delegated functions, such as processing and paying claims for other care providers.

What does it mean for you if you are not a capitated/delegated care provider?

You may enter into direct agreements with capitated or delegated organizations. These agreements may differ from your Participation Agreement with UnitedHealthcare and should clearly define applicable protocols and procedures.

Key principles:

- **If you participate with both UnitedHealthcare and a capitated organization, and provide designated covered services to a capitated member:**
The capitated organization is solely responsible for payment, based on your agreement with them.
- **If you participate with UnitedHealthcare but not with the capitated organization, and provide designated covered services to a capitated member:**
The capitated organization remains solely responsible for payment. Payment follows your UnitedHealthcare Participation Agreement.
- **If you participate with both UnitedHealthcare and a capitated organization, and provide services to a non-capitated member:**
UnitedHealthcare (or the financially responsible entity) is solely responsible for payment, per your UnitedHealthcare Participation Agreement.

Chapter 5: Medical management

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

Ambulance services

Air ambulance

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

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

Non-emergent air ambulance requires prior authorization.



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

Emergency ambulance transportation

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

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

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

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

Non-emergent ambulance transportation

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



Non-emergent stretcher/ambulance transportation must be requested at least 2 business days in advance. Go to saferidehealth.com or call 1-844-714-2217.

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

Non-emergency medical transportation

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



NEMT must be requested at least 2 business days in advance. Go to saferidehealth.com or call 1-844-714-2217, TTY 711.

Cardiology

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

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Echocardiograms
- Stress echocardiograms

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

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

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

Request prior authorization online or by phone.

- Online: [UHCprovider.com/cardiology](https://uhcprovider.com/cardiology) > Sign In
- Phone: **1-866-889-8054**, Monday-Friday, 7 a.m.–7 p.m. local time

Make sure the medical record is available.

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

Care coordination/health education

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

The program goals are to:

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

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

Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Centralized enrollee record

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

You can find the following records in the CER:

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

We enable continuous access to the CER by:

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

To coordinate information access and improve record keeping:

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

Discharge planning

UnitedHealthcare Community Plan will assist you and hospitals in the inpatient discharge planning process. At the time of admission and during hospitalization, our medical management staff may discuss discharge planning with you, the member or their family. UnitedHealthcare Community Plan, where appropriate, recommends that our care providers adopt evidence-based health at home models.

Durable medical equipment

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

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



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

Emergency/urgent care services

Emergency services do not require prior authorization.

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

Covered services include:

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

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment

rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency care and Emergency Medical Treatment and Labor Act compliance

UnitedHealthcare Community Plan follows the Emergency Medical Treatment and Labor Act (EMTALA). This means our contracts require providers to meet EMTALA obligations and avoid any conflicts with hospital requirements under the law.

What this means for providers and members:

- In an emergency, members should go to the nearest emergency room. If they need help getting there, they can call 911.
- No referral or prior authorization is needed for emergency care or the initial medical screening.
- Members should contact their primary care provider (PCP) as soon as possible after receiving emergency care.
- Members pay no out-of-pocket costs for ER visits or emergency ambulance services.

Screening and coverage:

- Every member visiting an ER will be screened to determine if a medical emergency exists.
- Emergency services are covered even if the provider is not in our network.

After emergency care (post-stabilization services):

Once the member is stabilized, the hospital must request approval within 1 hour for additional care. If the hospital needs to appeal or speak with a medical director, call **1-800-955-7615**. Care may continue until one of these occurs:

- A UnitedHealthcare plan provider with hospital privileges takes over care
- The member is transferred to another facility under a plan provider's care
- The hospital and UnitedHealthcare agree on the care plan
- The member is discharged

Important: Post-stabilization services (care after the emergency) are covered at no cost to the member, whether care is provided inside or outside the service area.

Urgent care (non-emergent)

Contact Provider Services via [chat](#) or find a care provider at UHCprovider.com/findprovider. Care providers and health care professionals can search our directories to find medical, behavioral health, dental, and vision care providers for your patients.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

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



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

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

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

For policies and protocols, go to [UHCprovider.com](#) > Resources > Plans, Policies, Protocols and Guides > **For Community Plans**.

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

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

Facility admission notification requirements

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

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

Inpatient concurrent review guidelines

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

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

Concurrent review details

Concurrent review for all other programs is notification within 24 hours or 1 business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

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

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team 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 or medical director.

UnitedHealthcare Community Plan uses InterQual, 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.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

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

We don't consider experimental treatments medically necessary.

Determination process

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

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to [UHCprovider.com](https://uhcprovider.com).

