Welcome to UnitedHealthcare

Welcome to the UnitedHealthcare Care Provider Administrative Guide for Commercial and Medicare Advantage. This comprehensive guide allows you and your staff to find important information for topics such as processing a claim and prior authorizations, as well as protocol information for health care providers. This guide also includes important phone numbers and websites (see the Resources and How to Contact Us section in Chapter 1: Introduction). Operational policies and additional electronic tools are available on our website at UnitedHealthcareOnline.com.

- If you are looking for the TRICARE Provider Handbook click here to access the UHCMilitaryWest.com > Provider > Resources.
- If you are looking for capitated provider information, go to the Medicare Advantage Capitated Provider Supplement in this guide, or click here or go to Uhcwest.com > Library tab > Provider Administrative Guides in the left navigation menu.
- If you are looking for a Community and State manual, click here or go to UHCCommunityPlan.com > Health Care Professionals, and select the correct state.

You may easily find information in the (guide/manual) using the following steps:

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

Depending upon the version of PDF software you have, you may also be able use the binoculars icon to search for key words.

This 2017 UnitedHealthcare Provider Administrative Guide (this “guide”) applies to covered services you provide to our members or the members of our affiliates* through our benefit plans insured by or receiving administrative services from us, unless otherwise noted.

This guide is effective April 1, 2017 for physicians, health care professionals, facilities and ancillary providers currently participating in the our commercial and Medicare networks, and effective immediately for care providers who join the our network on or after Jan. 1, 2017. Please remember, this guide is subject to change. We frequently update content, including codes and coding, in our effort to support our health care provider networks.

Terms used in this guide include the following:

- “Member” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement with us (we sometimes refer to “members” as “customers”);
- “Commercial” refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers’ compensation, TRICARE, or other governmental programs. “Commercial” also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities;
- “You,” “your” or “provider” refers to any health care provider subject to this guide, including physicians, health care professionals, facilities and ancillary providers; except when indicated all items are applicable to all types of health care providers subject to this guide.
- “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this guide.

Medicare policies, protocols and information in this guide apply to covered services you provide to UnitedHealthcare Medicare Advantage members, including Erickson Advantage members, but excluding UnitedHealthcare Medicare Direct members. As used in this guide, references to “Medicare Advantage members” applies only to those Medicare Advantage members enrolled in UnitedHealthcare Medicare Advantage benefit plans offered under the AARP MedicareComplete, UnitedHealthcare Medicare Solutions and Erickson Advantage brands.* * If a particular section does not apply to such Medicare Advantage members, it is clearly indicated.

If there is a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this guide, the provisions of the Appendix controls for benefit plans within the scope of that Appendix.

If there is an inconsistency between your agreement with us and this guide, your agreement controls (except where your agreement with us provides protocols for our affiliates.) If those protocols are in a supplement to this guide, those protocols control for services you render to a member subject to that supplement).

*UnitedHealthcare affiliates offering commercial and Medicare Advantage benefit plans and other services, include, but are not limited to, UnitedHealthcare Benefits Plan of California UnitedHealthcare Insurance Company, UnitedHealthcare of Arizona, Inc. UnitedHealthcare of Colorado, Inc. UnitedHealthcare of Texas, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare Services, Inc.

** The only exception is UnitedHealthcare Senior Options, which is a benefit plan offered only in Massachusetts For this benefit plan, the logos on the back of the Medicare Advantage Member health care ID card are “Medicare Community Plan” and “UHC.”
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Chapter 1: Introduction

Manuals and Benefit Plans Referenced in This Guide

Some benefit plans included under your agreement with us may be subject to the requirements found in other health care provider guides, care provider manuals, or to the supplements found in the second half of this guide. The product list provided here is for your convenience and is subject to change.

This section provides information about some of the most common UnitedHealthcare products. Your agreement with us may use “benefit contract types”, “benefit plan types” or a similar term to refer to our products.

Visit UnitedHealthcareOnline.com > Tools & Resources > Products & Services for more information about our Products and Individual Exchange benefit plans offered by state.

If a member presents a health care ID card with a product name you are not familiar with, please call us at 877-842-3210.

The following is a general guide to where benefit plan information and the additional guides or manuals can be found. You are subject to the provisions of additional guides when providing covered services to a member of those benefit plans, as described in your agreement with us and in the table below. UnitedHealthcare may make changes to care provider guides, supplements and manuals that relate to protocol and payment policy changes.

UnitedHealthcare may change the location of a website, a benefit plan name, branding or the member health care ID card. We communicate those changes to you through one of our care provider communications resources, as applicable.

Benefit Plans Subject to this Guide

Empire Plan: In most states, UnitedHealthcare maintains a separate care provider network specifically for The Empire Plan. If you have a direct contract for UnitedHealthcare’s Empire Plan Network (The UnitedHealthcare Empire Plan Agreement), this guide does not apply. If you do not have an Empire Plan specific contract and are a care provider in AZ, CT, DC, FL, IL, MD, NJ, NC, PA, SC, VA, or WV, or if you are a national care provider, your UnitedHealthcare agreement allows Empire Plan members to access your services (unless it specifically excludes Empire Plan). In those cases, this guide applies.

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<th>Location of most members subject to additional guides</th>
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<td>All Savers: All Savers Insurance Company</td>
<td>All markets</td>
<td>All Savers Supplement to this guide <a href="http://myallsaversprovider.com">Myallsaversprovider.com</a></td>
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<tr>
<td>Harken Health: Harken Health Insurance Company</td>
<td>Some counties in GA, IL (Chicago and Atlanta areas)</td>
<td>For Harken Health plan information and provider directories, visit: <a href="http://harkenhealth.com">harkenhealth.com</a>. For eligibility verification, referral submissions, prior authorization submissions, claims status, benefit information and care management programs, go to: provider.harkenhealth.com. For all other provider information, go to: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>. For Member and Provider Assistance call 800-797-9921</td>
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<td>MDIPA: MD Individual Practice Association, Inc.</td>
<td>DC, DE, MD, VA, WV, some counties in southeastern PA</td>
<td>Mid-Atlantic Regional Supplement to this guide. <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
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<td>Medicare Advantage Capitated Provider Supplement</td>
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<td>Medicare Advantage Capitated Provider Supplement to this guide. <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
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<td>NHP: Neighborhood Health Partnership, Inc.</td>
<td>FL</td>
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<td>DC, DE, MD, NC, PA, VA, WV. Limited Network in: FL, GA, SC, TN</td>
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<td>• Oxford Health Insurance, Inc.</td>
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<td>River Valley Entities Supplement to this guide.</td>
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<td>• UnitedHealthcare Services Company of the River Valley, Inc.</td>
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<td>Your UnitedHealthcare contract specifically references River Valley or John Deere Health protocols or Guides; and</td>
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<td>You are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Mercer, Whiteside, Lee, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, KnoxStark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean, and</td>
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<td>Note: River Valley also offers benefit plans in LA, NC, OH &amp; SC, but the River Valley Additional Guide does not apply to those benefit plans.</td>
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<td>Sierra or Health Plan of Nevada:</td>
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<td>Services rendered outside of Nevada to Sierra or Health Plan of Nevada Customers with the health care ID card reference described in this row are subject to your UnitedHealthcare agreement and to this guide (unless you are in Arizona or Utah and have a contract directly with Sierra or Health Plan of Nevada.)</td>
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<td>UnitedHealthcare West Non-Capitated</td>
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<td>• UnitedHealthcare Benefits Plan of California</td>
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<td>• PacifiCare of Colorado, Inc.+</td>
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Chapter 1: Introduction

Benefit Plans Not Subject to this Guide

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<td>TRICARE West Region</td>
<td>TRICARE Provider Handbook <a href="http://UHCMilitaryWest.com">UHCMilitaryWest.com</a> <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
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<tr>
<td>UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured</td>
<td>Multiple states</td>
<td>UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured. <a href="http://uhccommunityplan.com">uhccommunityplan.com</a> and <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare West Capitated</td>
<td>AZ, CA, CO, NV, OK, OR, TX, WA.</td>
<td>UnitedHealthcare West Capitated Guide: <a href="http://Uhcwest.com">Uhcwest.com</a></td>
</tr>
</tbody>
</table>

Resources and How to Contact Us

The United Voice Portal is a simple and easy way for physicians and health care professionals to access to inquire about member benefits and eligibility, advanced notifications and check a claims status.

877-842-3210

For tips on using the Voice Portal go to UnitedHealthcareOnline > Contact Us and click on the link to the Quick Reference Guide.

Our Web-based provider portal ([UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com)) gives you easy access to provider communications pertaining to administrative functions. Our interactive website enables you to electronically determine member eligibility, submit claims, and verify the status of claims. The UnitedHealthcare website also contains clinical practice guidelines, electronic data interchange, quality, utilization requirements, and educational materials such as newsletters, bulletins and other provider information.

Commercial & Medicare Advantage Products

<table>
<thead>
<tr>
<th>Topic</th>
<th>Where to go</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Provider website</td>
<td>Link or <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>. Resources there:</td>
</tr>
<tr>
<td></td>
<td>• Access to care provider policies and protocols, tools, training and network bulletins.</td>
</tr>
<tr>
<td></td>
<td>• Enroll in Electronic Payments and Statements (EPS) for direct deposit for covered services and electronic remittance advice.</td>
</tr>
<tr>
<td></td>
<td>• Authorizations and referrals information, submissions and status.</td>
</tr>
<tr>
<td></td>
<td>• Verify eligibility and benefits.</td>
</tr>
<tr>
<td></td>
<td>• Verify your network and tier status for a member’s benefit plan.</td>
</tr>
<tr>
<td></td>
<td>• Claims management including filing, status information, and claims reconsiderations.</td>
</tr>
<tr>
<td></td>
<td>Help Desks: 866-842-3278 (option 1 for <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>, option 3 for Link)</td>
</tr>
</tbody>
</table>
## Chapter 1: Introduction

<table>
<thead>
<tr>
<th>Commercial &amp; Medicare Advantage Products</th>
<th>Where to go</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advance Notification, Prior Authorization and Admission Notification</strong> <em>(To submit and get status information)</em></td>
<td>Online: <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Notifications/Prior Authorizations or: Clinician Resources &gt; Advance &amp; Admission Notification Requirements EDI - see EDI transactions and code sets on <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Tools &amp; Resources &gt; EDI Education for Electronic Transactions or Phone: United Voice Portal, 877-842-3210. See member's health care ID card for specific service contact information.</td>
</tr>
<tr>
<td><strong>Appeal - Urgent Submission</strong> <em>(Commercial members)</em></td>
<td>UnitedHealthcare Harken Health Members An expedited appeal may be available to you if the member’s medical conditions are such that the time needed to complete a standard appeal could seriously jeopardize the member’s life, health or ability to regain maximum function. Urgent Medical fax: 801-994-1083 Urgent Pharmacy fax: 801-994-1058 Urgent Medical or Pharmacy Appeals fax: 844-518-7413</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Use Services</strong></td>
<td>See member's health care ID card for carrier information and contact numbers.</td>
</tr>
<tr>
<td><strong>Cardiology, Radiology, and Outpatient Injectable Chemotherapy</strong> Notification/Prior Authorization – Submission &amp; Status</td>
<td>Online: <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Notification/Prior Authorization Phone: 866-889-8054 (For more information related to chemotherapy notifications/prior authorization, go to <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Clinical Resources &gt; Oncology &gt; Chemistry (Injectable) Prior Authorization Program).</td>
</tr>
<tr>
<td><strong>Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers</strong> <em>(Contracted with OptumHealth Physical Health, a UnitedHealth Group company)</em></td>
<td>Online: <a href="https://myoptumhealthphysicalhealth.com">myoptumhealthphysicalhealth.com</a> Phone: 800-873-4575</td>
</tr>
<tr>
<td><strong>Member/Customer Care</strong> <em>(Commercial and Medicare Advantage)</em></td>
<td>Phone: 877-842-3210</td>
</tr>
<tr>
<td><strong>United Voice Portal</strong> Save time by using the prompts to: • Verify member eligibility and benefits • Check the status of a claim, or an appeal • Update your demographic information</td>
<td>Quick Reference Guide: <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Contact Us &gt; UnitedHealthcare for Health Care Professionals (United Voice Portal), click on the quick reference guide link. Phone: 877-842-3210</td>
</tr>
<tr>
<td><strong>Erickson Advantage</strong> <em>(A UnitedHealthcare Medicare Advantage product for residents of Erickson Retirement Communities.)</em></td>
<td>See member’s health care ID card for Member Care contact information.</td>
</tr>
<tr>
<td><strong>Fraud, Waste and Abuse</strong> <em>(Report Potential Non-Compliance or Suspected Issues)</em></td>
<td>Phone: 877-842-3210 (United Voice Portal) For more information on Medicare fraud, waste, and abuse prevention efforts, please go to: Chapter 14: Fraud, Waste and Abuse.</td>
</tr>
</tbody>
</table>
## Chapter 1: Introduction

<table>
<thead>
<tr>
<th>Topic</th>
<th>Where to go</th>
</tr>
</thead>
</table>
| (For services to commercial and Medicare Advantage members). | OptumRx:  
  • Phone: 800-711-4555  
  • Fax: For non-specialty meds: 800-527-0531  
  • Fax: For specialty meds: 800-853-3844 |
| **Provider Relations:**             | Online: [UnitedHealthcareOnline.com](https://www.UnitedHealthcareOnline.com) > [Contact Us](https://www.UnitedHealthcareOnline.com/Contact-Us) > Network Contacts > enter the state you where you practice. |
| For participating hospitals, health care, and ancillary providers; Locate your Physician or Hospital Advocate. |                                                                                                                                           |
| (Free-standing)                     | Phone: 877-842-3210 (for Provider Service)                                                                                                 |
| **Referral Submission and Status**  | Link – Eligibility and Benefits Center where you can submit a referral and check the status.  
  Electronic Data Interchange (EDI) (278r).  
  **Note:** Submitted referrals are effective immediately but may not be viewable for 48 hours. |
| **Therapeutic Radiation Prior Authorization** (IMRT, SRS, and SBRT) | For program information:  
| (For Medicare Advantage members)    | To request an authorization Online:  
  Phone: 866-889-8054 |
| **Transplant Services**             | See member’s health care ID card for carrier information and contact numbers.                                                                 |
| **Vision Services**                 | See member’s health care ID card for carrier information and contact numbers.  
  (The health care ID card is available when you verify the member’s eligibility using the Benefits & Eligibility application on Link.) |

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**5 | 2017 UnitedHealthcare Care Provider Administrative Guide**
Electronic Data Interchange (EDI)

The fastest way we can communicate with you is electronically. EDI is the preferred method for conducting business transactions with physicians and health care industry partners, participating and non-participating. Using EDI to exchange information with us and other payers has many advantages:

- 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

If you are not taking advantage of all available electronic transactions, you are not maximizing your savings and experiencing the full benefits of EDI.

Getting Started

- If you have a practice management or hospital information system, contact your software vendor to determine what electronic transactions are offered.
- Contact clearinghouses to review which electronic transactions can interact with your software system. Read our Clearinghouse Options page for ideas.

EDI Education and Support

Our EDI Education section of UnitedHealthcareOnline.com offers a variety of resources to help you with EDI connectivity, tips to submit claims electronically and better understand the purpose of each available EDI transaction. We publish UnitedHealthcare Companion Guides noting the required data elements for exchanging EDI transactions with us and a Companion Guide Directory related to our strategic partners.

Verifying Eligibility, Benefits, and Your Network Participation Status

Check the member’s eligibility and benefits prior to rendering services. This helps ensure that you submit the claim to the correct payer, allows you to collect copayments, determine if a referral and prior authorization or notification is required and reduces denials for non-coverage.

There are three easy ways to verify eligibility and benefits:

- **Online**: using the eligibility application on Link (requires login)
- **EDI**: Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse
- **Phone**: 877-842-3210

EDI: Eligibility and Benefit Inquiry (270) and Response (271)

The EDI transaction is a powerful productivity tool that allows you to instantly obtain members’ eligibility and benefit information in “real-time,” using a computer instead of the phone. The HIPAA ANSI X12 270/271 format is the only acceptable format for this EDI transaction. One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. Verify the eligibility of members before you see them and obtain information about their benefits including required copayments any deductibles, out-of-pockets maximums or co-insurance for which your patients are responsible.

Your network status is not returned on 271 transactions at this time so be sure to know your status prior to submitting 270 transactions.

Eligibility Grace Period for Individual Exchange Members

Health insurance benefit plans are required to provide a three-month grace period before terminating coverage for certain individuals who enroll in a health benefit plan through the Individual Health Insurance Marketplace (also known as Individual Exchange). The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month’s premium within the benefit year.

You can verify if the member is within the grace period when you verify eligibility, as described previously.

If the date of service is scheduled to occur after the date, the member is in the grace period and at risk of retroactive termination if the premium is not paid in full at the end of the three-month period.

Understanding Your Network Participation Status

As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status and tier status (for tiered benefit plans) while checking eligibility on Link or by call us at 877-842-3210. If you are not participating in the member’s benefit plan or are outside the network service area for the benefit plan (i.e., Compass) the member may have higher cost share or no coverage. For more information about Tiered benefit Plans, visit UnitedHealthcareOnline.com > Tools & Resources > Products & Services > Tiered Benefit Plans.
Health Care Identification (ID) Cards

UnitedHealthcare members receive health care ID cards that include information necessary for you to submit claims, such as the payer ID for electronic claims submission. Information on the cards may vary by health benefit plan.

Please check the member’s health care ID card at each visit, and keep a copy of both sides of the health care ID card for your records. Possession of a health care ID card is not proof of eligibility.

Bar-coded Health Care ID Cards

UnitedHealthcare uses bar codes on our health care ID cards to make it easy for you to access member information at the point of service.

A 2D bar code scanner is required to scan these cards. The scanner can be used in conjunction with UnitedHealthcareOnline.com to access the Member’s Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions. We use the national Workgroup for Electronic Data Interchange (WEDI) card standards for our ID cards.

Commercial Health Care ID Card Legend

Front

2. Member Plan Identifier: This is a customized field to describe the member’s benefit plan (i.e., Individual Exchange, Tiered Benefits, ACO, etc.).
3. Payer ID: Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
4. Primary Care Provider (PCP) name and phone number: Included for benefit plans that have PCP selection requirements. For Individual Exchange Members ‘PCP required’ is listed in place of the PCP name and number. This section may also include Laboratory (LAB) and Radiology (RAD) participant codes.
5. Copay information: If this area is blank, the member is not required to make a copay at the time of service.
6. The Benefit Plan Name: Identifies the applicable benefit plan name.
7. Referral requirements identifier: Identifies plans with referral requirements
   Prescription information: Including the prescription plan name, prescription bin, PCN and Group code.
8. For Members section: contains benefit plan contact information and if applicable, referrals and notifications information.
9. For Providers section: contains benefit plan and pharmacy contact information, and if applicable key benefit plan features.
Medicare Advantage Health Care ID Card

To see specific Medicare Advantage benefit plan ID cards go to UnitedHealthcareOnline.com > Tools & Resources > Medicare > HMO, POS & PPO or Special Needs Plans (SNP), and see the Benefit Plan Name Overviews in the Reference Materials section.

Medicare Advantage ID Example

Front

Medicare Advantage ID card legend:

1. **Dental Benefits**: Included if routine dental benefits are part of the benefit plan and/or if the member purchased an optional supplemental dental benefit rider.