Hearing services

Through UnitedHealthcare Hearing, members can choose from a broad selection of hearing aids including brand-name and value-brand options with a variety of technology options and helpful features. Hearing aids can be fit in-person with a provider in the UnitedHealthcare Hearing network.

Hearing aids purchased outside of the UnitedHealthcare Hearing network will not be covered.

Members can contact UnitedHealthcare Hearing at **1-855-523-9355** or visit uhchearing.com to get started.

Hospice

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

Home hospice

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

Respite hospice

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

Inpatient hospice

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

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

Laboratory

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



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

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

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com/policies > **For Community Plan**.

Medication for Opioid Use Disorder

Medication-assisted treatment (MAT) combines behavioral therapy and FDA-approved medications, including buprenorphine, methadone, and naltrexone, to treat opioid use disorder (OUD). To prescribe buprenorphine, you must be registered with the Drug Enforcement Administration (DEA) and authorized in accordance with state requirements. You may provide MAT services without offering in-house counseling; however, you are responsible for referring patients to qualified behavioral health care providers for counseling services when needed. To locate participating MAT care providers, including medical care providers, use the UnitedHealthcare provider directory at UHCprovider.com/findprovider. You can search the directory using applicable treatment or specialty terms, such as medication assisted treatment, to identify care providers for the applicable plan and state.



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

Personal care attendant program

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

Refer to your provider contract and state transmittal letters at mass.gov/masshealth for contractual obligations.

Refer to the Personal Care Attendant Services Manual for regulations and requirements of the MassHealth PCA program.

Oncology

Prior authorization

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

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

Pharmacy

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

1. If the prescriptions are related to a medical emergency or urgently needed care. Members will need to pay the full cost when filling their prescription and submit the bill for payment with the appropriate documentation.
2. A member is traveling in the United States, but outside of the plan's service area, and becomes ill, loses or runs out of their prescription drugs. The member will need to pay the full cost when filling their prescription and submit the bill for payment with the appropriate documentation.
 - Before submitting a prescription to an out-of-network pharmacy, call Member Services to see if a network pharmacy is in the member's traveling area. If there are no network pharmacies in that area, Member Services may be able to arrange for the member to get their prescription(s) from an out-of-network pharmacy.

3. A member is unable to get a covered drug timely and in our service area because there are no network pharmacies in a reasonable driving distance providing 24-hour service.
4. A member need to fill a covered prescription drug not regularly stocked at an eligible retail network pharmacy (this includes orphan drugs or other specialty pharmaceuticals).

Formulary

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

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

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

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

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



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

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



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

Pharmacy prior authorization

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

Utilization management program

We have additional coverage requirements or limits for certain prescription drugs. A team of doctors and pharmacists developed the following requirements and limits to help us provide quality coverage to our members. The following are utilization management examples.

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

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

Exception request

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

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

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



Call Member Services at **1-888-867-5511**, TTY **711 (SCO)** or **1-877-790-6543**, TTY **711 (One Care)** to request a formulary exception.

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

Specialty pharmacy medications

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

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



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

Prior authorization request

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

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

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

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

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal** or call Provider Services. Not doing so may result in claim denial.
- Check the member's UCard each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
 1. To access the Prior Authorization app go to, **UHCprovider.com** then Sign In
 2. Select the **Prior Authorization and Notification tool**.
 3. View notification requirements.
- Identify and bill other insurance carriers when appropriate.

If you have questions, chat options and contact information, visit **UHCprovider.com/contactus** Monday-Friday, 7 a.m. –9 p.m. CT.

Services requiring prior authorization



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

Direct access services – Native Americans

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

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission:** within 24 hours, unless otherwise indicated
- **Inpatient admissions; after ambulatory surgery:** 1 business day
- **Non-emergency admissions or outpatient services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

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



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



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

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

Radiology

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

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

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

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

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

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

Request prior authorization online or by phone at:

- Online: UHCprovider.com/radiology > Sign In
- Phone: **1-866-889-8054** Monday-Friday, 7 a.m. -7 p.m. local time. Make sure the medical record is available.



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

Care provider payments

UnitedHealthcare Community Plan authorization helps ensure payment for all covered services.

You should:

- Determine if the member is eligible on the date of service by using the UnitedHealthcare Provider Portal on UHCprovider.com, contacting UnitedHealthcare Community Plan's Provider Services department, or the MassHealth Medicaid eligibility system.
- Submit documentation needed to support the medical necessity of the requested procedure

- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

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

Second opinion benefit

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

Criteria:

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

Screening, brief interventions, and referral to treatment services

Screening, brief interventions, and referral to treatment (SBIRT) services are covered when:

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

What is included in Screening, brief interventions, and referral to treatment?