2. **Payer ID**: Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.

3. **PCP name and phone number**: Included for benefit plans with PCP selection requirements.

4. **Prescription Information**: If the benefit plan includes Part D prescription drug coverage, the Rx Bin, PCN and Group code are visible. If Part D coverage is not included, this area lists information for Medicare Part B Drugs.

5. **Copay Information**: Including PCP, specialist, and ER copays. Some Special Needs Plans do not list copay information. Select HMO benefit plans in FL and NC have tiered copayments. These plans have two copayments for PCPs and for specialists.

6. **Referral Requirements Identifier**: Identifies benefit plans with referral requirements. Refer to the Medicare Advantage Referral Required Plans of this guide for more detailed information.

7. **The Benefit Plan Name**: Identifies the applicable benefit plan. Examples of some Medicare Advantage benefit plans include, but are not limited to:
   - AARP Medicare Complete benefit plans
   - Care Improvement Plus benefit plans
   - UnitedHealthcare Assisted Living Plans
   - UnitedHealthcare Dual Complete benefit plans
   - UnitedHealthcare MedicareComplete benefit plans
   - UnitedHealthcare Nursing Home Plans

8. **For Members**: Section contains benefit plan contact information for the Member.

9. **For Providers**: Section contains benefit plan contact information for the care provider.

Harken Health’s Health Care ID Card Legend

Harken Health ID cards will look like this:

Access Standards

**Covering Physician**

As a Primary Care Provider, you must arrange for coverage of your patients who are our members 24 hours a day, seven days per week. If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with the Member’s benefit plan, so that services may be covered under the Member’s network benefit.

You must notify us if the covering physician is not in your medical group practice to prevent claim payment issues. When billing services as a covering physician, modifiers substitute physician (Q5), Covering Physician (CP) and locum tenens (Q6) must be used. PCP copay is to be collected at the time of service.

To find the most current directory of our network physicians and health care professionals go to UnitedHealthcareOnline.com > Physician Directory.

**Appointment Standards**

UnitedHealthcare establishes standards for appointment access and after-hours care to help ensure timely access to care for members. Performance against these established...
standards is measured at least annually. Our standards are shown in the table below.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>Within four weeks</td>
</tr>
<tr>
<td>Regular/Routine Care</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Appointment</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Appointment</td>
<td>Same day</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>24 hours/seven days a week for primary care providers</td>
</tr>
</tbody>
</table>

The guidelines listed above are general UnitedHealthcare guidelines. State or federal regulations may require more stringent standards. Contact your Network Management representative for assistance with determining your state or federal-specific regulations.

**After-hours Phone Message Instructions**

We ask that you and your practice have a mechanism in place for after-hours access to make sure every member calling your office after-hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911, or its local equivalent, or
- Go to the nearest emergency room.

In non-emergent circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:

- Go to a network urgent care center,
- Stay on the line to be connected to the physician on call,
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames, or
- Call an alternative phone or pager number to contact you or the physician on call.

**Provider Privileges**

In order to help our members get access to appropriate care and to help minimize their out-of-pocket costs, care providers must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to members. This includes, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

**Primary Care Physicians (PCP) Responsibilities**

As a PCP, it is your responsibility to deliver medically necessary primary care services. You are the coordinator of your patients’ total health care needs. You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. Some benefit plans require PCPs to submit electronic referrals for the member to see another network physician. Go to Chapter 5: Referrals for detailed information on referral requirements.

**Non-discrimination**

You must not discriminate against any patient, regarding quality of service or accessibility of services, on the basis that the patient is a member of UnitedHealthcare or its affiliates, or if the patient obtained coverage through the Health Insurance Marketplace, on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any patients in need of the services you provide.

**Cooperation with Quality Improvement and Patient Safety Activities**

Every participating physician and care provider must cooperate with our quality improvement and patient safety activities and programs to improve the quality of care and services and member experience. These include, but are not limited to, the following:

- Timely provision of medical records upon request including contracted business associates requests if the provision of copies or access to such records are free of charge (or as indicated in your agreement with us) during site visits or by email, secure email, or secure fax.
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans; Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review; (HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)).
- Allowing use of practitioner and provider performance data.
Proactive Notification of Changes

If you have received the upgraded My Practice Profile on Link and have been granted editing rights by your ID administrator, you can use Link to make many of the updates required in this section.

Physician/Health Care Professional Verification Outreach

UnitedHealthcare is committed to providing our members with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO).

Your office may receive a call from us asking to verify your data currently on file in our provider database. This information is confidential and is immediately updated in our database.

Provide Official Notice

You must send notice to us at the address noted in your agreement with us and delivered by the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice. For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility
- Relocation or closing of your practice, and, if applicable, transfer of member records to another physician/facility.

Provide Timely Notice of Demographic Changes

PCPs are responsible for monitoring your office capacity based on member assignments and for notifying us if you have reached your maximum capacity. A self-reporting tool is available for you to generate a PCP panel roster report at UnitedHealthcareOnline.com > Tools & Resources > Reports.

Notification of Changes Must be Proactive

You or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare (a “delegate”) are expected to review, update care provider records and attest to the information available to our members, including the information listed here, at least quarterly. If you or the delegate cannot attest to the information, you or the delegate must supply corrections to UnitedHealthcare online or through the Provider Service Center. At least 30 calendar days before the change is effective, you or the delegate must notify us of changes to all care provider information. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph. Delegates are responsible for notifying us of these changes for all of the participating providers credentialed by the delegate. If you or a delegate fail to update your records, or give 30 days prior notice of changes, or fail to attest to the information available to our members, you or the participating care providers credentialed by the delegate may be subject to penalties. Penalties may include, but are not limited, to the delay of processing claims or the denial of claims payment, until the records are reviewed and attested to, or until corrections are submitted.

You and the delegates are required to update all care provider information, including but not limited to the following:

- The status as to whether the participating care provider is accepting new patients or not
- The address(es) of the office locations where the participating care provider currently practices
- The phone number(s) of the office locations where the participating care provider currently practices
- The email address of the participating care provider
- Whether or not the participating care provider is still affiliated with listed care provider groups
- The hospital affiliation(s) of the participating care provider
- The specialty of the participating care provider
- The license(s) of the participating care provider
- The tax identification number used by the participating care provider
- The NPI(s) of the participating care provider
- The languages spoken/written by the participating care provider or the staff
- The ages/genders served by the participating care provider
- Office hours
- In the event of a departure of health care providers from your practice, we ask that you notify us immediately to allow sufficient time for member notification.

To Change Status of Panel (Open/Closed)

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance and state that the change applies to all patients for all products, not only UnitedHealthcare members. We may notify you in writing of changes in our panel status including closures.
Chapter 2: Provider Responsibilities and Standards

based on state and/or federal requirements, current market dynamics and patient quality indicators. You can update your panel status online using the upgraded My Practice Profile on Link.

To change an Existing TIN or to add a Physician or Health Care Provider
To submit the change, please complete and fax the Provider Demographic Change Form to the appropriate fax number listed on the bottom of the fax form.
The Provider Demographic Change Form is available at UnitedHealthcareOnline.com > Tools & Resources > Forms.
Alternatively, submit detailed information about the change and the effective date of the change on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

To Update Your Practice or Facility Information
As a registered health care provider, you can make all other updates to your practice information by:
1. Signing in to UnitedHealthcareOnline.com > Practice/Facility Profile found on the global navigation at the top of any web page.
2. Submit your change by: completing the Provider Demographic Change Form and emailing the form to the appropriate email address listed on the bottom of the form; or
3. Calling our Enterprise Voice Portal at 877-842-3210.

Administrative Terminations for Inactivity
We are committed to working with physicians and other health care providers to keep our network information and directories up to date. Up to date directories are a critical element of providing our members with the information they need to manage their health. In an effort to provide more accurate and up-to-date directories reflecting providers in our network who are actively treating our members effective Aug. 1, 2015, we began:

• Administratively terminating provider agreements for care providers who had not submitted claims for a period of one (1) year on the basis that they are not actively treating UnitedHealthcare members, and have voluntarily ceased participation in our Network, and
• Inactivating any TIN under which there have been no claims submitted for a period of one (1) year on the basis that they are not in active use.

When physicians, other health care providers and practice administrators inform UnitedHealthcare of practitioners leaving a practice, we make multiple attempts to obtain documentation of that change. Effective April 1, 2017, we will also begin to administratively terminate a provider if:
• We receive oral notification that a practitioner is no longer with the practice, and
• No documentation confirming the practitioner’s departure is obtained from the practice after three attempts, and
• The practitioner has not submitted claims under that practice’s TIN(s) for a period of six (6) months prior to our receipt of oral notification that the practitioner left the practice or the effective date of departure provided to us, whichever is sooner.

Continuity of Care Following Termination of Your Participation
If your participation agreement terminates for any reason, you may be required to assist in the transition of our members’ care to another physician or health care professional who participates in our network. This may include providing services for a reasonable time at our contracted rate during the continuation period, per your participation agreement and any applicable laws. Our staff is available to help you and our members with the transition. We notify affected members at least 30 calendar days prior to the effective date of termination of your participation agreement, or as required under applicable laws.

Medicare Opt-Out
We abide by, and require our providers to abide by, Medicare requirements for physicians and other practitioners that opt out of Medicare. For its Medicare Advantage membership, if a physician or other practitioner opts out of Medicare, they may not accept federal reimbursement. Care providers who opt-out of Medicare (this may include care providers not participating in Medicare) are not allowed to bill Medicare or its Medicare Advantage benefit plans during their opt-out period for two years from the date of official opt-out. For its Medicare Advantage membership, we and our delegated entities do not contract with, or pay claims to, care providers who have opted-out of Medicare.

Exception: In an emergency or urgent care situation, if you have opted out of Medicare, you may treat a Medicare Advantage beneficiary and bill for the treatment. In this situation, you may not charge the member more than what a non-participating care provider would be permitted to charge and you must submit a claim to us on the beneficiary’s behalf. Payment is made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary member has not signed a private contract with the care provider.
Additional Medicare Advantage Requirements

If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements for services you provide to our Medicare Advantage Members.

- You may not discriminate against members in any way based on health status.
- You must allow members to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services. For additional information, please refer to the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries.
- You must provide female members with direct access to a women’s health specialist for routine and preventive health care services.
- You must make sure that members have adequate access to covered health services.
- You must make sure that your hours of operation are convenient to members and do not discriminate against members.
- You must make sure that medically necessary services are available to members 24 hours a day, seven days a week.
- Primary care providers must have backup for absences.
- You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member’s medical record whether they have executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions including, but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.
- The payments that you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying members of network participation agreement terminations.
- You must submit to us all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as we may request, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information and belief.
- You must comply with our Medicare Advantage medical policies, quality improvement programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within two hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
Chapter 3: Commercial Products

We are creating new commercial products and network configurations to meet member needs around affordability and access to quality care. We offer a variety of commercial products for small and large groups on a fully insured and self-funded basis and for individual benefit plans. These products vary by their network size and composition, gated or non-gated requirements, and the benefit structure.

**Health Insurance Marketplaces (Exchanges)**
Exchanges are another way for members to participate in our existing commercial products. We offer one or more of our commercial products on the Individual or SHOP Exchange (Small Business Health Options Program) in certain states. Commercial products offered through the Individual and SHOP Exchange follow the same policies and protocols as outlined within this guide, except as otherwise required by your agreement.

**Understanding Your Network Participation Status**
As a UnitedHealthcare care provider, you are contracted to see all commercial members (including Exchange), unless your agreement excludes you from participation from one or more benefit plans. This includes new benefit plans introduced into your market after your agreement effective date. UnitedHealthcare Compass requires providers to be located in a limited geographic market called the Compass network service area. Verify the current Compass network service area at [UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > Tools & Resources > Products & Services > UnitedHealthcare Compass.

<table>
<thead>
<tr>
<th>Commercial Product Overview Table</th>
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<table>
<thead>
<tr>
<th>Product Name</th>
<th>How do members access physicians and health care professionals?</th>
<th>Is a specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Choice and Choice Plus</td>
<td>Members can choose any network physician or health care professional without a referral and without designating a PCP. UnitedHealthcare Choice Plus provides out-of-network benefits. UnitedHealthcare Choice does not cover out-of-network services (except for emergency services).</td>
<td>No, members have open access to a national network of care providers.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Select and Select Plus</td>
<td>Members choose, or are assigned, a network PCP for each family member. The member is encouraged to see their PCP to coordinate their care, but is not required to see that PCP or to obtain a referral from a PCP when accessing a specialist or facility for care. UnitedHealthcare Select Plus provides out-of-network benefits. UnitedHealthcare Select does not cover out-of-network services (except for emergency services).</td>
<td>No, members have open access to a national network of care providers.</td>
<td>Yes, on selected procedures, as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Options PPO</td>
<td>Members can choose any network physician or health care professional without a referral and without designating a PCP. Options PPO provides, out-of-network benefits.</td>
<td>No, members have open access to a national network of care providers.</td>
<td>In states other than Colorado members are responsible for notifying us using the phone number on their health care ID card, as described under the members benefit plan. In Colorado, the treating physician is required to give notice, for selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Indemnity</td>
<td>Members can choose any physician or health care professional.</td>
<td>No, members have open access to a national network of care providers.</td>
<td>No, members are responsible for notifying us using the phone number on their health care ID card.</td>
</tr>
<tr>
<td>UnitedHealthcare CORE and CORE Essential</td>
<td>Members can choose any network physician or health care professional without a referral and without designating a PCP. CORE provides out-of-network benefits. CORE Essential does not (except for emergency services).</td>
<td>No, members have open access to a limited network of care providers available nationally.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
</tbody>
</table>
### Chapter 3 Commercial Products

<table>
<thead>
<tr>
<th>Product Name</th>
<th>How do members access physicians and health care professionals?</th>
<th>Is a specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Navigate®, Navigate Balanced®, Navigate Plus®</td>
<td>Members must see their assigned PCP and have electronic referrals submitted by their PCP before seeing another network specialist. Navigate Balanced and Plus benefit plans provide additional network coverage at a higher member cost share for services without referrals or for PCPs not assigned to the member. Navigate does not. Navigate Plus provides out-of-network benefits. Navigate and Navigate Balanced do not (except for emergency services).</td>
<td>Yes, an electronic referral from the member’s PCP is required prior to the member receiving specialist services. See Chapter 5: Referrals of this guide.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Charter®, Charter® Balanced, Charter® Plus</td>
<td>Members must see their assigned PCP and have electronic referrals submitted by their PCP before seeing another network specialist to receive the highest level of coverage. Charter Balanced and Plus benefit plans provide additional network coverage at a higher member cost share for services without referrals or for PCPs that are not assigned to the member. Charter does not. Charter Plus provides out-of-network benefits. Charter and Charter Balanced do not (except for emergency services).</td>
<td>Yes, an electronic referral from the member’s PCP is required prior to the member receiving specialist services. See Chapter 5: Referrals of this guide.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Compass, Compass Balanced, Compass Plus</td>
<td>Members must see their assigned PCP and have electronic referrals submitted by their PCP before seeing another network specialist within the network service area to receive the highest level of coverage. Compass Balanced and Plus benefit plans provide network coverage at a higher member cost share for services without referrals, or for PCPs not assigned to the member. Compass does not. Compass Plus provides out-of-network benefits. Compass and Compass Balanced do not (except for emergency services).</td>
<td>Yes, an electronic referral from the member’s PCP is required prior to the member receiving specialist services. See Chapter 5: Referrals of this guide.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>NexusACO OA (Open Access), NexusACO OAP (Open Access Plus)</td>
<td>Members choose, or are assigned, a network PCP for each family member. The member is encouraged to see their PCP to coordinate their care, but is not required to see that PCP or obtain a referral when accessing other network care providers. UnitedHealthcare NexusACO OAP provides out-of-network benefits. UnitedHealthcare NexusACO OA does not cover out-of-network services (except for emergency services).</td>
<td>No, members have open access to a national network of care providers.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>NexusACO R (Referral Required, NexusACO RB (Referral Required Balanced), NexusACO RP (Referral Required Plus)</td>
<td>Members must see their assigned network PCP and have electronic referrals submitted by their PCP before seeing another network specialist to receive the highest level of coverage. NexusACO R provides out-of-network benefits. NexusACO RB and RP do not (except for emergency services).</td>
<td>Yes, an electronic referral from the member’s PCP is required prior to the member receiving specialist services see Chapter 5: Referrals of this guide.</td>
<td>Yes, on selected procedures as described in Chapter 6: Medical Management of this guide.</td>
</tr>
</tbody>
</table>

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1 The UnitedHealthcare Network may be different among commercial products in your local market. Please refer to your contract to determine whether you are part of that local network.

2 Physicians and health care professionals must be licensed for the health services provided and the health care services provided must be covered under the member’s benefit contract.

3 The benefit level for non-emergency services from out-of-network physicians and other care providers generally less than for services from network physicians and other care providers.

4 For more information the Compass service area, please go to [UnitedHealthcareOnline.com](https://www.UnitedHealthcareOnline.com) > Tools & Resources > Products & Services > UnitedHealthcare Compass.

### Commercial Networks

Each commercial product has a distinct network of care providers with whom we can collaborate more closely to provide more affordable, quality health care. Our commercial benefit plans include a subset of our commercial network care providers: Navigate, Charter, Core, and Compass and NexusACO. You can find a list of participating care providers by each benefit plan at [UnitedHealthcareOnline.com](https://www.UnitedHealthcareOnline.com) > Physician Directory > General Physician Directory. Care providers are required through their agreement with us to coordinate care with other participating care providers for the particular member’s benefit plan (in-network).
Benefit Plan Types

**Open access benefit plans:** Open access benefit plans provide members the flexibility to see network care providers with no PCP or referral requirement. These benefit plans do require prior authorization and notifications for certain services as described in Chapter 6: Medical Management with the exceptions noted in the below table. Benefit plans vary in the type of coverage offered based on your network status and tier status (for tiered benefit plans only).

**Gated benefit plans:** Gated benefit plans require members to select and see their assigned PCP and have electronic referrals submitted by their PCP before seeing another network specialist to receive the highest level of coverage. Benefit plans vary in type of coverage offered based on PCP and referral requirements, your network status, and your tier status (for tiered benefit plans only).

**Tiered Benefit Plans:** Members with tiered benefit plans may have lower copays and co-insurance amounts for services provided by a tier 1 provider or at a free standing facility for certain outpatient services. The definition for tier 1 providers differs from plan to plan so it is important for you to check your tier status for each member when checking eligibility on Link. Any one of our commercial products may feature tiered benefits; NexusACO is only offered as a tiered benefit plan. Members with tiered benefit plans have an identifier on the front of the healthcare ID and on Link to help you more easily identify these benefit plan types.

**W500 Additional Network**
Some benefit plans include Additional Network Benefits (referred to as W500 Emergent Wrap), which extends the network of providers available to members outside their primary network for select services (urgent, emergent, gap exceptions). UnitedHealthcare contracted with providers who are not participating for the member’s benefit plan to provide in network coverage for these services. Members with additional network benefits display W500 on the back of their ID card. You can find a list of participating care providers for Additional Network Benefits at UnitedHealthcareOnline.com > Physician Directory > W500 Emergent Wrap network.