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

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder.

This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.

SBIRT services will be covered when all are met:

- The billing and servicing provider are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is Z71.41
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per provider, per year. The SBIRT assessment, intervention, or treatment takes places in 1 of the following places of service:
 - Office
 - Urgent care facility
 - Outpatient hospital
 - ER - hospital
 - Federally qualified health center (FQHC)
 - Community mental health center
 - Indian health service - freestanding facility
 - Tribal 638 freestanding facility
 - Homeless shelter



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

Services not covered by UnitedHealthcare Community Plan

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are otherwise listed by our plans as covered
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under original Medicare

- Private hospital room, except when it is considered medically necessary
- Any health care not given by a doctor from our list (except emergency treatment)
- Personal comfort items used in the hospital or skilled nursing facility, such as a phone, television or barber
- Fees charged by a member's immediate relative or members of their household, except as described in the MassHealth benefit chart
- Elective or voluntary enhancement procedures or services including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, except when otherwise covered and medically necessary
- Cosmetic surgery, unless it is because of an accidental injury or to improve a malformed part of the body. However, all stages of breast reconstruction are covered after a mastectomy, including the unaffected breast to produce a symmetrical appearance.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, except as described in the MassHealth benefit chart
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services



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

Transplant services: Solid and Hematopoietic Stem Cell

UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants Solid and Hematopoietic Stem Cell (HSC) including the transplant evaluation, work-ups, the transplant procedure with post-care follow-up. Optum manages the transplant prior authorization for the evaluation and episode.



Contact Optum intake at **1-888-936-7246**.

Tuberculosis screening and treatment; Direct Observation Therapy

Guidelines for Tuberculosis (TB) screening and treatment; Direct Observation Therapy (DOT) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

Responsibilities

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

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

Utilization management guidelines

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

Utilization management appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decision may file a UM appeal. See Appeals in Chapter 11 for more details.

Chapter 6: Mental health and substance use

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

The National Optum behavioral health manual is located at providerexpress.com. This chapter does not replace the national Optum network manual.

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



How to Join Our Network

Credentialing information is available at providerexpress.com > Our Network.

Role of behavioral health

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

- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours a day, 7 days a week via the clinical intake line at **1-888-867-5511**
- Fully supports PCPs with assessment and referrals to mental health and chemical dependence services
- Provides behavioral health case management. (Call the number on the member's UCard to contact dedicated One Care case management.)
- Reviews, monitors, and authorizes behavioral health care
- Responsible for provider relations for behavioral health care providers
- Staffed by professionals with extensive experience in mental health and chemical dependence services

Screening for behavioral health problems

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

Behavioral health emergencies

If you believe the member is having a psychiatric emergency, you should either call 911 or direct the member to the designated county screening center or nearest hospital emergency room.



If you are unsure of the member's mental status, call Optum at **1-877-614-0484**.

Covered services

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

Inpatient services

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

- **Inpatient mental health services:** For acute psychiatric conditions posing danger or severe dysfunction.
- **Inpatient substance use disorder services (level 4):** For medically complex withdrawal and co-occurring conditions.
- **Observation/holding beds:** Up to 24 hours for stabilization and assessment.
- **Administratively necessary day services:** Continued inpatient care when discharge is clinically appropriate but no placement is available.

Outpatient services

Mental health and SUD services provided in person in an ambulatory care setting such as a mental health center or SUD clinic, hospital outpatient department, community health center or practitioner's office.

Services may also be provided at a member's home or school.

- Diversionary services
 - Alternatives to inpatient care, including community crisis stabilization: 24-hour and non-24-hour support services to maintain community functioning or assist with transitions
- Outpatient services
 - Behavioral health urgent care: Same-day or next-day access for evaluations and treatment
 - Electro-convulsive therapy (ECT) and other therapeutic services
- Specialized programs
 - Community behavioral health centers (CBHCs): Provide crisis, urgent, and routine services, including adult mobile crisis intervention (AMCI)
 - Behavioral health emergency screening: Available 24/7
 - Community support program for justice-involved individuals (CSP-JI): Focused on behavioral health and community tenure for those with justice involvement
 - Tenancy preservation programs: Behavioral health supports to maintain housing stability

Member resources

The website - [Liveandworkwell.com](https://liveandworkwell.com)- includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.



For member resources, go to providerexpress.com click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Eligibility

Verify the member's eligibility on the Provider Portal before treating them. Go to providerexpress.com > login to your account. In the secure transactions section, you can search for a Member's benefits and eligibility.

For more information on checking a member's eligibility, visit providerexpress.com.

Authorizations

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

No prior authorization is required for community behavioral health center (CBHC) services. MOUD services are covered and accessible without referral.



Get prior authorization by going to: providerexpress.com > login to your account. In the secure transactions area, you can verify what services need an authorization.

Access and coordination

Enrollees may self-refer to any network behavioral health provider. Providers must coordinate with PCPs and ICTs.

Collaboration with other health care professionals

Coordination of care

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

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

Please talk to your patients about the benefits of sharing essential clinical information. It is also essential to coordinate care between behavioral health providers and state agencies, including but not limited to Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole, and Executive Office of Aging & Independence (AGE).

Portal access

UHCprovider.com/portal

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

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

Claims

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

Addressing the opioid epidemic

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

Brief summary of framework

- Prevention:
 - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education
- Treatment:
 - Access and reduce barriers to evidence-based and integrated treatment
- Recovery:
 - Support case management and referral to person-centered recovery resources

- Harm Reduction:
 - Access to Naloxone and facilitating safe use, storage, and disposal of opioids
- Strategic community relationships and approaches:
 - Tailor solutions to local needsEnhanced solutions for pregnant mom and child:
 - Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics:
 - Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free SUD/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain.

Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources. Access these resources at UHCprovider.com > Resources > **Drug Lists and Pharmacy**. Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prescribing opioids

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

Drug management program

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

Expanding medication assisted treatment access and capacity

Evidence-based medication-assisted treatment (MAT) is critical to the treatment of opioid use disorder (OUD). MAT uses a chronic-condition approach that includes medication, counseling, cognitive behavioral therapies, and recovery support. We work to expand MAT access and maintain a robust network of participating care providers to support member needs. To locate participating behavioral health MAT care providers in your state, use the UnitedHealthcare provider directory at [UHCprovider.com/findprovider](https://uhcprovider.com/findprovider). You can search the directory using applicable treatment or specialty terms, such as medication assisted treatment, to identify care providers for the appropriate plan and service area.

Substance use disorder recovery coaching

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

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

Chapter 7: Member rights and responsibilities

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

Privacy regulations

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

Access to protected health information

Members may access their protected health information (PHI), medical records, or billing information either through you or us. If their information is electronic, member may ask that you or we send a copy in an electronic format.

Member may also ask that a copy of their information be provided to a third party, including access to electronic health records or care management portals.

Providers must maintain and follow protocols for communication and coordination between members of the member's interdisciplinary care team (ICT), which include ensuring secure and timely access to electronic health records or care management portals for all authorized ICT participants.

Amendment of protected health information

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

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request.

This accounting must include disclosures by business associates. It will not include disclosures made:

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

Right to request restrictions

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

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

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

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

Member rights

Members have the right to:

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

- Make suggestions about our member rights and responsibilities policies
- Receive up to 90 days of continuity of care services, or until a comprehensive assessment and the integrated care plan are completed, reviewed and agreed upon by the member
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member UCard
- Prevent others from using their UCard
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Give you a copy of their advance directive
- Use the emergency room only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health

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

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

Chapter 8: Medical records

Medical record charting standards

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

Topic	Required elements
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records. – Release only to entities as designated consistent with federal requirements – Keep in a secure area accessible only to authorized personnel
Procedural elements	• Medical records are legible. • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place

Topic	Required elements
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • Medical and surgical history • A family history that includes relevant medical history of parents or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, or substance use disorder/history beginning at age 11 • Current and history of age-appropriate immunizations of children, adolescents and adults • Tracking, referrals, and follow-up documentation of age and gender appropriate preventive health services consistent with preventive health guidelines such as: screenings and referrals made (if applicable) or follow-up documented: - Recommended preventive health screenings/tests - Dementia - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Substance use disorder, including drugs and alcohol, sexual activity, exercise and nutrition and counseling as appropriate - Abuse, neglect and exploitation identification and documentation of follow-up action (if applicable)
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - Chief complaint - Physical assessment - Diagnosis - Treatment plan • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines • Documentation of all elements of age appropriate federal Early, Periodic, creening, Diagnosis and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis - Time frame for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Member input or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

Member copies

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

Medical record review

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

- Problem list with:
 - Biographical data with family history
 - Past and present medical and surgical intervention
 - Significant medical conditions with date of onset and resolution
 - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times).
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions

- Immunization record
- Tobacco habits, alcohol use and substance use disorder
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; Notes regarding the date of return visit or other follow-up
- Lab and other studies as appropriate
- Member education, counseling or coordination of care with other care providers
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK, PHQ-9, PHQ-2, GDS)

Chapter 9: Quality management program and compliance information

What is the quality improvement program?