Primary Care Physicians (PCP) Selection

- Each member must select a network PCP at the time of enrollment or we assign one on their behalf. A PCP is defined may be a physician specializing in family practice, internal medicine, pediatrics, or general practice, as well as other specialties if required by state law.
- Some PCPs have multiple TINs but may not participate under each of those TINs for the member’s benefit plan. Members are required to see their PCP or their covering physician at the address location that shares the same TIN listed on the Link eligibility application. (Verifying Eligibility, Benefits, and Your Network Participation Status section in Chapter 2: Provider Responsibilities and Standards.) Prior to scheduling appointments, be sure to verify that you are the member’s assigned PCP and the TIN listed for the member is the same TIN for the address location where the member will be seen. Submit your address corrections through the Provider Data Management application on Link, or call the phone number on the back of the member’s health care ID card before seeing the member.

There are three ways to identify the member’s assigned PCP:

- **Online:** Using eligibility application on Link (requires login)
- **EDI:** Transactions 270/271 through your vendor or clearinghouse
- **Phone:** 877-842-3210

HRAs and HSAs Consumer-Driven Health Benefit Plans

Consumer-driven health care is a term used to describe health benefit plans intended to help members become more informed and careful about their health care choices and take control over their health and health care purchases. These benefit plans are identified on the health care ID card or by checking the eligibility application on Link.

The key concepts associated with consumer-driven health benefit plans include:

1. The member responsibility, which is the amount members pay from their own pockets for the deductibles, copayments and co-insurance payments required by their benefit plans, up to the out-of-pocket maximum.

2. An account that helps members pay the out-of-pocket expenses on a pre-tax basis. The account can either be a health savings account (HSA) or a health reimbursement account (HRA).
3. Health coverage that pays benefits after members meet the deductible and that pays 100% of network preventive care services.

4. Information resources that help members make informed decisions and also provide useful information about physicians and health care professionals who are in the network, the cost of health care services, and options for accessing health care that may save them money.

**HRAs and HSAs are similar in many ways:**
- They are both a type of medical savings account.
- The medical benefit includes a deductible; however members typically use their HSA or HRA to pay out-of-pocket expenses until they meet the deductible. The benefit plans include an out-of-pocket maximum and, once met, 100 percent of covered services, including pharmacy benefits, are covered.
- The benefit plans encourage routine preventive care and eligible services are covered under the basic medical benefit and are not subject to the deductible.

**HRAs and HSAs differ in that:**
- HRAs are most often funded by the employer.
- HSAs are most often funded by the employee.
- With HSAs, if members do not have sufficient funds in their account, or choose to save those funds for a later date, they pay any remaining cost share out-of-pocket. The HSA belongs to the account holder even if they change employers. The Internal Revenue Service allows annual deposits that can equal the benefit plan’s deductible.
UnitedHealthcare Medicare Solutions offers Medicare Advantage benefit plans for Medicare eligible individuals and employer group retirees. If a member presents a health care ID card with a product name with which you are not familiar, please contact the United Voice Portal at 877-842-3210 for a product list. Product lists are provided for your convenience and are subject to change at any time.

This guide does not apply to UnitedHealthcare Medicare Direct, our Medicare Advantage Private Fee-for-Service product, which does not use a contracted provider network. For information about UnitedHealthcare MedicareDirect, go to: UnitedHealthcareOnline.com > Tools & Resources > Medicare > Private Fee-For-Service (PFFS).

**Medicare Product Overview Tables**

**Medicare Advantage – Products for Individuals**

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Medicare Member’s Eligibility</th>
<th>How do members access physicians and health care professionals?</th>
<th>Does a primary care physician have to make a referral to a specialist?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>HMO and HMO-POS plans under the UnitedHealthcare or AARP brands:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO • MedicareComplete • MedicareComplete Essential</td>
<td>Members who are Medicare eligible</td>
<td>Members choose a PCP from the network of physicians who can help coordinate their care. HMO-POS benefit plans provide out-of-network coverage for some covered benefits.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td>A referral may or may not be required to see a specialist, depending on the benefit plan. ** Yes, see guidelines in Chapter 6: Medical Management.</td>
<td></td>
</tr>
<tr>
<td>HMO-POS • MedicareComplete Plus</td>
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<td></td>
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<tr>
<td>Local PPO and Regional PPO (RPPO) benefit plans under the UnitedHealthcare or AARP brands:</td>
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<td></td>
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</tr>
<tr>
<td>• MedicareComplete Choice • MedicareComplete Choice Essential</td>
<td>Members who are Medicare eligible</td>
<td>Members choose a PCP from the network of physicians who can help coordinate their care. PPO benefit plans provide out-of-network coverage for all covered network benefits.*</td>
<td>No, a referral is not needed. Yes, see guidelines in Chapter 6: Medical Management.</td>
<td></td>
</tr>
<tr>
<td>Local PPO and RPPO benefit plans under the Care Improvement Plus name:</td>
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<td></td>
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<tr>
<td>• Care Improvement Plus Medicare Advantage</td>
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</tr>
<tr>
<td>Institutional Special Needs Plans (HMO, HMO- POS, PPO) • UnitedHealthcare Nursing Home Plan • UnitedHealthcare Assisted Living Plan</td>
<td>Members reside in a contracted skilled nursing facility or assisted living communities and require an institutional level of care.</td>
<td>Members choose a PCP from the network of physicians to coordinate their care. PPO and HMO-POS benefit plans provide out-of-network coverage.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td>No, a referral is not needed. Yes, see guidelines in Chapter 6: Medical Management.</td>
<td></td>
</tr>
</tbody>
</table>

* The benefit level for non-emergency services from non-network physicians and other care providers is generally less than that for services from network physicians and other care providers.

** Most services provided to members of gatekeeper benefit plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement. See Medicare Advantage Referral Required Plans in Chapter 5 for more information.
# Chapter 4: Medicare Advantage Products

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Medicare Member’s Eligibility</th>
<th>How do members access physicians and health care professionals?</th>
<th>Does a primary care physician have to make a referral to a specialist?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Special Needs Plans (HMO, PPO and Regional PPO)</td>
<td>Members who are both Medicare and Medicaid eligible.</td>
<td>Members choose a PCP from the network of physicians, to coordinate their care. POS and PPO benefit plans provide out-of-network coverage.*</td>
<td>A referral may or may not be required to see a specialist, depending on the benefit plan. For further information, see UnitedHealthcareOnline.com &gt; Tools &amp; Resources &gt; Medicare. Or call 877-842-3210. Please have the health care ID card and your TIN available. PCPs should coordinate care with the appropriate network specialists.</td>
<td>Yes, see guidelines in Chapter 6: Medical Management.</td>
</tr>
<tr>
<td>Chronic Special Needs Plans (PPO and Regional PPO)</td>
<td>Members who have one or more of the following qualifying chronic conditions: diabetes, chronic heart failure, and/or cardiovascular disorders.</td>
<td>Members choose a PCP from the network of physicians who can help coordinate their care. PPO benefit plans provide out-of-network coverage for all covered network benefits.*</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in Chapter 6: Medical Management.</td>
</tr>
<tr>
<td>Erickson Advantage Plans</td>
<td>Members who reside in an Erickson Retirement Community.</td>
<td>Members are assigned a PCP from the Erickson Health Medical Group network of physicians. The primary physician coordinates their care. Erickson Advantage provides out-of-network coverage.*</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in Chapter 6: Medical Management.</td>
</tr>
</tbody>
</table>

## Medicare Solutions Products for Groups

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Member’s Eligibility</th>
<th>How do members access physicians and health care professionals?</th>
<th>Does a primary care physician have to make a referral to a specialist?</th>
<th>Is the treating physician and or facility required to give notice when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Group Medicare Advantage (HMO)</td>
<td>Members meet employer’s requirements.</td>
<td>Members choose a PCP from the network of physicians. The primary physician coordinates their care. HMO benefit plans provide out-of-network coverage for some covered benefits.*</td>
<td>A referral may or may not be required to see a specialist based on the benefit plan.*</td>
<td>Yes, see guidelines in Chapter 6: Medical Management of this guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Group Medicare Advantage Plans (Regional PPO)</td>
<td>Members meet employer’s requirements.</td>
<td>Members may choose a primary care physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care. Regional PPO plans provide out-of-network coverage.*</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in Chapter 6: Medical Management of this guide.</td>
</tr>
</tbody>
</table>
# Responsibilities of Medicare Select Members

Medicare Select members are required to use participating facilities for all inpatient and outpatient medical services (except emergency care and services provided when members are outside of their service area). If Medicare Select members do not use a participating facility for inpatient or outpatient services, the services may not be covered unless required by law.

## Primary Care Physicians (PCP) Selection

Members are required to select a network PCP or one is automatically assigned in order for the member to receive the highest level of benefits. Prior to scheduling appointments, it is important to verify that you are the member’s assigned PCP on the Patient Eligibility screen. If you are not the assigned PCP, please have the member contact the number on the back of their health care ID card.

## Changing PCP

Members may elect to change their PCP at any time. Changes submitted to UnitedHealthcare are generally effective on the first day of the following month. Referrals previously submitted by the member’s PCP are not affected by the change in PCP.

## Hospital Responsibilities

Participating hospitals agree to a reduced or waived reimbursement of the Medicare Part A Inpatient Hospital deductible. Cost savings associated with hospitals’ reduction/waiver of Medicare’s Part A Inpatient Hospital deductible contribute to lower premium costs for members. To submit a Medicare Part A claim for a Medicare Select member, mail a completed copy of the UB-04 claim form, or submit the electronic equivalent, along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

UnitedHealthcare Claim Division  
P.O. Box 740819  
Atlanta, GA 30374-0819

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* The benefit level for non-emergency services from non-network physicians and other care providers is generally less than that for services from network physicians and other care providers.

** Most services rendered to members in gatekeeper benefit plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement. See UnitedHealthcareOnline > Medicare > Medicare Advantage Referral Required Plans for more information.

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To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the member’s 11-digit AARP membership number.

## Medicare Supplement Benefit Plans

### AARP Medicare Select Benefit Plans

Medicare Select is a Medicare Supplement product available only to AARP members who reside within the service area of a hospital that participates in our Medicare Select network.

### Medicare Select Plans C & F

In addition to coverage for the Medicare Part A Inpatient Hospital deductible, Medicare Select Plans C & F reduces member out-of-pocket expenses by providing coverage for:

- Inpatient Hospital Part A coinsurance for days 61 through 90 in a Medicare Benefit Period
- Inpatient Hospital Part A coinsurance for days in which Lifetime Reserve days are used. Original Medicare covers up to 90 days in a hospital per benefit period and offers an additional 60 days of coverage with a higher coinsurance. Each reserve day can be used only once during a member’s lifetime. They do not have to be applied towards the same hospital stay but may be used for various hospital stays in a given lifetime.
- Medicare Part A eligible expenses for a Lifetime Maximum of 365 days after all Medicare Part A benefits are exhausted
- Medicare Part B coinsurance (which is generally 20% of Medicare’s approved amount)
- Medicare Part B deductible amount applied each calendar year
- The daily coinsurance amount for days 21 to 100 for Skilled Nursing Facility stays eligible under Medicare.
- Charges incurred as a part of Medicare Parts A and B Blood deductible for the first 3 pints of un-replaced blood furnished in a calendar year
- Foreign travel emergencies
- Hospice Care and Respite Care Medicare copayments and coinsurance
Additionally, Select Plan F provides coverage for Medicare Part B Excess Charges for Medicare approved services.

**Medicare Select Benefit Design**

Under AARP Medicare Select Plans C and F, neither inpatient hospital stays, nor outpatient hospital services, are covered unless they are received at a participating hospital. The participating hospital agrees to a reduced reimbursement of Medicare’s Part A deductible. UnitedHealthcare reimburses all other Medicare Part A eligible expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare. If a non-participating hospital provides inpatient or outpatient services to a Medicare Select insured member the services are not covered.

More than 90% of all claims are payments to hospitals are processed within 10 business days.

All Medicare Select Plans meet “Safe Harbor” requirements under federal Anti-Kickback legislation. For more information on our AARP Medicare Select Plans and other AARP Medicare Supplement Plans, contact us at 800-523-5800, (para Español 800-822-0246). For TTY/TDD hearing impaired, use your TTY machine and call 711 or you can access services through the National Relay Center at 800-828-1120.

**Coverage Policies and Guidelines**

Covered benefits, limitations and exclusions are specified in the UnitedHealthcare Medicare Advantage Plan Evidence of Coverage (EOC) and Summary of Benefits (SB). UnitedHealthcare Medicare Advantage Coverage Summaries and Policy Guidelines are policies based on current Medicare National Coverage Determinations, Local Coverage Determinations, UnitedHealthcare Medical Policies, and applicable UnitedHealthcare Medicare Advantage Plan EOCs and SBs. Benefit interpretations for UnitedHealthcare Medicare Advantage Plan members are made on a case-by-case basis using these policies. The policies are subject to change based upon changes in Medicare’s coverage requirements, evidence based clinical information, and technology and evolving practice patterns. Care providers are responsible for reviewing the CMS Medicare Coverage Center guidance. If there is a conflict between our policies and the CMS Medicare Coverage Center guidance, the CMS Medicare Coverage Center guidance controls. UnitedHealthcare Medicare Advantage Coverage Summaries and Policy Guidelines are available at: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries.

**Coverage Summary Updates**

UnitedHealthcare publishes monthly editions of the “Medicare Advantage Coverage Summary Update Bulletin”, an online resource that gives network physicians and facilities notice of any change to our Medicare Advantage Coverage Summaries. The bulletin is posted on the first calendar day of every month at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries > Update Bulletin. As a supplemental reminder to the detailed policy update summaries announced in the Medicare Advantage Coverage Summary Update Bulletin, a list of recently approved, revised and/or retired Coverage Summaries is also provided in the monthly Network Bulletin at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > News & Network Bulletin.

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**Hierarchies of References/Resources**

UnitedHealthcare Medicare Advantage Coverage Summaries and Policy Guidelines are developed using the following references/resources:

2. Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC)
3. UnitedHealthcare Commercial Medical Policies/ Coverage Determination Guidelines
Chapter 5: Referrals

Specialist Referrals
The member’s assigned PCP coordinates the member’s care and submits electronic referrals to us before the member sees another network physician (a network physician that is not within the same tax ID).

Referrals are valid for any care provider within the same TIN as the specialist included on the referral.

You should submit referrals when required, even if the specialist’s TIN is not known.

Commercial Products Referrals
These referral requirements apply to covered services provided to commercial members enrolled in the below benefit plans:

• Navigate, Navigate Balanced, Navigate Plus
• Charter, Charter Balanced, Charter Plus
• Compass, Compass Balanced, Compass Plus
• NexusACO R, NexusACO RB, NexusACO RP

If referral requirements for the specialists are not followed, the network specialist and associated facility services may not be covered or may have higher member cost shares.

For services requiring a referral:

• Navigate, Charter, Compass and Nexus ACO R have no coverage if the referral is not obtained.
• Navigate, Charter, Compass and Nexus ACO R (Balanced and Plus versions) have a higher member cost share if the required referral is not obtained.

Online Referral Submission & Status Verification

Use the referral or eligibility applications on Link for referral submissions and status information. You can see existing referrals for a member when verifying eligibility on Link.

Managing Referrals for Commercial Benefit Plans
Specialists and facilities must confirm the status of a referral before each member visit. For planned admissions and outpatient services rendered by a physician, facilities must confirm the servicing physician has a referral to see the member, otherwise, the facility claim may not be covered or the member may incur significantly higher cost share. Referrals are made to the specialist rendering the service or to the facility where the services are performed. A list of referrals related to the member is available on Link when verifying the member’s eligibility.

• Referrals are only valid for the authorized number of visits or through the indicated referral end date. Any unused visits are no longer valid after the end date of the referral.
• If a referral is no longer valid, but additional care is needed, the member or specialist must contact the member’s PCP to request a new referral. The PCP then decides whether to issue an additional referral.
• If a network specialist identifies the need for a member to see another specialist, the specialist must ask the member’s PCP, who decides whether or not to issue an additional referral.

Commercial Benefit Plan Services Not Requiring a Referral
Referrals are not required for the following services:

• Any services from network physicians in the same TIN as the member’s PCP or their covering network physicians
• Any services from a network OB/GYN specialists, nurse practitioners, nurse midwives, and physicians assistants
• Routine refractive eye exam from a network care provider
• Network optometrists
• Mental health/substance use services with network behavioral health clinicians
• Services rendered in any emergency room, network urgent care center, network convenience care clinic or designated network online “virtual clinic visits”
• Services billed as Observation
• Admitting physician services for emergency/unscheduled admissions
• Any services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons
• Any services from a network pathologist, network radiologist or network anesthesia physician.
• Outpatient network lab, network, x-ray, or network diagnostic services (Services billed by a network specialist require referral.)
• Network rehabilitative services with exception of manipulative treatment and vision therapy (physician services)
• Any other services for which applicable law does not allow us to impose a referral requirement

Referral Submission Requirements (Commercial)
Referrals must be submitted electronically by the member’s PCP on Link using either the referral application or the eligibility application or EDI278R transactions.

• Once submitted, referrals are effective immediately and are viewable online within 48 hours.
• Referrals cannot be accepted by phone, fax or paper, unless state law requires us to accept referrals in one of these ways.
• Referral submissions may be backdated up to five calendar days from the date of submission.
• Web users must have access to the Referral Submission role on their user profile to submit and verify referrals.
• Only the member’s PCP or other PCP practicing under the same TIN can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

**Referral and Prior Authorization/Notification Impacts**

When a specialist performs a service that requires prior authorization or notification, the specialist must follow the notification requirements as outlined in this guide. The referral is not a substitution for following the advance notification/prior authorization process.

For planned admissions, the facility admission will be denied or have significantly higher member cost share if a referral is not on file for the member to see the servicing specialist.

**Maximum Referral Visits**

The PCP may submit up to six visits. Any unused visits expire after six months. For members with the following chronic conditions, the PCP may submit 99 visits for up to six months. Conditions eligible for standing referrals of up to 99 visits are:

- AIDS/HIV
- Anemia
- Cancer
- Cystic Fibrosis
- Schizophrenia spectrum and other psychotic disorders
- Parkinson’s Disease
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Epileptic Seizure
- Myasthenia Gravis
- Glaucoma
- Retinal detachment
- Thrombotic Microangiopathy
- Allergic Rhinitis
- Renal Failure (acute)
- Seizure
- Fracture Care

**Non-Participating Care Provider Referrals (All Commercial Plans)**

When services are not available from a network care provider, the member’s PCP, direct access care provider or referred network specialist can submit a request for an out-of-network review. If approved, services rendered by the non-participating care provider are covered at the network benefit level. The request can be made by calling the number on the back of the member’s health care ID card. We review the request and determine whether or not a network care provider is available to treat the member’s condition and whether eligible services are covered at the network benefits level.

We send a written confirmation with the final decision to the requesting care provider and the member.

**Before Submitting a Request for Services From a Non-Participating Care Provider:**

1. Confirm there is no network care provider available by searching on the [Physician Directory](#).
2. If a network care provider is not available, determine if the W500 icon appears on the back of the member’s health care ID card.
   a. If W500 is indicated, search for a network care provider in the W500 Emergent Wrap directory. To access the W500 Emergent Wrap directory:
      ii. If a W500 Emergent Wrap care provider is found submit a request for coverage for the member to see the care provider participating in the W500 Emergent Wrap Network.
   b. If W500 is not indicated on the back of the member’s health care ID card or if a network care provider is not found in the W500 Emergent Wrap Directory, proceed with submitting a notification request for the member to see a non-participating care provider outside of the W500 network.
Chapter 5: Referrals

Medicare Advantage Referral Required Plans

For a list of Medicare Advantage Referral Required Plans, go to UnitedHealthcareOnline > Tools & Resources > Medicare > Referral Required Plans (scroll to the bottom left web part).

The Medicare Advantage benefit plans that require a referral focus on coordination of care through the member’s PCP with referrals required to specialists and rehabilitation centers. Referral Required Plans are network-only benefit plans where members must have a referral from their PCP to receive network benefits for services from any specialist who is not practicing under the same TIN as their PCP. If members seek care from a specialist without a referral, there is no payment for the services. The liability for the claim falls to the care provider. The member cannot be billed for such services. Referral required benefit plans also require prior authorization for some services by UnitedHealthcare or delegated entity for selected services, as referenced in this guide. A referral is not a substitute for notification.

The referral language is displayed on the front of the health care ID cards. You can also see whether a referral is required by using the eligibility application on Link. For more detailed information on health care ID cards and to see a sample health care ID card, please refer to the Health Care Identification (ID) Cards section of Chapter 2: Provider Responsibilities and Standards.

Medicare Advantage Services Not Requiring a Referral*

The following is a list of services that do not require a referral. However, some of these services may require prior notification or authorization.

- Any service provided by a network PCP
- Any service provided by a network physician practicing under the same tax ID as the member’s assigned PCP
- Any service from a network OB/GYN, chiropractor, optometrist, ophthalmologist, optician podiatrist, audiologist, oncologist, nutritionist, or disease management and infectious disease specialist
- Services performed while in observation
- Allergy immunotherapy
- Mental health/substance use services with behavioral health clinicians
- Any service from a pathologist or anesthesiologist (excludes office-based or pain management services), and any inpatient consulting physicians including hospitalists
- Services rendered in an emergency room, emergency ambulance, or a network urgent care center or convenience clinic

Referral Submission Requirements

Referrals must be submitted electronically by the member’s assigned PCP using the eligibility application on Link, or to the delegated entity’s website shown on the back of the member’s health care ID card.

Referral submissions may be entered on Link with a start date with a start date of five or fewer calendar days prior to the date of entry. Referrals are effective immediately once submitted. This is viewable online within 48 hours from submission. If referral requirements are not followed the claim is denied and you cannot bill the member.

Maximum Referral Visits

The PCP determines the number of visits necessary for each referral for a six months period. After the initial visits are used (or if unused visits expire), the PCP may submit another referral to the network specialist. Services rendered under a new referral are considered established patient encounters.

Referral Status

Specialists are expected to confirm the existence of a referral (specific to the specialist’s TIN) before seeing the member. A list of existing referrals can be viewed using the eligibility application on Link, including information on the network specialist to whom the referral is made, number of visits authorized and number of visits remaining.

Referrals and Notification requirements-Medicare Advantage Referral Required Plans

The physician performing a service that requires notification, has the responsibility to follow our advance notification or prior authorization process (see Chapter 6: Medical Management). This process is in addition to the referral submission process. If a referral has not been obtained, coverage is denied for no referral on file. All other protocols and guidelines outlined in this guide apply to the Medicare Advantage Referral Required Plans.

** Applies to select Medicare Advantage benefit plans.
The purpose of the UnitedHealthcare Medical Management Program is to determine if medical services are:

- Covered under the member’s benefit plan;
- Clinically necessary and appropriate; and
- Performed at the most appropriate setting for the member.

Benefit Plans Not Subject to this Protocol

Please refer to the Additional Guide, Manual or Supplement in the Benefit Plans Subject to this Guide section for additional details. Some benefit plans may have separate advance notification and prior authorization requirements.

### Excluded Plans (Benefit Plans Not Subject to this Protocol*)

- UnitedHealthcare Options PPO (Care providers are not required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization. However, care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado, because Colorado members are not responsible for providing notification or requesting prior authorization).
- UnitedHealthcare Indemnity
- UnitedHealthOne - Golden Rule Insurance Company (“GRIC” group number 705214)
- All Savers products offered off-Exchange
- M.D.IPA, Optimum Choice or OneNet
- Neighborhood Health Partnership (NHP)
- Oxford Commercial, except for UnitedHealthcare Oxford Navigate benefit plans
- Benefit plans subject to the River Valley Entities Supplement.
- UnitedHealthcare West or UHC West
- UnitedHealthcare Community Plan Medicare Advantage benefit plans
- Plans subject to an additional guide or supplement. (see Chapter 1.) (As explained in the in the Benefit Plans Subject to this Guide section, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an additional guide, manual or supplement and, therefore, are subject to this guide and this notification program.)
- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither commercial nor Medicare Advantage.

The advance notification requirements outlined in this Protocol do not apply to services subject to the following Protocols, each of which are addressed in separate sections later in this guide:

- Cardiology Notification/Prior Authorization Protocol.
- Laboratory Services Protocol.
- Laboratory Benefit Management Program Administered by BeaconLBS™.

### Advance Notification vs. Prior Authorization

Advance notification is the first step in the coverage determination process and for case and condition management program referrals. Information received about planned medical services supports the processes of pre-service clinical coverage review and care coordination. Advance notification helps to support our members’ needs throughout their course of treatment, from pre-service planning to coordination of discharge planning needs.

Advance notification is required for services listed on the UnitedHealthcare Advance Notification Lists.

For some commercial benefit plans, and for all Medicare Advantage benefit plans, prior authorization is required to verify whether the services are medically necessary and are covered. Once you notify us of a planned service that is on the Advance Notification/Prior Authorization List, we inform you as to whether a clinical coverage review, as outlined in our prior authorization process, is required in order for the service to be covered under the member’s benefit plan. We also advise you of the required information necessary to complete the clinical coverage review, according to our prior authorization process. You are notified of our coverage decision within the time required by applicable law. Requiring advance notification for specific services does not indicate or imply the service is a covered benefit. Coverage is determined by the member’s benefit plan.

In the event of a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

### Advance Notification/Prior Authorization Requirements

- Physicians, health care professionals and ancillary care providers are responsible for providing advance notification or requesting prior authorization for services listed on the Advance Notification/Prior Authorization List as further explained below.
- Members may be required to obtain prior authorization for out-of-network services. Physicians, health care professionals and ancillary care providers are responsible for directing members to care providers within the member’s health plan network.
- Facilities are responsible, prior to the date of services, for confirming coverage approval is on file as further explained below.
- Facilities are responsible for admission notification for inpatient services even if coverage approval is on file as further explained below.
- If advance notification or prior authorization requirements are not followed, claims may be denied in whole or in
part and, as required under your agreement with us and the member cannot be billed for the service.

- Advance notification or prior authorization is valid only for the date of service or date range stated on the notification or prior authorization. If that specified date of service or date range has passed and the service(s) has not been delivered, you must submit a new advance notification or prior authorization request.

- Subject to state and federal regulations, including regulations pertaining to a care provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System (PECOS) list, and Medicare Advantage guidelines, the provision of advance notification or receipt of a prior authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon:
  - Coverage within an individual member’s benefit plan,
  - Whether you as the care provider are eligible for payment,
  - Any claim processing requirements, and
  - Your participation agreement with UnitedHealthcare.

See Coverage Determinations and Utilization Management Decisions section for additional details.

Information Required for Advance Notification/Prior Authorization Requests

Advance notifications or prior authorizations must contain the following information about the planned service:

- Member name and member health care ID number
- Ordering physician, health care professional or ancillary care provider name and TIN or National Provider Identification (NPI)
- Rendering physician or health care professional name and TIN or NPI
- ICD-10-CM diagnosis code for the diagnosis for which the service is requested
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service (when applicable)
- Service setting (e.g., inpatient, outpatient facility, ambulatory surgical center, physician office, home)
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease (ESRD) only)

If a clinical coverage review is required by the member’s benefit plan, we may request additional information in order to make the necessary determination, as described in more detail in the Clinical Coverage Review.

**Advance Notification/Prior Authorization List**

To view the most current and complete Advance Notification List, including procedure codes and associated services, go to: [UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements](https://www.UnitedHealthcareOnline.com).

The list of services that require advance notification and prior authorization is the same, and the process for providing notification and submitting a prior authorization request is the same. Services that require prior authorization also require clinical information, and a clinical coverage review based on medical necessity, and a coverage determination.

The Advance Notification/Prior Authorization List is provided online and is subject to change. You are informed of changes to this List through the Network Bulletin. (Please refer to the section titled Network Bulletin).

If you ask, we provide you with a paper copy of the Advance Notification/Prior Authorization List. Please contact your Network Management representative or Physician Advocate if you would like a paper copy of the Advance Notification/Prior Authorization List.

**When to Submit Advance Notification or Prior Authorization Requests**

Physicians, health care professionals and ancillary care providers are responsible for advance notification for planned services on the Advance Notification List. Additionally, members may be required to obtain prior authorization for out-of-network services. When you submit your request you receive a service reference number. This is not an authorization to proceed with the service. When a coverage determination is made, it is issued under this reference number.

You should submit advance notification with supporting clinical documentation as far in advance as possible, but at least two weeks before the planned service date is recommended (unless otherwise specified in the Advance Notification List) to allow enough time for coverage review. Following facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

It may take up to 15 calendar days to render a decision (14 calendar days for Medicare Advantage) particularly when required information is missing or incomplete. Prioritization of case review is based on the specifics of the case, the completeness of the information received, CMS requirements, or other state or federal requirements. Time may be extended if additional information is needed.

For services requiring expedited review, please call the telephone number on the member’s health care ID card (unless specified differently below). Expedited coverage
review for services that require advance notification or authorization prior to receiving medical care is available under certain circumstances. You must explain the clinical urgency when requesting an expedited review, and you are responsible for providing required clinical information in the same calendar day. Expedited review is available when:

- The member’s medical condition could, in a very short time, seriously jeopardize the member’s life or health, or the ability to regain maximum function, or
- In the opinion of a physician with knowledge of the member’s medical condition, it could cause severe disabling pain.

## Facilities: Standard Notification Requirements (for most states*)

### Confirming Coverage Approvals

For any inpatient or outpatient service on the Advance Notification/Prior Authorization List (except when those services are provided to members of benefit plans identified as table below) prior to rendering the service the facility must confirm the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation. In cases where the service is not covered the member can then decide whether to receive and pay for the service.

If the facility fails to confirm that the coverage approval is on file and performs the service:

- If the service is determined not to have been covered under the member’s benefit plan, we may deny the facility’s claim for the non-covered service as provided under the facility’s agreement with us. The facility must not bill the member or accept payment from the member, due to the facility’s non-compliance with our notification protocols.
- If a coverage review is in process on the date of service as a result of the advance notification or prior authorization request and that coverage review ultimately determines the service to have been a covered service under the member’s benefit plan, we do not deny the facility’s claim despite the facility’s failure to take specific action to confirm the coverage approval.

### Facilities are responsible for Admission Notification for the following types of inpatient admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All Skilled Nursing Facility (SNF) admissions
- All admissions following outpatient surgery
- All admissions following observation
- All newborns admitted to Neonatal Intensive Care Unit (NICU)
- All newborns who remain hospitalized after the mother is discharged. Notice is required within 24 hours of the mother’s discharge.

Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission. For weekend and holiday admissions, notification must be received by 5 p.m. local time on the next business day.

Admission notification by the facility is required even if advance notification was supplied by the physician and a pre-service coverage approval is on file.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon the member’s benefit plan, the facility’s

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*For state specific variations, refer to UnitedHealthcareOnline.com > Tools and Resources > Policies, Protocols, and Guides > Advance and Admission Notification.
eligibility for payment, claim processing requirements, and the facility’s participation agreement with us.

Admission notifications must contain the following details regarding the admission:

• Member name, health care ID number, and date of birth
• Facility name and TIN or NPI
• Admitting/attending physician name and TIN or NPI
• Description for admitting diagnosis or ICD-10-CM diagnosis code
• Actual admission date

For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us by phone or fax within 24 hours (or the next business day, for weekend or holiday admissions) from the time the information is known, and communicate the extenuating circumstances. We do not apply any notification-related reimbursement deductions.

All Skilled Nursing Facility admissions for UnitedHealthcare Nursing Home and Assisted Living Plan members must be authorized by an Optum Care Plus nurse practitioner or physician’s assistant. Claims may be denied in part or in full if authorizations are not coordinated through Optum.

Reimbursement Reductions for Lack of Timely Admission Notification

Facilities must provide timely admission notification as follows or claims payments are denied in full or in part:

<table>
<thead>
<tr>
<th>Admission Timeframe</th>
<th>Reimbursement Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission notification received after it was due, but not more than 72 hours after admission.</td>
<td>100% of the average daily contract rate1 for the days preceding notification.2</td>
</tr>
<tr>
<td>Admission notification received after it was due, and more than 72 hours after admission.</td>
<td>100% of the contract rate (entire stay).</td>
</tr>
<tr>
<td>No Admission Notification received.</td>
<td>100% of the contract rate (entire stay).</td>
</tr>
</tbody>
</table>

1 The average daily contract rate is calculated by dividing the contract rate for the entire stay by the number of days for the entire length of stay.

2 Reimbursement reductions are not applied to “case rate facilities” if admission notification is received after it was due, but not more than 72 hours after admission.

As used here, “case rate facilities” means those facilities in which reimbursement is determined entirely by a MS-DRG or other case rate reimbursement methodology for every inpatient service for all benefit plans subject to these Admission Notification requirements.

If advance notification or prior authorization is required but admission notification is not made by the facility in a timely manner, payment reductions are limited to facility room and board charges when applicable.

Inpatient Concurrent Review: Clinical Information

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

• Your cooperation is required with all UnitedHealthcare requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

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

Maryland State-Specific Notification Requirements for Facilities

If advance notification or prior authorization is required for the requested elective inpatient procedure, it is the physician’s responsibility to obtain the relevant approval. It is the responsibility of the facility to notify us within 24 hours (or the following business day if the admission occurs on a weekend or holiday) of the elective admission.
How to Submit Advance or Admission Notifications/Prior Authorizations

There are several ways to submit advance or admission notifications and requests for prior authorizations. Once an advance or admission notification or prior authorization is submitted and confirmation is received, please do not resubmit.

- Notify us using online functions. [UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorization Submission](#).

We accept daily composite census logs for inpatient admissions by fax (see fax numbers in the following table).

If you do not have electronic access, please call us at the number on the member’s health care ID card.

<table>
<thead>
<tr>
<th>Method</th>
<th>EDI 278 Transactions</th>
<th>Link/UnitedHealthcareOnline.com</th>
<th>Live Call</th>
<th>VoiCert</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>12 different EDI submissions available directly to UnitedHealthcare or through a clearinghouse.</td>
<td>Vendor website UnitedHealthcareOnline.com.</td>
<td>Phone submission directly to UnitedHealthcare through 877-842-3210 (Option 3) OR dial the number provided on Member’s health care ID card. For Erickson Advantage, call Erickson Campus Customer Service number on the member’s health care ID card.</td>
<td>Phone submission through assigned 800 number specific to facility.</td>
<td>Commercial members: 866-756-9733; Medicare Advantage members: 800-676-4798; Medicare Special Needs Plan members: 800-538-1339.</td>
</tr>
</tbody>
</table>

**Business Hours (all times Eastern)**

- Monday – Friday: 7 a.m. to 2 a.m.
- Saturday: 7 a.m. to 6 p.m.
- Sunday: 7 a.m. to 6 p.m.
- Holidays: Same as above

<table>
<thead>
<tr>
<th>Monday – Friday: 7 a.m. to 8 p.m.</th>
<th>Saturday: 9 a.m. to 6 p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday: 9 a.m. to 6 p.m.</td>
<td></td>
</tr>
<tr>
<td>Holidays: Same as above</td>
<td></td>
</tr>
</tbody>
</table>

- UnitedHealthcareOnline.com: Generally available 24 hours per day, seven days a week. Maintenance is scheduled outside of the following hours: Monday – Friday: 6:30 a.m. to 12 a.m. Saturday: 7 a.m. to 6 p.m. Sunday: 7 a.m. to 5 p.m. Holidays: Same as above

- VoiCert can be used 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.

- Faxes can be sent 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.

**Updating Advance Notification or Prior Authorization Requests**

Update or provide additional information related to an advance notification submission or prior authorization request before a coverage decision is made regarding the service. Once an approval has been given, the only update that can be made is to the date of service, as long as the original date of service has not passed, (on UnitedHealthcareOnline.com or by phone). Otherwise you must submit a separate advance notification or prior authorization. If you receive an adverse determination, you may not make any changes in the request. If you don’t agree with the decision, you may submit an appeal following the steps outlined in the Adverse Determination Letter you received.

No updates can be made to an existing advance notification or prior authorization after the service has been delivered. If during the service, you perform an additional or different service than was originally approved, submit the supporting clinical information for the service at the time of claim submission for prompt adjudication of your claim.
Coverage Determinations and Utilization Management Decisions

At UnitedHealthcare, and all of its affiliated companies, and delegates, all applicable coverage decisions on health care services are based on the member’s benefit documents and applicable state and federal requirements. For commercial members, this includes the contract the member’s employer plan sponsor has with UnitedHealthcare. For Medicare Advantage members, this also includes National Coverage Determinations, Local Coverage Determinations, Medicare Benefit Policy Guide (CMS publication 100-02), and general Medicare guidelines.

UnitedHealthcare employees, contractors, or delegates involved in making these coverage decisions are not compensated or otherwise rewarded for issuing non-coverage decisions. UnitedHealthcare and our delegates do not offer incentives to physicians or utilization management decision makers to encourage underutilization of care or services or to encourage barriers to care and service. Hiring, promoting or terminating employees or contractors is not based upon the likelihood or the perceived likelihood that the individual supports or tends to support denying benefits.

We use tools (e.g. Medical Policies, or coverage determination documents (CDGs)) third party resources, such as the MCG® Care Guidelines, (formerly known as Milliman Care Guidelines®) or other guidelines, to assist us in administering health benefits, to determine coverage and to assist clinicians in making informed decisions in many healthcare settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and are not equivalent to the practice of medicine or medical advice.

For Medicare Advantage members, if MCG other guidelines or any other medical policies or CDGs contradict CMS Guidance, including National Coverage Determinations and Local Coverage Determinations, then we follow CMS guidance. In some cases for Medicare Advantage members, if a pre-service clinical coverage review is not performed, Medicare guidelines, including National Coverage Determination and Local Coverage Determination guidelines may be utilized to perform a clinical review when the claim is received.

You can obtain copies of the CDGs, Medical Policies, and the UnitedHealthcare Medicare Advantage Coverage Summaries online at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Policies.

You can request a copy of the clinical criteria used to make coverage determinations by calling the telephone number included in an Adverse Determination Notice.

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Medical Policies, Drug Policies and Coverage Determination Guidelines for Commercial Members

UnitedHealthcare has developed Medical Policies, Drug Policies, and Coverage Determination Guidelines to assist us in administering health benefits. These policies and guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

- **Medical and Drug Policies** express our determination of whether a health service (e.g., test, drug, device or procedure) is proven to be effective based on the published clinical evidence. They are also used to decide whether a given health service is medically necessary. Services determined to be experimental, investigational, unproven, or not medically necessary by the clinical evidence are typically not covered.