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

The program consists of:

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

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

If you are interested in being a member of the Community Plan's Provider Advisory Committee which meets on the second Thursday of the month 4 times a year, please contact the Massachusetts Community Plan Quality Team at ma.cs.quality@uhc.com. A stipend is provided to providers who attend these meetings.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities.

These include:

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

We require your cooperation and compliance to:

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

Collecting data from care providers

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

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

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

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

Care provider satisfaction

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

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

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

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

Member satisfaction

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

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

Credentialing standards

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

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

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

Credentialing and recredentialing process

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

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

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

Health facilities

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

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

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

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



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



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

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

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

Peer review

Credentialing process

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

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website.

Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

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

Applicant rights and notification

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

You also have the right to receive the status of your credentialing application. Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at **UHCprovider.com/chat**.

Confidentiality

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

Failure to meet recredentialing requirements

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

Resolving disputes

Contract concerns

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

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

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

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

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

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

Health Insurance Portability and Accountability Act compliance – your responsibilities

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

Transactions and code sets

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

Unique identifier

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

National Provider Identifier

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

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

Privacy of individually identifiable health information

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

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

Security

Covered entities must meet basic security measures:

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

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



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

Ethics and integrity

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

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group ethics and integrity program. The UnitedHealthcare Community Plan compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the ethics and integrity program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by educating employees
- Assessing compliance by monitoring and auditing
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management or the ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations

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

Reporting and auditing

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

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



To report questionable incidents involving members or care providers, call our fraud, waste, and abuse hotline or go to uhc.com/fraud.

Refer to the fraud, waste, and abuse section of this manual for additional details about the UnitedHealthcare Community Plan fraud, waste, and abuse program.

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

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

Extrapolation audits of corporate-wide billing

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

Federal fund laws

Payments you receive for providing services to our members are, in whole or part, from federal funds. You and any subcontractors must comply with laws that apply to individuals and entities receiving federal funds, including, but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84
- The Age Discrimination Act of 1975 as implemented by 45 CFR part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act (ADA) of 1990

Record retention, reviews, and audits

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

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

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

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

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

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

Monitoring audits

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

Delegating and subcontracting

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

Critical incidents

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

- All vehicle accidents involving our transportation vendor that result in serious injury
- Criminal activity or fraud involving care workers or family members impacting the member’s health or finances
- Displacement (temporary or permanent) due to unsafe living conditions, including fire, flooding, pest infestation, hoarding, or natural disaster; all evictions must be reported

- Direct medical care incidents
- Exposure to hazardous materials (including lead, chemicals, or bloodborne pathogens) that may cause serious injury
- Falls with fractures
- Fire or natural disaster
- Medication errors that might result in serious injury or death
- Mistreatment or allegations of mistreatment, including abuse, neglect, emotional harm, sexual or financial exploitation, or any other mistreatment/assault by any person (family members, care staff, care providers)
- Missing person/elopement
- Mistreatment, abuse, or neglect
- Overdose
- Premature death resulting from suicide, homicide, drug overdose, or suspected medication error
- Preventable pressure ulcer and similar conditions
- Self-injurious behavior
- Serious physical or psychological injury related to:
 - Delivery of care from a care staff
 - Medical equipment failure
 - Second-degree or higher burns
 - Suicide attempt
- Unauthorized use or failure to follow policies and procedures for restraints, whether or not injury occurs

Serious reportable events

Serious reportable events (SRE) results in an adverse patient outcome and are clearly identifiable and measurable. It's also influenced by facility policies or procedures where the event occurred. In 2025, the National Quality Forum updated their list of SREs to align with the Joint Commission's list of Sentinel Events.

Provider Preventable Conditions

Provider Preventable Conditions (PPC) meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Preventable Condition (OPPC). PPCs are reasonably preventable through evidence-based guidelines and occur during care provided to a UnitedHealthcare Community Plan member.

Reporting requirements for critical incidents, serious reportable conditions and provider preventable conditions:

Must be reported to UnitedHealthcare Community Plan of Massachusetts at Critical_Incident_SCO@uhc.com.

Timely reporting is critical to ensure member safety.