- **Coverage Determination Guidelines** are used to determine whether a service falls within a benefit category or is excluded from coverage. Coverage Determination Guidelines may address such matters as whether services are skilled versus custodial, or reconstructive versus cosmetic.

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 that may require coverage for a specific service. The enrollee’s benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the enrollee’s specific benefit document supersedes these policies and guidelines.

Medical Policies, Drug Policies and Coverage Determination Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. The information presented in these policies and guidelines is believed to be accurate and current as of the date of publication, and is provided on an “as is” basis. Additionally, UnitedHealthcare may use tools developed by third parties, such as the MCG® Care Guidelines to assist us in administering health benefits.

**Medical Policy updates**


**Pre-Service Appeals**

Although most of the appeals submitted by care providers are post service, (defined as a request to change a claim denial or reduction of payment for services already received by the member), there are cases when the care provider contacts the insurance company to obtain authorization prior to providing services. A pre-service appeal is defined as a request to change a planned denial of coverage for proposed healthcare service. The pre-service appeal process is governed by the member’s rights under the member’s benefit plan. You should request an urgent pre-service appeal on behalf of the member by using the urgent fax line number provided in the pre-service denial letter, for the following:

1. When the standard review timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or

2. In the opinion of the practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

For cases that do not involve either of the scenarios referenced above, you should submit a pre-service appeal request using the standard fax line, or mail the request to the applicable address, set forth in the pre-service denial letter. An expedited or urgent appeal is not available when services have already been rendered. All cases that can wait the standard appeal turn-around time should use the standard fax line or mail the request to the applicable address.
Cardiology Notification/Prior Authorization Protocol

This protocol applies to commercial and Medicare Advantage benefit plans, but does not apply to the following commercial or Medicare Advantage benefit plans, or other benefit plan types, including Medicare, CHIP, or Uninsured benefit plans. The benefit plans listed below may have separate cardiology notification or prior authorization requirements. Refer to Chapter 1: Introduction for additional details.

Commercial Benefit Plans Not Subject to This Protocol

**UnitedHealthcare Options PPO** (Care providers are not required to follow this protocol for Options PPO benefit plans because Members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization. Exception: Care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado because Colorado members are not responsible for providing Notification/requesting prior authorization).

**UnitedHealthOne Individual Plans – Golden Rule Insurance Company** (“GRIC”) group number 705214 only

M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement), or OneNet PPO

**Oxford** (USA, New Jersey Small Group, certain NJ public Sector groups, CT public Sector, Brooks Brothers (BB1627) and Well, Gotshal and Manages (WG00101), any member at VAMC facility.)

UnitedHealthcare Indemnity / Managed Indemnity

Benefit plans sponsored or issued by certain self-funded employer groups

Medicare Advantage Benefit Plans Not Subject to This Protocol

**Hawaii**: AARP® MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008

**New York**: AARP® MedicareComplete Plan 1 - Group 66074, AARP® MedicareComplete Plan 2 - Group 13012, AARP® MedicareComplete Essential - Group 66075, AARP® MedicareComplete Mosaic - Group 66076. Continue the existing process of obtaining authorization from Montefiore Care Management Organization (CMO).

**Utah**: AARP® MedicareComplete Plan 1 - Group 42000, AARP® MedicareComplete Essential - Group 42004, UnitedHealthcare Group Medicare Advantage - Group 42020, AARP® MedicareComplete Plan 2 - Group 42022, UnitedHealthcare® MedicareComplete Choice – Group 42023

**UnitedHealthcare Community Plan Medicare Advantage benefit plans** subject to an additional manual, as further described in Chapter 1: Introduction.

Erickson Advantage® Plans

UnitedHealthcare Assisted Living Plan

UnitedHealthcare Nursing Home Plan (HMO SNP, HMO-POS SNP, PPO SNP)

UnitedHealthcare Senior Care Options (HMO SNP)

Senior Dimensions Medicare Advantage Plans

The Cardiology Notification/Prior Authorization Protocol applies to all participating care providers that order or render any of the following cardiology procedures:

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

Advance notification and prior authorization is required under this protocol only for these specified cardiology procedures:

- Diagnostic catheterizations, echocardiograms and stress echocardiograms: Notification or prior authorization is required only for outpatient and office-based services.
- Electrophysiology implants: advance notification or prior authorization is required for outpatient, office-based and inpatient services.

Cardiology procedures performed in, and appropriately billed with, any of the following places of service do not require notification or prior authorization:

- Emergency room visits,
- Observation unit,
- Urgent care or
- Inpatient stays (except for electrophysiology implants).

Cardiology procedures for which notification or prior authorization is required are referred to herein as ‘cardiac procedures’.

If the entire process described below is not completed before the cardiac procedure is performed a partial or whole administrative claim reimbursement reduction occurs. The member must be held harmless as required under your agreement with us.

For the most current listing of CPT codes for which notification and prior authorization is required pursuant to this protocol, refer to: UnitedHealthcareOnline.com > Clinician Resources > Cardiology.

Advance Notification/Prior Authorization Process Ordering Care Provider

The care provider ordering the cardiac procedure must provide notification by contacting us prior to scheduling the procedure.

Once we receive notification of a cardiac procedure and if the member’s benefit plan requires health services to be medically necessary in order to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary. You do not need to determine whether a clinical coverage review is required because once we receive notification, we will let you know.

We must be notified, or prior authorization must be requested, by contacting us as follows:
Chapter 6: Medical Management

• Online: UnitedHealthcare, UnitedHealthcare West, UnitedHealthOne, Neighborhood Health Partnership and UnitedHealthcare of the River Valley Commercial and Medicare Benefit Plans subject to this Protocol: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Cardiology.

• Phone: 866-889-8054

Non-participating care providers can provide notification and complete the prior authorization process if applicable either through UnitedHealthcareOnline.com, (once registered), or by calling 866-889-8054.

The information listed below may be requested at the time notification is provided:

Member Procedure Information:
• Member’s name, address, phone number and date of birth
• Member’s health care ID number and group number
• The examination(s) or type of service(s) being requested, with the CPT code(s)
• The working diagnosis with the appropriate ICD code(s)

Care Provider Information:
• Ordering care provider’s name, TIN/NPI, specialty, address, and phone number
• Care provider to whom the member is being referred, if specified, address and phone number
• Rendering care provider’s name and TIN/NPI (if different)

Clinical information:
• The member’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
• Dates of prior imaging studies performed.
• Any other information the ordering care provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

If the member’s benefit plan requires health services to be medically necessary in order to be covered:
• If the service is consistent with evidence-based clinical guidelines, a notification number is issued to the ordering care provider.
• If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we let the ordering care provider know whether they must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches.

If a physician-to-physician discussion is required, that process must be completed to help ensure eligibility to receive payment. Upon completion, the care provider confirms the procedure ordered and a notification number is issued. The purpose of the physician-to-physician discussion is to support the delivery of evidence-based health care by discussing evidence-based clinical guidelines. This discussion is not a prior authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

Receipt of a notification number or prior authorization number does not guarantee or authorize payment unless applicable regulations, including regulations pertaining to a care provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list, and Medicare Advantage guidelines require it. Payment for covered services depends upon:
• Coverage with an individual member’s benefit plan,
• The care provider being eligible for payment,
• Claims processing requirements, and
• The care provider’s participation with UnitedHealthcare.

The notification or prior authorization number is valid for 45 calendar days, and is specific to the procedure requested for one date of service within the 45 day period. When a notification/prior authorization number is entered for a procedure, we use the date the number was issued as the starting date for the 45 calendar day period in which the procedure must be performed. If the procedure is not performed within 45 calendar days, a new notification/prior authorization number must be requested.

* PECOS is the CMS online enrollment system where care providers and healthcare entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.
Urgent Requests During Regular Business Hours
The ordering care provider may make an urgent request for a notification or prior authorization number if they determine the service is medically urgent. Urgent requests must be made by calling 866-889-8054. The ordering care provider must state that the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within three hours of our receipt of all required information.

Retrospective Review Process for Urgent Requests Outside of Regular Business Hours
If the ordering care provider determines that a cardiac procedure is medically required on an urgent basis, and a notification/prior authorization number cannot be requested because it is outside of our normal business hours, the notification/prior authorization number must be requested retrospectively following the guidelines below.

For the following procedures, the retrospective review request must be made within two business days after the date of service:
- Echocardiograms and
- Stress echocardiograms.

For the following procedures, retrospective review request must be made within 15 calendar days following the date of service:
- A diagnostic catheterization or
- An electrophysiology implant

The retrospective review request must be made by calling 866-889-8054.

Documentation must include an explanation as to why the procedure was required on an urgent basis and why a notification/prior authorization number could not have been requested during our normal business hours.

- Once we receive notification of a cardiac procedure on a retrospective basis, if the member’s benefit plan requires services to be medically necessary in order to be covered, we conduct a clinical coverage review to determine whether the service is medically necessary. If the service is determined to be medically necessary, a prior authorization number is issued to the ordering care provider. If the service is determined not to be medically necessary, a clinical denial is issued (a prior authorization number is not issued) and the member cannot be billed for the service. For commercial members, the member and care provider receive a denial notice which includes information regarding the appeal process. For Medicare Advantage members, the denial notice, including information regarding the appeal process, is only sent to the care provider.

• If the rendering care provider determines there is no evidence of services.
• If a cardiac procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The member cannot be billed for the service.
• If the rendering care provider determines there is no notification number on file, and the ordering care provider participates in our network, we will use reasonable efforts to work with the rendering care provider to obtain the notification number from the participating ordering care provider prior to the rendering of services.

Claims are administratively denied if you do not obtain an advance notification or prior authorization number before rendering care or retrospectively.

Rendering Care Provider
Prior to performing a cardiac procedure, the rendering care provider must confirm with us that a notification number is on file, and if the member’s benefit plan requires that health services be medically necessary in order to be covered, the rendering care provider must validate that the prior authorization process has been completed and a coverage determination has been issued. If the rendering care provider finds a coverage determination has not been issued, and the ordering care provider is not a participating care provider, and is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the notification/prior authorization process and verify that a coverage decision has been issued in accordance with this protocol, prior to performing the service. Contact us at the phone number or online address set forth in the Ordering Care Provider section above if you need to notify us, request prior authorization, confirm that a notification number has been issued or confirm whether a coverage determination has been issued.

If the member’s benefit plan does not require that services be medically necessary in order to be covered:

• If a cardiac procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The member cannot be billed for the service.

If the member’s benefit plan does not require that services be medically necessary in order to be covered:

• If a cardiac procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The member cannot be billed for the service.
Chapter 6: Medical Management

• If the rendering care provider determines there is no notification number on file, and the ordering care provider does not participate in our network, and is unwilling to obtain a notification number, the rendering care provider is required to obtain a notification number.

• If the rendering care provider does not obtain a notification number for cardiac procedures ordered by a non-participating care provider, we administratively deny the claim, in part or in whole, for failure to provide notification. The member cannot be billed for the service.

If the member’s benefit plan does require services to be medically necessary in order to be covered:

• If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider is a participating care provider, we will use reasonable efforts to work with the rendering care provider to urge the ordering care provider to complete the prior authorization process and obtain a coverage decision prior to rendering the services.

• If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider is not a participating care provider, and is unwilling to complete the prior authorization process, the rendering care provider is required to complete the prior authorization process and verify that a coverage decision has been issued prior to rendering the service.

• If the rendering care provider provides the service before a coverage decision is issued, the rendering care provider’s claim is denied administratively, in part or in whole. The member cannot be billed for the service.

• Services that are not medically necessary are not covered under the member’s benefit plan. If the service is determined to be medically necessary, a prior authorization number will be issued to the rendering care provider. If the service is determined not to be medically necessary, a clinical denial is issued (a prior authorization number is not issued). The member and rendering care provider will receive a denial notice outlining the appeal process.

Crosswalk Table
Care providers are not required to modify the existing notification or prior authorization request, or request a new notification or prior authorization record for the CPT code combinations outlined in the Cardiology Notification/Prior Authorization CPT Code List and Crosswalk table, available online at UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification/ Prior Authorization.

For code combinations not listed on the Cardiology Notification/Prior Authorization CPT Code List and Crosswalk table, care providers must follow the Cardiology Notification/ Prior Authorization Protocol process outlined here.

Outpatient Radiology Notification/ Prior Authorization Protocol
This protocol applies to commercial members and Medicare Advantage members, but does not apply to the following commercial or Medicare Advantage benefit plans, or other benefit plan types including Medicaid, CHIP, or Uninsured benefit plans. The benefit plans listed below may have separate radiology notification or prior authorization requirements. Refer to Chapter 1: Introduction for additional supplements or health care provider guides that may be applicable.

Commercial Benefit Plans not Subject to These Requirements

| UnitedHealthcare Options PPO | (Care providers are not required to follow this protocol for Options PPO benefit plans because Members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization. Exception: Care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado. Colorado members are not responsible for providing notification or requesting prior authorization). |
| UnitedHealthOne – Golden Rule Insurance Company (“GRIC”) group number 705214 only | M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement), or OneNet |
| Oxford | (USA, New Jersey Small Group, certain NJ public Sector groups, CT public Sector, Brooks Brothers (BB1627) and Weil, Gotshal and Manages (WG00101), any member at VAMC facility.) |
| UnitedHealthcare Indemnity / Managed Indemnity | Benefit plans sponsored or issued by certain self-funded employer groups |
Medicare Advantage Benefit Plans not Subject to These Requirements

<table>
<thead>
<tr>
<th>State</th>
<th>Plans</th>
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<tbody>
<tr>
<td>Hawaii</td>
<td>AARP® MedicareComplete Choice Plan 1 - Group 77000 &amp; 77007 and AARP MedicareComplete Choice Essential - Group 77003 &amp; 77008</td>
</tr>
<tr>
<td>New York</td>
<td>AARP® MedicareComplete Plan 1 - Group 66074, AARP® MedicareComplete Plan 2 - Group 13012, AARP® MedicareComplete Essential - Group 66075, AARP® MedicareComplete Mosaic - Group 66076. Continue the existing process of obtaining authorization from Montefiore Care Management Organization (CMO).</td>
</tr>
<tr>
<td>Utah</td>
<td>AARP® MedicareComplete Plan 1 - Group 42000, AARP® MedicareComplete Essential - Group 42004, UnitedHealthcare Group Medicare Advantage - Group 42020, AARP® MedicareComplete Plan 2 - Group 42022, UnitedHealthcare® MedicareComplete Choice – Group 42023</td>
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UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an additional manual, as further described in Chapter 1: Introduction.

- Erickson Advantage® Plans
- UnitedHealthcare Assisted Living Plan
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)
- Senior Dimensions Medicare Advantage plans

Erickson Advantage Plans

UnitedHealthcare Assisted Living Plan

UnitedHealthcare Nursing Home Plan (HMO SNP, HMO-POS SNP, PPO SNP)

UnitedHealthcare Senior Care Options (HMO SNP)

Senior Dimensions Medicare Advantage Plans

This protocol applies to all participating care providers that order or render any of the following advanced imaging procedures:

- Computerized Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron-Emission Tomography (PET)
- Nuclear Medicine
- Nuclear Cardiology

Notification/prior authorization is required under this protocol only for advanced imaging procedures listed above.

Advanced imaging procedures for which notification/prior authorization is required is referred to herein as ‘Advanced Outpatient Imaging Procedures’.

Notification/prior authorization under this protocol is required for outpatient and office-based services only.

Advanced imaging procedures performed in, and appropriately billed with, any of the following places of service do not require notification/prior authorization:

- Emergency room visits,
- Observation unit,
- Urgent care or
- Inpatient stay.

If the entire process in this protocol is not completed before the procedure is performed, the administrative claim reimbursement is reduced or not paid. The member must be held harmless as required under your agreement with us.

For the most current listing of CPT codes for which notification/prior authorization is required pursuant to this protocol, refer to: UnitedHealthcareOnline.com > Clinician Resources > Radiology.

Notifications/Prior Authorizations Process for Advanced Outpatient Imaging Procedures Ordering Care Provider

The care provider ordering the Advanced Outpatient Imaging procedure must provide notification by contacting us prior to scheduling the procedure. Once we receive notification of an Advanced Outpatient Imaging Procedure and if the member’s benefit plan requires health services to be medically necessary in order to be covered, we conduct a clinical coverage review, pursuant to our prior authorization process, to determine whether the service is medically necessary. You do not need to determine whether a clinical coverage review is required because once we receive notification, we will let you know whether a clinical coverage review is required.

We must be notified, or prior authorization must be requested, by contacting us as follows:

- **Online:** UnitedHealthcare, UnitedHealthcare West, UnitedHealthOne, Neighborhood Health Partnership and UnitedHealthcare of the River Valley Commercial and Medicare benefit plans subject to this Protocol: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Radiology Notification & Authorization - Submission & Status

- **Phone:** 866-889-8054

Non-participating care providers can provide notification and complete the prior authorization process if applicable either through UnitedHealthcareOnline.com, (once registered), or by calling 866-889-8054.
Chapter 6: Medical Management

The information listed below may be requested at the time notification is provided:

**Member Procedure Information:**
- Member’s name, address, phone number and date of birth
- Member’s health care ID number and group number
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)

**Care Provider Information:**
- Ordering care provider’s name, TIN/NPI, specialty, address, and phone number
- Care provider to whom the member is being referred, if specified, address and phone number
- Rendering care provider’s name and TIN/NPI (if different)

**Clinical Information:**
- The member’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering care provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

If the member’s benefit plan requires health services to be medically necessary in order to be covered, and if the service is determined to be medically necessary, a prior authorization number will be issued to the ordering care provider by fax, phone, or online. To help ensure proper payment, the prior authorization number must be communicated by the ordering care provider to the rendering care provider.

If it is determined that the service is not medically necessary, a clinical denial will be issued. If we issue a clinical denial for lack of medical necessity, the member and care provider will receive a denial notice which includes an outline of the appeal process.

Medicare Advantage benefit plans and certain commercial benefit plans require health services to be medically necessary in order to be covered.

If the member’s benefit plan does not require health services to be medically necessary in order to be covered:
- If the service is consistent with evidence-based clinical guidelines, a notification number will be issued to the ordering care provider.
- If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will let the ordering care provider know whether they must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches.

- If a physician-to-physician discussion is required, that process must be completed to help ensure eligibility to receive payment. Upon completion, the care provider confirms the procedure ordered and a notification number is issued. The purpose of the physician-to-physician discussion is to support the delivery of evidence-based health care by discussing evidence-based clinical guidelines. This discussion is not a prior authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

Certain commercial benefit plans do not require health services to be medically necessary in order to be covered.

Receipt of a notification number or prior authorization number does not guarantee or authorize payment unless state regulations, (including regulations pertaining to a care provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list), and Medicare Advantage guidelines require it. Payment for covered services depends upon:
- Coverage with an individual member’s benefit plan,
- The care provider being eligible for payment,
- Claims processing requirements, and
- The care provider’s participation with UnitedHealthcare.

The notification/prior authorization number is valid for 45 calendar days, and is specific to the Advanced Outpatient Imaging procedure requested for one date of service within the 45 day period. When a notification/prior authorization number is entered for a procedure, we will use the date the number was issued as the starting date for the 45-day period in which the procedure must be performed. If the procedure is not performed within 45 calendar days, a new notification/prior authorization number must be requested.

**Urgent Requests during Regular Business Hours**

The ordering care provider may make an urgent request for a notification or prior authorization number if they determine the service is medically urgent. Urgent requests must be made by calling 866-889-8054. The ordering care provider must state that the case is clinically urgent and explain the clinical urgency. We will respond to urgent requests within three hours of our receipt of all required information.

**Retrospective Review Process for Urgent Requests Outside of Regular Business Hours**

If the ordering care provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and a notification/prior authorization number cannot be requested because it is outside of our normal

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*PECOS is the CMS online enrollment system where care providers and healthcare entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.
business hours, the notification/prior authorization number must be requested retrospectively within two business days after the date of services. The retrospective review must be requested by calling 866-889-8054 and following the phone prompts, according to the process described below:

- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a notification/prior authorization number could not have been requested during our normal business hours.

- Once we receive notification of an Advanced Outpatient Imaging procedure on a retrospective basis, and if the member’s benefit plan requires services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. A clinical denial will be issued and a prior authorization number will not be issued if it is determined the service is not medically necessary; the member cannot be billed for the service. For commercial members, the member and care provider will receive a denial notice which includes information regarding the appeal process. For Medicare Advantage members, notice including information regarding the appeal process, is only sent to the care provider.

- If the member’s benefit plan does not require that services be medically necessary in order to be covered: If the member’s benefit plan does not require services to be medically necessary in order to be covered, the member cannot be billed for the service. For commercial members, the member and care provider will receive a denial notice which includes information regarding the appeal process. For Medicare Advantage members, notice including information regarding the appeal process, is only sent to the care provider.

Failure to obtain a notification number or prior authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

Rendering Care Provider

Prior to performing an Advanced Outpatient Imaging Procedure, the rendering care provider must confirm with us that a notification number is on file, and if the member’s benefit plan requires that health services be medically necessary in order to be covered, the rendering care provider must validate that the prior authorization process has been completed and a coverage determination has been issued. If the rendering care provider finds a coverage determination has not been issued, and the ordering care provider is not a participating care provider, and is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the notification/prior authorization process and verify that a coverage decision has been issued in accordance with this protocol, prior to performing the service. Contact us at the phone number or online address set forth in the Ordering Care Provider section above if you need to notify us, request prior authorization, confirm that a notification number has been issued or confirm whether a coverage determination has been issued.

If the member’s benefit plan does not require that services be medically necessary in order to be covered:

- If an Advanced Outpatient Imaging Procedure is rendered and a claim for the service is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The member cannot be billed for the service.

- If the rendering care provider determines there is no notification number on file, and the ordering care provider participates in our network, we will use reasonable efforts to work with the rendering care provider to obtain the notification number from the participating ordering care provider prior to the rendering of services.

- If the rendering care provider determines there is no notification number on file, and the ordering care provider does not participate in our network, and is unwilling to obtain a notification number, the rendering care provider is required to obtain a notification number.

- If the rendering care provider does not obtain a notification number for Advanced Outpatient Imaging Procedures ordered by a non-participating care provider, the rendering care provider’s claim will be denied administratively, in part or in whole, for failure to provide notification. The member cannot be billed for the service.

If the member’s benefit plan does require services to be medically necessary in order to be covered:

- If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider is a participating care provider, we will use reasonable efforts to work with the rendering care provider to urge the ordering care provider to complete the prior authorization process and obtain a coverage decision prior to the rendering of services.

- If the rendering care provider determines a coverage determination has not been issued, and the ordering care provider is not a participating care provider, and is unwilling to complete the prior authorization process, the rendering care provider is required to complete the prior authorization process and verify that a coverage decision has been issued prior to rendering the service.

- If the rendering care provider provides the service before a coverage decision is issued, the rendering care provider’s claim will be denied administratively, in part or in whole, and the member cannot be billed for the service.
• Services that are not medically necessary are not covered under the member’s benefit plan. Upon issuance of the denial for lack of medical necessity, the member and rendering care provider will receive a denial notice with the appeal process outlined. A clinical denial will be issued, and a prior authorization number will not be issued, if it is determined during the prior authorization process or Retrospective Review Process that the service is not medically necessary. A prior authorization number will be issued to the rendering care provider if the service is medically necessary.

**Provision of an Additional or Modified Advanced Outpatient Imaging Procedure**

If during the delivery of an Advanced Outpatient Imaging Procedure, the rendering care provider determines that an additional Advanced Outpatient Imaging Procedure should be delivered above and beyond the service(s) for which a notification/prior authorization number has already been obtained, the ordering care provider must request a new notification/prior authorization number prior to rendering the additional service, in accordance with this protocol.

If during the delivery of an Advanced Outpatient Imaging procedure for which the care provider completed the notification/prior authorization processes outlined this protocol, the physician modifies the Advanced Outpatient Imaging procedure, and if the CPT code combination is not listed on the CPT Code Crosswalk Table, the process below must be followed:

- **Contiguous body part** – if the procedure being performed is for a contiguous body part, the ordering or rendering care provider must modify the original notification/prior authorization number request online or by calling within two business days after the procedure is rendered.

- **Non-contiguous body part** – if the procedure being performed is not for a contiguous body part, the ordering care provider must submit a new notification/prior authorization number request and a coverage determination must be issued, in accordance with this protocol prior to rendering the procedure.

**Crosswalk Table**

Care providers are not required to modify the existing notification/prior authorization request, or request a new notification/prior authorization record for the CPT code combinations outlined in the UnitedHealthcare Radiology Notification /Prior Authorization Crosswalk Table available online at UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification & Prior Authorization.

For code combinations not listed on the UnitedHealthcare Radiology Notification /Prior Authorization Crosswalk Table care providers must follow the Radiology Notification/Prior Authorization Protocol process outlined here.
Chapter 7: Specific Protocols

Air Ambulance, Fixed-Wing Non-Emergency Transport

This protocol applies to all participating physicians and health care professionals, and it applies to all non-emergency fixed-wing air ambulance transports, ordered by physicians and health care professionals.

We maintain a network of air ambulance transportation providers. These participating air ambulance providers deliver fixed-wing air ambulance transportation to meet the needs of our members, and the facilities and physicians participating in the UnitedHealthcare network. In many benefit plans, members receiving services for out-of-network non-emergency air ambulance services may incur increased financial liability and therefore higher out-of-pocket expenses.

You are required to refer non-emergency fixed-wing air ambulance services to a participating air ambulance provider, except as otherwise authorized by us or a payer. Participating non-emergency fixed-wing air ambulance providers can be found in our Physician Directory online at UnitedHealthcareOnline.com. If you need assistance locating or using a participating non-emergency fixed-wing air ambulance provider or believe no participating air ambulance service is available, please contact UnitedHealthcare. We will work with you to assure that required non-emergency fixed-wing air ambulance services are received, even if that means the use of a non-participating air ambulance provider if necessary.

Administrative Actions for Referral to Out-of-Network Fixed-Wing Air Ambulance Providers

We anticipate that we will be able to easily find a participating fixed-wing air ambulance provider that will meet the physician's, health care professional's, facility's and ancillary provider's needs. If we identify an ongoing and material practice of referrals to out-of-network fixed-wing air ambulance providers, we will inform the responsible participating physicians, health care professionals, facilities and/or ancillary providers in the UnitedHealthcare network of the issue and remind them that they are required to refer members to participating care providers. While it is our expectation that these actions will rarely be necessary, compliance with this Protocol will be reviewed by UnitedHealthcare, in accordance with relevant state and federal laws and regulations, and failure to comply with this protocol may result in appropriate action under your participation agreement, which may include, but is not limited to, ineligibility for performance based compensation, or termination of your participation agreement.

Designated Specialty Pharmacy or Home Infusion Providers for Specialty Medications (Commercial Plans)

Coverage of Self-Infused/Injectable Medications under the Pharmacy Benefit

This protocol applies to the provision and billing of self-infused/injectable medications, such as Hemophilia Factor products, under the pharmacy benefit.

Under most UnitedHealthcare products, self-infused/injectable medications are generally excluded from coverage under the medical benefit. Coverage for a self-infused/injectable medication is provided through the pharmacy rider. This exclusion from the medical benefit does not apply to self-infused/injectable medications necessary to treat diabetes or to medications, that due to their characteristics, as determined by UnitedHealthcare, are typically administered or directly supervised by a qualified physician or licensed/certified health care professional in an outpatient setting.

If medications are subject to this exclusion, participating physicians, health care professionals, home infusion providers, hemophilia treatment centers or pharmacies fulfilling, distributing, and billing for the provision of self-infused/injectable medications to members are required to submit claims for reimbursement under the member’s pharmacy benefit.

Prohibition of Provision of Non-Contracted Services

• This protocol applies to the provision and billing of specific specialty pharmacy medications covered under a member’s medical benefit.

• This protocol prohibits specialty pharmacy or home infusion providers from providing non-contracted services for a therapeutic category, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, and billing us as a non-participating or non-contracted specialty pharmacy or home infusion provider.

• This protocol does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional who procures and bills directly to us for the specific specialty medications.
Chapter 7: Specific Protocols

Requirement of Specialty Pharmacy and Home Infusion Provider(s) to be a Network Care Provider
We have contracted with a network of specialty pharmacy and home infusion care providers by therapeutic category to distribute specialty medications covered under a member’s medical benefit. The contracted specialty pharmacy and home infusion providers have been selected by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and member services. This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our members and our network. Full program participation requirements are identified in the contracted specialty pharmacy or home infusion provider’s participation agreement.

Laboratory Benefit Management Program Administered by BeaconLBS™ (Florida and Texas)
The UnitedHealthcare Laboratory Benefit Management Program applies to fully insured members who live in Florida. This protocol is effective for fully insured commercial members who live in Texas, on March 1, 2017. If you order laboratory services and your practice is located outside of Florida or Texas, this program does not apply to you. This program provides physicians and laboratories with point of order support for test selection and laboratory selection. Certain laboratory services are subject to additional protocols, including but not limited to, advance notification and Laboratory Point of Performance Requirements. Claims for laboratory services are subject to additional complete claim requirements.

For more information on requirements and implementation, please visit UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > UnitedHealthcare Laboratory Benefit Management Program.

Laboratory Services Protocol
Clinical Information Submission
We request clinical data from care providers to comply with state and federal data collection and reporting requirements. This clinical data helps us to measure quality care for UnitedHealthcare members and collaborate with care providers to address gaps in care. Care providers must submit all clinical data including, but not limited to, laboratory testing results by any available means including EDI, fax, telephone and/or physical data collection methods. All clinical data must be made available to us within 30 calendar days of the date of service or within the time specified by applicable law.

Clinical data must be provided to us consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). Evidence of data provenance will be provided upon request by UnitedHealthcare to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. Care providers must confirm the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering care provider.

We will verify that security measures, protocols, and practices are compliant with HIPAA regulation and UnitedHealthcare data usage, governance, and security policies, and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. UnitedHealthcare will use this data to perform treatment, payment or health care operations – as defined in HIPAA – for our members.

Health care operations may include the following:

1. Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), NCQA accreditation, Centers for Medicare & Medicaid Services’ (CMS) Star Ratings, and CMS Hierarchical Condition Category Risk Adjustment System

2. Care coordination and other care management and quality improvement programs including physician performance, pharmaceutical safety, member health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare and other member and care provider health awareness programs

3. Quality assessment and benchmarking data sets

4. Any other lawful health care operations

We will work collaboratively with the care provider to help ensure all clinical data values are being transmitted effectively to allow for lawful identification and use of the clinical data.

HIPAA minimum necessary data requirements will be defined in specific documents related to the method of clinical data acquisition, including HL7 companion guide(s) and process documentation related to proprietary file exchange, fax submissions, paper data submission and/or guide data collection by UnitedHealthcare authorized personnel. The companion guides are available at UnitedHealthcareOnline.com > Tools & Resources >
Chapter 7: Specific Protocols

EDI Education for Electronic Transactions > General EDI Info > Companion Guide Documents; numbers 11 and 12.

**Requirement to Use Participating Laboratories**
This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals, except this protocol does not apply:

- When the physician bears financial risk of laboratory services.
- When the physician provides laboratory services in their offices.

We maintain a robust network of regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the UnitedHealthcare network. Participating laboratories also provide clinical data and related information to support HEDIS® reporting, care management, the UnitedHealth Premium Designation program, and other clinical quality improvement activities. Members receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

You are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us. Participating laboratory providers can be found in our [Physician Directory on UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). If you need assistance in locating or using a participating laboratory provider, or you believe no participating laboratory is available, please contact UnitedHealthcare in advance to confirm that the specific laboratory test is covered. We will work with you to assure that those covered tests are performed, even if that means the use of a non-participating laboratory. Some benefit plans are capitated for Laboratory services and only the capitated laboratory provider can be utilized for services.

**Administrative Actions for Out-of-Network Laboratory Services Referrals**
UnitedHealthcare network physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that physicians will be able to easily find a participating laboratory that will meet their needs.

If we identify a material practice of referrals to out-of-network laboratory service providers, we will inform the responsible participating physicians of the issue and remind them of the general requirements to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:

- Loss of eligibility for the Practice Rewards programs;
- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

**Self-Referral and Anti-Kickback**
This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals. Referrals for laboratory services that results in the physician earning a profit, including, but not limited to the following, are not allowed:

- Profits resulting from an investment in an entity for which the referring physician or health care professional generates business; or
- Profits resulting from collection, processing and/or transport of specimens.

Failure to comply with this protocol may result in:
- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

**Non-Participating Providers Consent Form**

<table>
<thead>
<tr>
<th>Excluded Plans (benefit plans not subject to the following requirements)</th>
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<tbody>
<tr>
<td>Neighborhood Health Partnership</td>
</tr>
<tr>
<td>M.D.IPA, Optimum Choice, or OneNet</td>
</tr>
<tr>
<td>Benefit plans subject to theRiver Valley Entities Supplement</td>
</tr>
<tr>
<td>UnitedHealthcare West</td>
</tr>
</tbody>
</table>

Except in emergent situations, when a participating care provider is recommending, referring, including or utilizing one of the following types of non-participating care providers/services, the requirements within this protocol apply so that our members may make informed choices regarding their health care providers.

**Impacted Care Provider/Service Types:**

- Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent
- Assistant Surgeon - a physician or other health care professional who is assisting the physician performing a surgical procedure, where the participating surgeon selects the assistant surgeon
- Home Health
- Air Ambulance, fixed-wing non-emergency transport
• Laboratory Services – for specimens collected in the physician’s office and sent out to a non-participating laboratory for processing

• Outpatient Dialysis

• Specialty Drug vendor

• For Oxford Members on New York Products – refer to the Participating Provider Laboratory & Pathology Protocol (New York) for specific requirements and instructions on nonparticipating laboratory and pathology services.

• For UnitedHealthcare Members on Delaware, New York, Oklahoma, Pennsylvania and Texas Products – refer to UnitedHealthcareOnline.com > Tools & Resources > Protocols > Participating Provider Laboratory & Pathology Protocol for specific requirements and instructions on nonparticipating laboratory and pathology services.

In advance of any services being rendered, you must:

1. Verbally discuss care provider options and financial impacts with the member:
   • Review this policy and the Member Advance Notice Form with the member
   • Provide participating care provider alternatives and explain the reason for using the non-participating care provider
   • Discuss the financial impact of utilizing a non-participating care provider
     › If the member has out-of-network benefits, they may utilize those benefits to receive services from a non-participating care provider. However, they may have higher out-of-pocket costs when using a non-participating care provider.
     › Members who do not have out-of-network benefits may be responsible for the entire cost of the service(s) provided by the non-participating care provider.

2. Complete the UnitedHealthcare Member Advance Notice Form if the member has elected to use the non-participating care provider. Fill in the required information on the Member Advance Notice Form and obtain the Member’s signature on the completed form.
   • A copy of the signed form must be kept on file by the participating care provider to give to us upon request.
   • A separate UnitedHealthcare Member Advance Notice Form is required for each non-participating care provider/service
   • A copy of the Member Advance Notice Form can be found at UnitedHealthcareOnline.com > Tools & Resources > Forms > Patient/Member.

This protocol does not apply in emergent situations or instances where the care provider or member has obtained a network exception to utilize a non-participating physician, facility or other health care provider.

This protocol is intended to assist members in making informed decisions about their care and out-of-pocket cost. It is not intended to deter them from using their out-of-network benefits, if available. Members who have out-of-network benefits can exercise their right to use those benefits at any time.

**Administrative Actions for Non-Compliance**

We will monitor the involvement of the non-participating care provider types and services outlined above in our ER’s care and may request a copy of the completed Member Advance Notice Form at any time. Compliance with this protocol will be reviewed by UnitedHealthcare, in accordance with relevant state and federal laws and regulations, and failure to comply with this protocol may result in appropriate action under your participation agreement, which may include, but is not limited to, ineligibility for performance based compensation, or termination of your participation agreement.

**Nursing Home and Assisted Living Plans**

This protocol is only applicable to primary care physicians, nurse practitioners (NP), and physician assistants (PA) who participate in the network for the UnitedHealthcare Nursing Home Plan (i.e., Medicare Advantage Institutional Special Needs Plans), and or the UnitedHealthcare Assisted Living Plan Care Team, (which includes both an on-site Advance Practice Clinician (ARNP/PA) and a registered nurse who cooperate with and are bound by these additional protocols).

If these protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan or Assisted Living On-site Care members, these protocols will govern unless statutes and regulations dictate otherwise.

**Nursing Home Plan Primary Care Provider (PCP) Protocols**

If these PCP protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan members, these PCP protocols will govern unless statutes and regulations dictate otherwise.

As the PCP, you will cooperate with and be bound by these additional protocols:

1. Attend PCP orientation session and annual PCP meetings thereafter.

2. Conduct face-to-face initial and ongoing assessments of the medical needs of our Nursing Home Plan members (our members), including all assessments mandated by regulatory requirements.
3. Deliver health care to our members at their place of residence in collaboration with the Primary Care Team.

4. Participate in formal and informal Family Care Conferences with responsible parties, family and/or legal guardian of our member to discuss the member’s condition, care needs, overall plan of care and goals of care, including advance care planning.

5. Primary Care Team collaboration and coordination - Collaborate with other members of the Primary Care Team designated by UnitedHealthcare and any other treating professionals to provide and arrange for the provision of covered services to our UnitedHealthcare Nursing Home Plan members. This includes, but is not limited to, making joint visits with other Primary Care Team members to members and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled member reassessment, significant change in plan of care and/or condition.

6. Collaborate with us when a change in the Primary Care Team is necessary.

7. Provide us a minimum of 45 calendar days’ prior notice when discontinuing delivery of covered services at any facility where our members reside.

8. When admitting a UnitedHealthcare member to a hospital, immediately notify the PCP and UnitedHealthcare Nursing Home Plan or Payer of the admission and reasons for such admission (i.e., if the admission is for an emergency or for observation).

Nursing Home Plan Nurse Practitioner and Physician Assistant protocols

If these Nurse Practitioner and Physician Assistant protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan members (our members), these Nurse Practitioner and Physician Assistant protocols will govern unless statutes and regulations dictate otherwise.

The Nurse Practitioner, Physician Assistant, and/or UnitedHealthcare Assisted Living Plan Care Team member, (i.e., registered nurse, or ARNP/PA), will cooperate with and be bound by these additional protocols:

1. Attend training and orientation meetings as scheduled by UnitedHealthcare Nursing Home Plan.

2. Deliver health care to our members at their place of residence in collaboration with a Primary Care Physician.

3. Family Care Conferences - Communicate with the member’s responsible parties, family and/or legal guardian on a regular basis. Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the member to discuss the member’s condition, care needs, overall plan of care and goals of care, including advance care planning.