Office site quality

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

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

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

Criteria for site visits

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

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient’s safety.	Access to facility in poor repair to pose a potential risk to patients. Needles and other sharps exposed and accessible to patients. Drug stocks accessible to patients. Other issues determine to pose a risk to patient safety.	1 complaint.
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space.	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy.	2 complaints in 6 months.
Othe.	All other complaints concerning the office facilities.	3 complaints in 6 months.

Evidence-based medicine/ clinical practice guidelines

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

You must be compliant with clinical practice guidelines found on our care provider online portal at UHCprovider.com/MAcommunityplan > **Current Policies and Clinical Guidelines** > Clinical Guidelines. Additional provider resources are also available at this site regarding abuse, neglect and exploitation, and appropriate nursing facility institutionalization.

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

Chapter 10: Billing and submission

Our claims process



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

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on UHCprovider.com/guides.

Claims process from submission to payment

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

National Provider Identifier

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



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

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements.

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

Fee schedule

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

Modifier codes

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

Member UCard for billing

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

Acceptable claim forms

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

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

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

Clean claims and submission requirements

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

Clean claims have:

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

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

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

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

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

Mail paper claims to:

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

Electronic claims submission and billing

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

- All claims are set up as "commercial" through the clearinghouse
- Claim payer ID is 87726
- ERA payer ID: UFNEP
- Clearinghouse acknowledgment reports and payer-specific acknowledgment reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms
- For more information, see EDI Claims section

Electronic data interchange companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA.

The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

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

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements. The companion documents are located on UHCprovider.com/edi > **EDI transaction and code sets**.

Clearinghouse and status reports

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



For clearinghouse options, use our EDI at UHCprovider.com/resourcelibrary > Electronic Data Interchange > **EDI Clearinghouse Options**.

e-Business support

Visit UHCprovider.com/contactus and select the self service or chat options or call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

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



To find more information about EDI online, go to **UHCprovider.com/resourcelibrary** to find Electronic Data Interchange menu.

Electronic payment solutions: OptumPay

UnitedHealthcare Community Plan has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for care provider payment.

You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment (virtual card). The only alternative to a virtual card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

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

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and virtual card statement will be available online through Document Library

- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

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

Completing the CMS 1500 claim form



Companion documents for 837 transactions are on **UHCprovider.com/resourcelibrary** to find the EDI section.

Visit the [National Uniform Claim Committee](#) website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

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

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

Capitated services

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

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

This applies to all benefit plans for members:

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

Additionally, capitated care providers may be subject to any or all delegated activities.

Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

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

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

Form reminders

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

Subrogation and coordination of benefit

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

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

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

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

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

Hospital and clinic method of billing professional services

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

Global days

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

For payment, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on [UHCprovider.com/policies](https://uhcprovider.com/policies) > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

Correct Coding Initiative

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

Comprehensive and component codes

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

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

Clinical Laboratory Improvements Amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to the [cms.gov](https://www.cms.gov)

Billing multiple units

When billing multiple units:

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

Billing guidelines for obstetrical services

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

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

Billing guidelines for transplants

UnitedHealthcare Community Plan covers medically necessary, non-experimental transplants including the transplant evaluation and work-ups. Prior authorization for the transplant evaluation must be obtained.

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

Optum intake phone: 1-888-936-7246

Ambulance claims (emergency)

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

Federally qualified health center billing guidelines

Participating care provider

- Care provider contracted as FQHCs must bill UnitedHealthcare Community Plan for services according to their agreement
- Encounter/PPS services must be billed on the UB-04 (institutional) claim form using the appropriate encounter codes and revenue codes
- Non-FQHC services (e.g., laboratory tests, diagnostic imaging such as X-rays) must be billed on the CMS-1500 (HCFA) claim form using applicable CPT/HCPCS codes

Non-participating care provider

- Non-participating FQHC and RHC care providers must use published encounter codes for FQHC/RHC services (per 101 CMR 304.00) on a UB-04 claim form
- All additional reimbursable services outside the encounter (e.g., labs, vaccines, X-rays) should be billed separately on a CMS-1500 claim form

National drug code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed

- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered

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

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

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

Medical necessity

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

You may not charge members for any service if:

1. It is not a medically necessary covered or non-covered service.
 2. There are other covered or non-covered services available to meet the member’s needs.
 3. The provider did not explain items (1) and (2).
- The member will not be liable to pay for the provision of any such services. You must document compliance with this provision.

Billing guidelines for Indian Health Services claim form requirement

All Indian Health Services (IHS) providers are required to submit claims using the CMS-1500 (HCFA) claim form type.

Place of Service codes

Go to [cms.gov](https://www.cms.gov) for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the **UnitedHealthcare Community Plan Provider Portal**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

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

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

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

UnitedHealthcare Community Plan Provider Portal

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

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

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

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

Find training on UHCprovider.com/training

Resolving claim issues

View the **appeals and grievances grid** for submission information.

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

For paper claims

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

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

Timely filing

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

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service
- All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.
- The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

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

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

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

Balance billing

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

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

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

Third-party resources

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

Chapter 11: Claim reconsiderations, appeals, and grievances

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

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

Appeals and grievances standard definitions and process requirements								
Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Original claim resubmission		Care provider	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims	Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543v , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or UHCprovider.com/claims .	90 days from date of service or as stated in your contract.	30 business days.
Claim resubmission	A claim originally denied because of missing documentation and is now being resubmitted with the required information.	Care provider		UHCprovider.com/claims	Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543 , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or UHCprovider.com/claims .	If denied or appealed, follow Medicare process. 90 days from date of denial.	45 business days.
Corrected claim	A replacement of a previously submitted claim, such as changes or corrections to charges, clinical or procedure codes, dates of service, member information.	Care provider		UHCprovider.com/claims	Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543 , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	Use Claims Management or Claims on the UnitedHealthcare Provider Portal or UHCprovider.com/claims .	365 days from date of service or denial, claim completion or provider remittance advice (whichever is later).	45 business days.
Claim resubmission after coordination of benefits		Care provider		UHCprovider.com/claims	Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543 , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations .	365 days from date of service or dated in your contract.	45 business days.
Claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim, corrected claim determination which you do not agree.	Care provider			1-800-600-9007 Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543 , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . For further information on reconsiderations see the Reconsiderations and Appeals interactive guide .	If appeal or dispute, follow Medicare processes. - 120 days from date of payment. - 90 days from date of denial.	45 business days.

Chapter 11: Claim reconsiderations, appeals, and grievances

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Digital submission and address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Claim formal appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider			1-800-600-9007 Senior Care Options 1-888-867-5511 , TTY 711 One Care 1-877-790-6543 , TTY 711 Monday-Friday, 8 a.m. -6 p.m. ET	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations . For further information on appeals see the Reconsiderations and Appeals interactive guide .	60 business days.	30 business days.
Member appeal	A request to change an adverse benefit determination that we made.	Member - Member's authorized representative (such as friend or family member) with written member consent - Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-0023	providerforms.uhc.com/ProviderAppealsandGrievance.html AOR Consent Form on this site for member appeals.	Call the customer service phone number on the back of the member's UCard	For online submissions using the UnitedHealthcare Provider Portal, go to: Pre- and post-service appeals and reconsiderations .	60 business days.	Urgent appeals: 72 hours. Standard appeals: 30 calendar days.
Member grievance	A member's expression of dissatisfaction regarding the plan or care provider, including quality of care concerns.	Member Care provider or authorized representative (such as friend or family member) with written member consent	UnitedHealthcare Community Plan Attn: Appeals and Grievances Unit P.O. Box 6103 MS CA 124-0187 Cypress, CA 90630-0023		Call the customer service phone number on the back of the member's UCard.		N/A	Send a confirmation letter of received grievance: 1 business day. Expedited grievance: Within 24 hours. Standard grievance: 30 calendar days.

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

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

Claim correction

What is it?

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

When to use:

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

How to use:

View the [appeals and grievances grid](#) for submission information.

Additional information:

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

Resubmitting a claim

What is it?

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

When to use it:

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

Common reasons for rejected claims:

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

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

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

View the [appeals and grievances grid](#) for submission information.

Claim reconsideration (step 1 of dispute)

What is it?

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

When to use:

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

For administrative denials:

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

For medical necessity denials:

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

How to use:

View the [appeals and grievances grid](#) for submission information.

Tips for successful claims resolution

To help process claim reconsiderations:

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

Valid proof of timely filing documentation (reconsideration)

What is it?

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

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

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

How to use:

View the [appeals and grievances grid](#) for submission information.

- Submit a screen shot from your accounting software that shows the date you submitted the claim with the screen showing:
 - Correct member name
 - Correct date of service
 - Claim submission date

Additional information:

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

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract.

If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

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

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

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

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

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**

Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/26	14A0000000001	01/31/26	\$115.03	\$115.03	Double payment of claim.
2222222	02/02/26	14A0000000002	03/15/26	\$77.29	\$27.29	Contract states \$50.00, claim paid \$77.29.
3333333	03/03/26	14A0000000003	04/01/26	\$131.41	\$98.56	You paid 4 units, we billed only 1.
44444444	04/04/26	14A0000000004	05/02/26	\$412.26	\$412.26	Member has other insurance.
55555555	05/05/26	14A0000000005	06/15/26	\$332.63	\$332.63	Member terminated.