4. Primary Care Team collaboration and coordination - Collaborate with other members of the Primary Care Team designated by UnitedHealthcare and any other treating professionals to provide and arrange for the provision of covered services for UnitedHealthcare members. This includes, but is not limited to, making joint visits with other Primary Care Team members to UnitedHealthcare members and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled member reassessment, significant change in plan of care and/or condition.

5. Collaborate and communicate with UnitedHealthcare’s designated Director of Clinical Operations to coordinate all inpatient, outpatient and facility care delivered to our members. Forward copies of the required documentation to our office. Work with the Director to develop a network of care providers cognizant of the special needs of the frail elderly.

6. Initial Assessment - Conduct a comprehensive initial assessment for all UnitedHealthcare Nursing Home Plan members within 30 calendar days of enrollment, (90 days for Assisted Living Plan members), that includes:
   a. History and physical examination, including mini-mental status (MMS) and functional assessment
   b. Review previous medical records
   c. Prepare problem list
   d. Review medications and treatments
   e. Review lab and x-ray procedures
   f. Review current therapies (Physical Therapy, Occupational Therapy, and Speech Therapy)
   g. Update treatment plan
   h. Review advance directive documentation including Do Not Resuscitate: Do Not Intervene (DNR/DNI) and use of other life-sustaining techniques
   i. Contact the family/responsible party within 30 calendar days of enrollment to:
      i. Schedule a meeting at the facility, if possible;
      ii. Obtain further history;
      iii. Agree on type and frequency of future contacts; and
      iv. Discuss advance directives.
   j. Perform clinical and quality initiative documentation as directed

7. Provide care management services to coordinate the full range of covered services outlined in our member’s benefit plan including, but not limited to:
   • All medically necessary and appropriate facility services
   • Outpatient procedures and consultations
8. Provide us a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where our members reside.

Specialty Pharmacy Requirements for Certain Specialty Medications (for Commercial Members)

This protocol applies to the specialty medications listed on UnitedHealthcare Online.com > Tools & Resources > Pharmacy Resources > Clinical and Specialty Programs > Specialty Pharmacy Program. The medications addressed in our Specialty Pharmacy Program are subject to change from time to time. This protocol does not apply when Medicare or another health benefit plan is the primary payer and UnitedHealthcare is the secondary payer.

Requirement to Use a Participating Specialty Pharmacy Provider for Certain Medications

UnitedHealthcare has contracted for the national distribution of these specialty medications. Our participating specialty pharmacy providers give fulfillment and distribution services on a timely basis to meet the needs of our members and our participating physicians and other health care professionals. Our participating specialty pharmacy providers also provide reviews consistent with the UnitedHealthcare Drug Policy for these drugs, and work directly with the Clinical Coverage Review unit in UnitedHealthcare’s Clinical Services to determine whether treatment is covered. The UnitedHealthcare Drug Policies for these drug preparations are reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy providers report clinical data and related information and are audited on an ongoing basis to support our clinical and quality improvement activities.

You must acquire these specialty medications from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. Requests for prescriptions of these specialty medications should be submitted to the participating specialty pharmacy using the applicable enrollment request forms available at UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources > Specialty Pharmacy Program > Prescription Enrollment Forms, Protocols & Administrative Guides. The specialty pharmacy will dispense these drugs in compliance with the UnitedHealthcare Drug Policy and the member’s benefit plan and eligibility, and bill UnitedHealthcare for the medication.

Physicians will only need to bill UnitedHealthcare the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing of the medication to the physician office.

For a list of the medications and participating specialty pharmacy provider(s), refer to the enrollment forms online.

Administrative Actions for Non-Network Acquisition for Certain Specialty Medications

We anticipate that all participating physicians and other health care professionals will be able to procure certain medications from a participating specialty pharmacy provider.

The use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers by you or any other health care professional without prior approval from us may result in a denial of the claim in whole or in part. In addition, you may be subject to other administrative actions as provided in your agreement with us.

Please contact your local UnitedHealthcare Network Manager if you have any questions.
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You can learn more about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at UnitedHealthcareOnline.com > Help > Claims & Payments, including: Claim Estimator with bundling logic and Real-Time Adjudication, training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-By-Step instructions and tutorials.

c. For more information and tips for submitting claims electronically, visit UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions > Electronic Claims.

d. If you need additional information on EDI, contact the EDI Support Line at 800-842-1109, Option 3. Issues can also be submitted online at UnitedHealthcareOnline.com > Contact Us > Electronic Data Interchange (EDI) Claims > EDI Transaction Support Form

Prompt Claims Processing

We know that you want your claims to be processed promptly for the covered services you provide to our members. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. Make sure you submit the claim to the correct payer by reviewing the member’s eligibility as outlined in Verifying Eligibility, Benefits, and Your Network Participation Status.

Note: Eligibility and benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage benefit plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. When applicable, notify us in accordance with the How to Submit Advance or Admission Notifications/Prior Authorizations section in this guide.

3. Prepare complete and accurate claims (see Claims and Encounter Data Submissions section or use our reference guides found on UnitedHealthcareOnline.com > Help > Claims and Payments).

4. Submit claims electronically for fast delivery and confirmation of receipt.

a. EDI and Clearinghouse Connections – Participating and non-participating physician, health care professional, facility and ancillary care provider claims are accepted electronically. A complete list of payer IDs can be found on UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions > Payer List for UnitedHealthcare, Affiliates and Strategic Alliances.

b. UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements. While some claims may require supporting information for initial review, we have reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed.

c. Electronic Payments and Statements (EPS)

Optum’s Electronic Payments and Statements (EPS) is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service brought to you by UnitedHealthcare. It is the standard for receiving UnitedHealthcare payments and explanation of benefits (EOBs)/remittance advice.

EPS delivers electronic payments and provides online remittance advice and 835 files to health care providers, hospitals or facilities.

You may make electronic payments by direct deposit/EFT into an organization’s bank account or by Virtual Card Payment (VCP). With VCP, your bank account information is not needed as you process payments like a credit card transaction.

EPS with Direct Deposit: No Credit Card Processing Fees

While funds are deposited to your account, UnitedHealthcare will not debit or deduct claim adjustments from your checking or savings account. You may also contact your bank to help ensure you have appropriately placed controls over the electronic funds transfers to and from your account.

Posting and Balancing With EPS with Direct Deposit:

1. Receive email notifications when payments are deposited to your designated bank account(s).

2. Log into EPS and view, save, or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

You should enroll with your clearinghouse if you would like to receive the 835 file from them.
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EPS with Virtual Card Payments:
- Process Virtual Card Payments using the same method used by your organization to process credit card transactions. Your current credit card processing fees will apply. Please confirm those rates with merchant processor directly.
- Banking information is not shared outside your organization.

Posting and Balancing with Virtual Card Payment:
1. Your practice will receive one or more virtual card numbers (a card number is issued for each payer ID) in the mail and should be retained in a secure location as you will need it for future payments.
2. You will be notified of new claim payments by email.
3. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

Note: you should enroll with your clearinghouse if you would like to receive the 835 file from them.

EPS Registration
To learn more about EPS and to register, visit WelcometoEPS.com. If you have questions about EPS, direct deposit, Virtual Card Payments or enrollment, call us at 877-620-6194, to speak with an EPS representative.

Claims and Encounter Data Submissions
You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the member at the time of service. If you have questions about submitting claims to us, please contact UnitedHealthcare at the phone number listed on the member’s health care ID card.

It is particularly important to accurately code because a member’s level of coverage under their benefit plan may vary for different services. To assist you in correctly coding your claims, the Claim Estimator on UnitedHealthcareOnline.com includes a feature called Professional Claim Bundling Logic, which helps you determine allowable bundling logic and other commercial claims processing edits for a variety of CPT (CPT is a registered trademark of the American Medical Association) and HCPCS procedure codes.

Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations for professional commercial claims are available under the Pre-Determination of Benefits option. Allow enough time for your claims to process and check the status in the claims management application on Link before sending second submissions or tracers. If you do need to submit a second submission or a tracer, please submit it electronically no sooner than 45 days after original submission.

Complete claims include the information listed under the Requirements for Complete Claims and Encounter Data Submission in the following section. Our preferred method to receive claims is electronically, but they can also be submitted on paper. If submitted electronically and required information is not provided or invalid codes used, the claim/encounter may be rejected or not processed or submitted to CMS for consideration in the risk adjustment calculation. If submitted using the paper form, the claim may be pended in order to obtain the correct information. In addition, we may require additional information for particular types of services, or based on particular circumstances or state requirements.

To order Form 1500 and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at 202-512-0455, or visit the Medicare website at: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html

Requirements for Complete Claims and Encounter Data Submission
(See also Requirements for Submission of Encounter Data in the Medicare Advantage – Capitated supplement)

Your claim may be pended or not processed if you omit any of the following:
- Member’s name, address, gender, date of birth (dd/mm/yyyy), relationship to subscriber (policy owner)
- Subscriber’s name (enter exactly as it appears on the member’s health care ID card), ID number, employer group name and employer group number
- Rendering care provider’s name, their signature or representative’s signature, address where service was rendered, “Remit to” address, phone number, NPI and federal TIN
- Referring physician’s name and TIN (if applicable)
- Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, current CPT and HCPCS procedure codes, with modifiers where appropriate, current ICD-10 diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- Charge per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available
- Retail purchase cost (or a cumulative retail rental cost) greater than $1,000 for DME
Chapter 8: Our Claims Process

- Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. You must enter the NDC number in the 24D field of the Form 1500, or the LIN03 segment of the HIPAA 837 Professional electronic form.

- Method of Administration (Self or Assisted) for Hemophilia Claims – note the method of administration and submit with the claim form with applicable J-CODES and hemophilia factor, in order to enable accurate reimbursement. Method of administration is either noted as self or assisted.

Additional Information Needed for a Complete UB-04 (or CMS-1450) Form:
Your claim may be pended or not processed if you omit any of the following:
- Date and hour of admission
- Date and hour of discharge
- Member status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current four digit revenue code(s)
- Attending physician ID
- For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount ($01 or $100) on all other surgical revenue code lines to assure appropriate adjudication
- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within three calendar days of an inpatient admission and are not related to the admission.

Risk Adjustment Data – Medicare Advantage and Commercial

Risk adjustment is required by the U.S. Department of Health and Human Services (HHS) for commercial small group and individual benefit plans. Similar to the CMS risk adjustment program for Medicare Advantage benefit plans, HHS utilizes Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the individual patient’s disease burden. In order to perform the calculation, CMS and HHS require information from us annually about the demographic and health status of our members. Therefore, the clinical documentation and diagnosis code information you submit to us must be accurate and complete. Because patient diagnoses do not carry forward from one year to the next under the commercial risk adjustment program, all existing and chronic conditions must be evaluated and documented at least once each calendar year in the patient’s medical record and claims or encounters you submit.

The risk adjustment data you submit to us must be accurate and complete. It is critical for your office to refer to the ICD-10-coding guide and code accurately, specifically and completely when submitting claims and/or encounters to us. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required. Some unspecified ICD-9 codes that were acceptable for risk adjustment are not acceptable for risk adjustment when submitted as an ICD-10-CM.

For example:
The former ICD-9 diagnosis 366.41 - Diabetic cataract maps to several more specific ICD-10 codes:

<table>
<thead>
<tr>
<th>ICD-10 Risk Adjustable Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.36</td>
<td>Diabetes mellitus due to underlying condition with diabetic cataract</td>
</tr>
<tr>
<td>E09.36</td>
<td>Drug or chemical induced diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>E10.36</td>
<td>Type 1 diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>E11.36</td>
<td>Type 2 diabetes mellitus with diabetic cataract</td>
</tr>
</tbody>
</table>

- Remember, risk adjustment is based on ICD-10-CM diagnosis codes and CPT codes. Use the correct CPT codes and the ICD-10-CM coding guide and code accurately, specifically, and completely when submitting claims and/or encounters to us.

- Medical records must support the diagnosis codes. Therefore, medical records must be clear, complete and support all conditions coded on claims or encounters you submit.

- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment or management.
• Never use a diagnosis code for a “probable” or “questionable” diagnosis. Instead, code only to the highest degree of certainty.

• Distinguish between acute and chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member’s condition and pertinent history at the time of the visit. Do not code conditions previously treated and no longer exist.

• Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member’s condition.

• Check the diagnosis code against the member’s gender.

• Sign chart entries with credentials.

• All claims and/or encounters submitted to UnitedHealthcare for risk adjustment consideration are subject to federal and/or internal audit. Audits may come from CMS, HHS, or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner and provide all available medical documentation for the services rendered to the member.

National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions.

In addition, based on state-specific regulations, you may be required to submit your NPI on paper claims.

HIPAA defines a covered health care provider as any health care provider who transmits health information, such as claims, electronically. You must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

• To avoid payment delays or denials, we require you to submit a valid Billing NPI, Rendering NPI and relevant Taxonomy code(s) on both paper and electronic claims and encounters. In addition, we strongly encourage you to submit all other NPIs as defined below.

• It is important that, in addition to the NPI, you continue to submit your TIN.

The NPI information you report to us now and on all future claims and encounters is essential in allowing us to efficiently process claims and encounters and to avoid delays or denials.

National Provider Identification (NPI)

We will continue to accept NPIs submitted through any of the following methods:

• **Link:** If you have received the upgraded My Practice Profile app and your ID administrator has granted you editing rights, you may update your NPI here for fastest service.

• **UnitedHealthcareOnline.com:** To update your NPI and related information online, login and go to “Practice/Facility Profile” and select the TIN. Click “Continue”, select the “View/Update NPI Information” tab.

• **Fax:** For all UnitedHealthcare business, you may fax your NPI to the appropriate fax number based on your geographic location/state. Find the fax form at UnitedHealthcareOnline.com > Tools & Resources > Forms > Form: Provider Demographic Change Form.

• **Phone:** United Voice Portal (UVP) at 877-842-3210. Select the “Health Care Professional Services” prompt. Say “Demographic changes” and your call will be directed to the Service Center to collect your NPI, Health Care Provider Taxonomy Codes, other NPI related information.

• **Credentialing/Contracting:** NPI and National Uniform Claim Committee (NUCC) taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and re-contracting efforts.

How to Submit NPI, TIN and Taxonomy on a Claim or Encounter

Information is provided for the location of NPI, TIN and Taxonomy on paper and electronic claims on UnitedHealthcareOnline.com > Tools & Resources > National Provider Identifier.

Medicare Advantage Claim Processing Requirements

Section 1833 of the Social Security Act prohibits payments to any care provider unless you have given sufficient information to determine the “amounts due such Provider.” To that end, UnitedHealthcare applies various claims processing edits based on National and Local Coverage Determinations, the Medicare Claims Processing Guide, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the Official ICD-10-CM Guidelines for Coding and Reporting. These edits are designed to provide us with sufficient information to determine:

• The correct amount to pay
• Whether you are authorized to perform the service
• Whether you are eligible to receive payment
• Whether the service is covered, correctly coded, and correctly billed to be eligible for reimbursement
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- Whether the service is provided to an eligible beneficiary, and
- Whether the service was provided in accordance with CMS guidance

As a care provider participating in our Medicare Advantage network, you must comply with all CMS guidance regarding billing, coding, claims submission, and reimbursement rules. For example, all participating Medicare care providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. If the “Never Event” has not been reported, we will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS, as a Serious Reportable Adverse Event. If you fail to comply with these requirements, your claim will be denied and will be your liability; you may not bill the member for these charges.

There may be situations when UnitedHealthcare implements edits and CMS has not issued any specific coding guidance. In these circumstances, UnitedHealthcare will review the available guidance in the Medicare Coverage Center and identify those coding edits that most align with the applicable coverage rules. Due to CMS requirements, you are required to adopt the 837 Version 5010 format. Incomplete submissions including blank data fields will result in rejection of the claim or encounter submission. A National Provider Identification (NPI) is a required data element on all claims; however, we may be financially responsible for any additional or optional supplemental benefits under the Medicare Advantage member’s benefit plan such as eyeglasses and hearing aids. Additional and optional supplemental benefits are not covered by Medicare and are not related to the member’s terminal condition, e.g. eyeglasses, hearing aids.

Medicare Crossover
Medicare Crossover is the process by which Medicare, as the primary payer, automatically forwards Medicare Part A (hospital) and Part B (medical) including Durable Medical Equipment (DME) claims to a secondary payer for processing. Medicare Crossover is a standard offering for most Medicare-eligible members covered under UnitedHealthcare commercial benefit plans. Enrollment is automatic for these members.

- Allow 15-20 days to receive and review the Explanation of Medicare Benefits (EOMB) from Medicare before filing the secondary claim to UnitedHealthcare, if required.
- Remark code MA-18 on the EOMB indicates the claim was sent by Medicare to the secondary payer. Allow an additional 15-30 days for UnitedHealthcare to receive and process the crossover claim.
- Do not send claims to UnitedHealthcare crossed over by Medicare, as denoted by code MA-18 on the EOMB. Sending another claim when one is already in our system will slow the payment process and create confusion for the member.
- If code MA-18 is not on the EOMB, you may file the secondary claim electronically.
- Allow up to 30 days after receiving the EOMB before following up on the receipt of the secondary claim by UnitedHealthcare from Medicare.
- To follow up on the receipt or status of a claim, check claim status (276/277) through your practice management system, a clearinghouse, UnitedHealthcareOnline.com.

Claim Submission Tips
Submit your claims and encounters as an 837 EDI Transaction
- Before submitting your EDI claims to us, refer to the member’s health care ID card to identify the payer id to use for electronic claims.
- If no payer ID is listed or you do not have access to the member’s ID card, refer to UnitedHealthcareOnline.com > Tools & Resources > EDI Educations for Electronic Transactions > Payer List for UnitedHealthcare, Affiliates, and Strategic Alliances for the correct Payer ID number.

Claims that were either denied or pended for additional information should not be resubmitted by EDI or paper claim. Please use the claim management application on Link.

The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims or encounters. In some cases, the Payer ID listed on UnitedHealthcareOnline.com may be different from the number issued by your clearinghouse. Validate any discrepant Payer IDs with your clearinghouse to avoid processing delays.
Submit professional and institutional claims and/or encounters electronically, including secondary claims. The HIPAA ANSI X1 25010 837 format is the only acceptable format for submitting claims and encounter data.
We accept primary and secondary claims electronically and support other HIPAA EDI transactions to assist you with your revenue cycle process. Locate specific claims using either your provider ID or a specific member’s ID and obtain a claim summary or line-item detail about claims status, including whether we have received the claims and whether they have been paid, pended or denied.

**Estimating Treatment Costs**
To facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of the Claim Estimator on UnitedHealthcareOnline.com.

The Claim Estimator tool provides a fast and simple way to obtain your commercial professional claim predeterminations through UnitedHealthcareOnline.com > Claims & Payments > Claim Estimator. With Claim Estimator, you can receive an estimate on whether a procedure will be covered, at what percentage, if any, and what the claim payment will be. Claim Estimator enables you to share this information with your patient before treatment.

**HRA and HSA Benefit Plans Claims Submission Tips**
To promote timely claims turnaround and accurate reimbursement with UnitedHealthcare HRAs or HSAs, please verify member eligibility and benefits coverage online using the eligibility application on Link Alternatively, you can call the member service number on the back of your patient’s health care ID card.