Where to send:

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

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

Instructions and forms are on UHCprovider.com/claims.

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

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

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

Appeals (step 2 of dispute)

What is it?

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

When to use:

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

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information.

View the [appeals and grievances grid](#) for submission information.

Questions about your appeal or need a status update?

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

Member appeals and grievances definitions and procedures

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

Member appeals

What is it?

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

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

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

When to use:

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

Where to send:

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

View the [appeals and grievances grid](#) for submission information.

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

How to use:

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

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

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

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

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

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

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at providerforms.uhc.com.

Member grievance

What is it?

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

When to use:

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

Where to send:

You or the member may call or mail the information anytime.

View the [appeals and grievances grid](#) for submission information.

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

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

Further appeal rights

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

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

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

Special appeal types

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

Another special appeal type applies only to a member dispute about when coverage will end for SNF, HHA or comprehensive outpatient CORF. SNFs, HHAs and CORFs are responsible for providing members with a written notice at least 2 days before their services will end. If the member thinks their coverage is ending too soon, the member may appeal directly and immediately to the IRE.

- If the member receives the notice 2 days before coverage ends, the member must request an appeal to Acentra Health no later than noon of the day after the member receives the notice
- If the member receives the notice more than 2 days before coverage ends, the member must make the request no later than noon the day before the date coverage ends.
- If the member misses the deadline for appealing to Acentra Health, they may request an expedited appeal from us

State fair hearings

What is it?

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

When to use:

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

How to use:

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

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

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

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member's health condition requires.
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the state fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy or regulation.

Fraud, waste, and abuse



Call the toll-free fraud, waste, and abuse hotline at **1-844-359-7736** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's anti-fraud, waste, and abuse program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste, and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its anti-fraud, waste, and abuse program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste, and abuse.

An important aspect of the compliance program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.



Find out how we follow federal and state regulations around false claims at **UHCprovider.com/MAcommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least \$5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste, and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- [Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities \(LEIE\)](#)
- [General Services Administration \(GSA\) System for Award Management](#)

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 12: Care provider communications and outreach

Communication with care providers

Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes, news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available:**
Have a question? Skip the phone and chat with a live service advocate when you sign in to the [UnitedHealthcare Provider Portal](#).
Available Monday-Friday, 7 a.m.–7 p.m. CT, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com:**
This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/MAcommunityplan** has resources, guidance and rules specific to Massachusetts.
- **Policies and protocols:** [UHCprovider.com/policies > For Community Plans](#) library includes UnitedHealthcare Community Plan policies and protocols
- **Social media:** Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics
 - Facebook
 - Instagram
 - LinkedIn
 - YouTube
 - X (formerly Twitter)

- **Health plans by state:** [UHCprovider.com/ma](#) is the fastest way to review all of the health plans UnitedHealthcare offers in Massachusetts. To review information for another state, simply use the drop down menu at [UHCprovider.com/plans](#) to select a state, then select the type of plan (commercial, Medicare Advantage, etc.), then review the specific plans offered in that market.
- **UnitedHealthcare Community & State newsletter:**
Stay current on the latest insights, trends and resources related to Medicaid. [Sign up](#) to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal:** This secure portal is accessible from [UHCprovider.com](#). It allows you to access patient information such as eligibility and benefit information and digital UCards.
 - You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting [UHCprovider.com/portal](#).
 - You can also access [self-paced user guides](#) for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News:**
Bookmark [UHCprovider.com/networknews](#). It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
 - Get news related to your role, specialty, health plan and state. When you [subscribe](#) to Network News, you can update your preferences to select what news you receive.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at [UHCprovider.com/training](#). Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

4. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
5. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
6. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to “Profile & Settings,” then “Account Information” to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

State websites and forms

Find the following forms on the state’s website at [mass.gov](https://www.mass.gov):

- Sterilization consent form
- Informed consent for hysterectomies form
- Provider Service Agreement (MC 19 form)

Marketing

You may not develop and use any materials that market UnitedHealthcare Community Plan One Care and Senior Care Options without the prior approval of UnitedHealthcare Community Plan in compliance with Medicare Advantage and state MassHealth requirements.

Under Medicare Advantage law, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS, and not disapproved within 45 days. State MassHealth laws are similar, and UnitedHealthcare Community Plan works with both CMS and the Massachusetts EOHHS to have marketing or outreach materials approved prior to distribution to member or prospective members.