Regarding UnitedHealthcare HRA enrollees: Once logged into the Patient Eligibility & Benefits, the “HRA Balance” field will be displayed if the member is enrolled in any UnitedHealthcare consumer-driven health plan. When there are funds available in an HRA account, the current balance will be displayed.

This amount is based on the most recent information available and is subject to change. The actual balance may differ from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed.

Balances for HSA enrollees are not available through the Patient Eligibility application on Link.

Most UnitedHealthcare HRA and HSA benefit plans do not require copayments; therefore, please do not ask your UnitedHealthcare members to make a copayment at the time of service unless indicated on their health care ID card.

Submit claims electronically through your clearinghouse or UnitedHealthcareOnline.com. Alternatively, submit claims to the address on the back of the member’s health care ID card.

Please wait until after a claim is processed and you receive your EOB/remittance advice before collecting funds from your patient who is our member with a HRA/HSA benefit plan. This is because the member responsibility may be reimbursable through their HRA account and paid directly to you. The remittance advice will indicate any remaining member balance. UnitedHealthcare will not automatically transfer the HSA balance for payment; however, the member can pay with their HSA debit card or convenience checks linked directly to their account balance.

**Consumer Account Cards and Qualified Medical Expenses**
You may charge UnitedHealthcare HRA or FSA consumer account cards only for “qualified medical expenses” (as defined in Section 213(d) of the Internal Revenue Code) incurred by the cardholder or the cardholder’s spouse or dependent. “Qualified medical expenses” are expenses for medical care which provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for the purpose of affecting any structure or function of the body.

You may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses; such non-qualifying expenses include, but are not limited to:

- Cosmetic surgery/procedures (i.e., procedures directed at improving a person’s appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), including the following:
  - Face lifts
  - Liposuction
  - Hair transplants
  - Hair removal (electrolysis)
  - Teeth whitening and similar cosmetic dental procedures
  - Advance expenses for future medical care
  - Weight loss programs (however, disease-specific nutritional counseling may be covered)
  - Illegal operations or procedures

An expense can be defined as a “qualified medical expense”, but might not be covered under a member’s benefit plan. For updated information regarding qualified medical expenses, please consult the Internal Revenue Service (IRS) website at: irs.gov or call the IRS toll-free phone number at 800-TAX-FORM (800-829-3676).
Pass-through Billing/CLIA Requirements/Reimbursement Policy

If you are a healthcare care provider, you must only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

For laboratory services, you will only be reimbursed for the services you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

Claim payment is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

Special Reporting Requirements for Certain Claim Types

Anesthesia Services

• Use one of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) for anesthesia services reporting.

• For electronic claims and/or encounters, report the actual number of anesthesia minutes in loop 2400 SV104 with an “MJ” qualifier in loop 2400 SV103. For Form 1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.

• When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

Laboratory Claims

Many UnitedHealthcare benefit plan designs exclude outpatient laboratory services from coverage if they were not ordered by a participating care provider. Our benefit plans may also cover such services differently when a portion of the service (e.g., the draw) occurs in the care provider’s office, but the analysis is performed by a laboratory care provider. In addition, many state laws require that most, if not all, laboratory services are ordered by a licensed care provider.

Therefore, all laboratory claims and/or encounters must include the name of the referring care provider and NPI number of the referring care provider, in addition to the other elements of a complete claim and/or encounter described in this guide. Laboratory claims that do not include the identity of the referring care provider will be rejected or denied.

This requirement applies to claims and/or encounters for both anatomic and clinical laboratory services. This requirement also applies to claims and/or encounters received from both participating and non-participating laboratories, unless otherwise provided under applicable law. This requirement does not apply to claims for laboratory services provided by care providers in their offices. Please also refer to the Laboratory Services Protocol, in Chapter 7: Specific Protocols.

Physical Medicine and Rehabilitation Services

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy care provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy care provider.

Assistant Surgeons or Surgical Assistants Claim Submission Requirements

The practice of directing or using non-participating care providers significantly increases the costs of services for our members, we require our participating care providers to use reasonable commercial efforts to use the services of network care providers, including network surgical assistants or assistant surgeons to render services to our members. Payment is subject to our payment policies (reimbursement policies).

Submission of Claims for Services Subject to Medical Claim Review

We may pend or deny a claim and request medical records to determine whether the service rendered is a covered service and eligible for payment.

In these cases, a letter will be sent explaining additional information is needed.

To facilitate claim processing and avoid delays due to pended claims, please resubmit only what is requested in our letter. The claim letter will state specific instructions of any required information to resubmit, which may vary for each claim. You must also return a copy of our letter with your additional documents.

For more information about our Medical and Drug Policies, please see UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial.

For Medicare Advantage benefit plans, if you are ineligible for payment even though the service is covered, you will be denied reimbursement for these claims and will be liable for the cost of care. You may not bill the member for the amount denied.

Erythropoietin (For Commercial Members)

For Erythropoietin (EPO) claims, we require you to submit the Hematocrit (Hct) level in order for us to determine coverage under the member’s benefit plan. For claims submitted by paper to UnitedHealthcare on a Form 1500,
you must enter the Hematocrit (Hct) level in the shaded area of line 24a in the same row as the J-code. Enter Hct and the lab value (Hctxx).

For electronic claims, the Hct level is required in the (837P) Standard Professional Claim Transaction, Loop 2400 – Service line, segment MEA, Data Element MEA03.

The MEA segment should be reported as follows:

- MEA01 = qualifier “TR”, meaning test results
- MEA02 = qualifier “R2”, meaning hematocrit
- MEA03 = hematocrit test result Example: MEA*TR*R2*33~

The following J codes require an Hct level on the claim:

- J0881 Darbepoetin alfa (non-ESRD use)
- J0882 Darbepoetin alfa (ESRD on dialysis)
- J0885 Epoetin alfa (non-ESRD use)
- J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)
- Q4081 Epoetin alfa (ESRD on dialysis)

For EPO claims submitted on a UB-04 claim form, an Hct level is not required.

Additional information is available online at UnitedHealthcareOnline.com > Clinician Resources > Oncology > Erythropoietin (EPO) Drug Policy.

Overpayments

If you identify an overpaid claim, or if we inform you in writing or electronically of an overpaid claim you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If you identify a claim for which you were overpaid by us, please use the Overpayment Refund/Notification Form located on UnitedHealthcareOnline.com > Tools & Resources > Forms > Claim to resolve your overpayment. We may also apply the overpayment against future claim payments unless precluded by your agreement with us or as required by applicable law. Mail refunds for overpayments to the name and address indicated on the refund request. Send credit balance refunds to:

UnitedHealth Group Recovery Services
Lockbox 945931
3585 Atlanta Ave.
Hapeville, GA 30354-1705

Please include appropriate documentation that outlines the overpayment, including member’s name, health care ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from UnitedHealthcare. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier’s EOB/remittance advice with the refund.

If we determine a claim was paid incorrectly, we may make a claim adjustment without requesting additional information from you. If the case of an overpayment, we will initiate a claim adjustment and request a refund at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA).

We may request additional or corrected information.

If you disagree with the claim adjustment, our request for an overpayment refund or a recovery made to recoup the overpayment, you may appeal the determination (see the Post-audit procedures section in Chapter 9: Compensation).

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

1. **Subrogation** — To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a member’s health care services when a third party causes the member’s injury or illness.

2. **Coordination of Benefits (COB)** — COB is administered according to the member’s benefit plan and in accordance with applicable law. We accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions > Quick Tips for Electronic Claims > Secondary/COB or Tertiary Claims. You can also contact EDI Support at 800-842-1109 or UnitedHealthcareOnline.com > Contact Us > Electronic Data Interchange (EDI) Claims > EDI Transaction Support Form.

When coordinating benefits with Medicare, if Medicare is the primary payer, we will process up to the Medicare allowed amount when you are a Medicare participating care provider. CMS determines the rules for when Medicare processes claims as the primary or secondary payer.

3. **Workers’ Compensation** — In cases where an illness or injury is employment-related, workers’ compensation is primary. If notification is received that the workers’ compensation carrier has denied a claim for services rendered to one of our commercial or Medicare Advantage members, you should submit the claim to UnitedHealthcare, regardless of whether the case is disputed. It is also helpful to send us the worker’s compensation carrier’s denial statement with the claim.
Claim Correction and Resubmission

Electronic Process:
- Use the claims reconsideration application on Link to resubmit corrected claims that have been paid or denied.
- If you received a letter asking for additional information, submit it using the claims management application on Link.
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim.

Paper Process:
- Submit a new Form 1500 or UB-04 CMS-1450 indicating the correction made. Please attach the Claim Reconsideration Request Form located on UnitedHealthcareOnline.com > Tools & Resources > Forms. Check Box number 4 for resubmission of a corrected claim.

Claim Reconsideration, Appeals Process and Resolving Disputes

Claim reconsideration does not apply to some states based on applicable state legislation (e.g. California or Colorado Commercial, excluding Individual Exchange benefit plans). Refer to Provider Dispute Resolution (CA, OR, and WA Commercial Plans) section for more information.

Step 1 of a 2 Step Process: Claim Reconsideration
A processed claim in which you do not agree with the outcome of the original payment/corrected claim.

Timeframe
You must submit your Claim Reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law, together with a completed UnitedHealthcare Claim Reconsideration Request form.

How to submit your Reconsideration:
If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration Request.
1. **Online**: in the claim reconsideration application on Link. More information is available at UnitedHealthcareOnline.com > Quick Links > Link: Learn More.
2. **Paper**: Find the form on UnitedHealthcareOnline.com > Tools & Resources > Forms > Claim > Paper Claim Reconsideration Form. Mail the form to the applicable address listed on the form instructions. (Address may differ based on product. Please see applicable benefit plan supplement for specific contact information.)

3. **Phone**: You can call the number on the member’s health care ID card to request an adjustment for a claim that does not require written documentation.

If you have a request involving 20 or more paid or denied claims and attachments are not required, aggregate these claims online. Go to UnitedHealthcareOnline.com > Claims & Payments > Claim Research Project.

If you are submitting medical documentation required for a denied claim:
1. **Online**: Go to the claims management application on Link.
2. **Paper**:
   - Complete the Claim Reconsideration Request Form and check “Previously denied/closed for Additional Information” as your reason for request.
   - Provide a description of the documentation submitted along with all pertinent documentation. It is extremely important to include the member name and health care ID number as well as your name, address and TIN on the Claim Reconsideration Request Form to prevent processing delays.

If you are submitting a Claim Reconsideration Request for a claim denied because filing was not timely:
1. **Electronic claims** - include confirmation we or one of our affiliates received and accepted your claim.
2. **Paper claims** - include a copy of a screen print from your accounting software to show the date you submitted the claim.

All proof of timely filing requests must also include documentation that the claim is for the correct patient and the correct date of service.

Step 2 of a 2 Step Process: Claim Appeal (Post Service)
(A second review in which you did not agree with the outcome of the reconsideration.) If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may use the following Claim Appeal process.

Timeframe
You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). The 2 step process described in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely submission and not 12 months for Step 1 and 12 months for Step 2.

Medical Records Request Submission Timeframe
(Which may include providing a copy of the denial notice) – if medical records are requested to process an appeal, the following timeframes are when the information is due:
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- Expedited appeals – within two hours of receipt of the request
- Standard appeals – within 24 hours of receipt of the request.

Timeframes may change based on applicable law, or your participation agreement.

What to Submit
Attach all supporting materials, such as member-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish included in the appeal review.

Our decision will be rendered based on the materials available at the time of formal appeal review. If you are appealing a claim denied because filing was not timely:

- Electronic claims - include confirmation we or one of our affiliates received and accepted your claim.
- Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

All proof of timely filing must also include documentation that the claim is for the correct member and the correct date of service.

Where To Send Your Appeal (Address may differ based on product. Please see applicable benefit plan supplement for specific contact information):
UnitedHealthcare Provider Appeals
P.O. Box 30997
Salt Lake City, UT 84130-0575

Response details: If, as a result of the appeal review, the claim requires an additional payment, the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) will serve as notification of the outcome on the review. If the original claim status is upheld, you will be sent a letter outlining the details of the review.

California only: If a claim requires an additional payment, the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) itself is insufficient to serve as notification of the outcome of the review. A letter will be sent to you with the determination. In addition, you must send payment within five calendar days of such determination based on the date on the determination letter. We will respond to you within the applicable time limits set forth by federal and state agencies. After the applicable time limit has passed, contact Provider Relations at 877-847-2862 to obtain a status.

If you are disputing a refund request that you received from UnitedHealthcare, please reference the Post-audit procedures section below.

In the event a member has authorized you to appeal a clinical or coverage determination on the member’s behalf, such an appeal will follow the process governing member appeals as outlined in the member’s benefit contract or handbook.

Retroactive Eligibility Changes
Eligibility under a benefit contract may change retroactively if:
1. We receive information an individual is no longer a member;
2. The member’s policy/benefit contract has been terminated;
3. The member decides not to purchase continuation coverage;
4. The member fails to pay their full premium within the three month grace period established by the Affordable Care Act (and applicable regulations) for subsidized Individual Exchange members; or
5. The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) affected by a retroactive eligibility change, a Claim Reconsideration may be necessary, except as otherwise required by state and/or federal law. The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA). If you are enrolled in Electronic Payment System (EPS), you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us. If we implement a Claim Reconsideration and a refund is requested, you will be notified at least 30 business days prior to any adjustment, or as provided by applicable law or your agreement with us.

Medicare Advantage Hospital Discharge Appeal Rights Protocol
Medicare Advantage members who are hospital inpatients have the statutory right to request an immediate review by the Quality Improvement Organization (QIO) when UnitedHealthcare and the hospital, with physician concurrence, determine that inpatient care is no longer necessary.

The QIO notifies the facility and UnitedHealthcare of an appeal.

- When UnitedHealthcare completes the Detailed Notice of Discharge (DNOD), UnitedHealthcare delivers it to the facility. The facility will deliver the DNOD, on behalf of UnitedHealthcare, to the Medicare Advantage member, or their representative, as soon as possible, but no later than 12 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO.
- When the facility completes the DNOD, the facility will deliver the DNOD, on behalf of UnitedHealthcare, to the Medicare Advantage member, or their representative, as soon as possible but no later than 12 p.m. local time of the day after the QIO notification of the appeal.
The facility will fax a copy of the DNOD to the QIO and UnitedHealthcare.

If the Medicare Advantage member fails to make a timely request to the QIO for immediate review and remains in the hospital, they may request an expedited reconsideration (appeal) by UnitedHealthcare.

**Resolving Disputes – Concern or Complaint**

If you disagree with the outcome of any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution as described below and in your agreement with us.

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

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, including but not limited to the notification or claim appeal processes described in this guide, we both will follow the dispute procedures set forth in those benefit plans to resolve the concern or complaint. After following these procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your agreement with us. For disputes regarding payment of claims, you must timely complete the claim reconsideration and appeal process as set forth in this guide prior to initiating arbitration.

If we have a concern or complaint about your compliance with your agreement with us, we will send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us. Arbitration proceedings will be held at the location described in your agreement with us, or if a location is not specified in your agreement, then at a location as described in the Arbitration Counties by Location section below.

**Arbitration Counties by Location:**

Unless your agreement with us provides otherwise, the following list contains locations where arbitration proceedings will be held. Locations listed under the state in which you provide care are the locations applicable to you.

<table>
<thead>
<tr>
<th>State</th>
<th>Counties</th>
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<tbody>
<tr>
<td>AL</td>
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<td>Franklin County, OH</td>
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<td>OK</td>
<td>Tulsa County, OK</td>
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Member Appeals, Grievances or Complaints

Member disputes arise from time-to-time. Members may be dissatisfied with UnitedHealthcare or our participating care providers. We respect the rights of our members to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All members receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

When there is a member grievance or appeal, network care providers are required to comply with the following requirements. Assist the member with locating and completing the Appeals and Grievance Form upon request from the member. This form is located by logging onto MyUHC.com > Claims and Accounts > Medical Appeals and Grievances > Member Service Request Form. Immediately forward all member grievances and appeals (complaints, appeals, quality of care/service concerns) in writing for processing to:

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<tr>
<th>State</th>
<th>Counties</th>
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<tr>
<td>OR</td>
<td>Multnomah County, OR</td>
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<tr>
<td>PA</td>
<td>Allegheny County, PA, Philadelphia County, PA</td>
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<tr>
<td>RI</td>
<td>Kent County, RI</td>
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<tr>
<td>SC</td>
<td>Richland County, SC</td>
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<td>SD</td>
<td>Hennepin County, MN</td>
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<td>TN</td>
<td>Davidson County, TN</td>
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<td>TX</td>
<td>Dallas County, TX, Harris County, TX, Travis County, TX</td>
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<td>UT</td>
<td>Salt Lake County, UT</td>
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<tr>
<td>VT</td>
<td>Chittenden County, VT, Washington County, VT, Windham County, VT</td>
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<td>VA</td>
<td>Montgomery County, MD</td>
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<td>WA</td>
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<tr>
<td>WV</td>
<td>Montgomery County, MD</td>
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<tr>
<td>WI</td>
<td>Milwaukee County, WI, Waukesha County, WI</td>
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<tr>
<td>WY</td>
<td>Laramie County, WY</td>
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</tbody>
</table>

- Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) Plans
  - UnitedHealthcare
  - P.O. Box 6106
  - Mail Stop CA 124-0157
  - Cypress, CA 90630

- For Medicare and Retirement Prescription Drug Plans (PDP)
  - UnitedHealthcare
  - P.O. Box 6106
  - Mail Stop CA 124-0197
  - Cypress, CA 90630

- For Commercial plans
  - UnitedHealthcare
  - P.O. Box 30573
  - Salt Lake City, UT 84130-0573

- All Savers Supplement
  - ASIC Members:
    - Grievance Administrator
    - P.O. Box 31371
    - Salt Lake City, UT 84131-0371
    - Fax: 317-715-7648
    - Phone: 800-291-2634

- UnitedHealthOne Individual Plans Supplement (Golden Rule Insurance Company, UnitedHealthcare Life Insurance Company, UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.)
  - Grievance Administrator
  - P.O. Box 31371
  - Salt Lake City, UT 84131-0370
  - Fax: 317-715-7648
  - Phone: 800-657-8205

- Respond to United Healthcare's requests for information relevant to the member’s appeal or grievance within the designated timeframe. You must supply records as requested within two hours for expedited appeals and 24 hours for standard appeals. This includes, but is not limited to, weekends and holidays.

- Comply with all final determinations made by UnitedHealthcare requesting member appeals and grievances.

- Cooperate with UnitedHealthcare and the external independent medical review organization, including but not limited to, promptly forwarding to the external review organization copies of all medical records and information relevant to the disputed health care service in your possession, as well as any newly discovered relevant medical records or any information in the participating medical group/IPA’s possession that is requested by external review organization.

- Provide us with proof that reversals of adverse determinations were carried out within the stated time frames. You must supply proof within:
  - Expedited appeals, within two hours of overturn notice
  - Standard appeals, within 24 hours of overturn notice.

This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).
Chapter 9: Compensation

Reimbursement Policies
UnitedHealthcare reimbursement policies are available online at:
- UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Reimbursement Policies - Commercial
- UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Reimbursement Policies

The term “reimbursement policies” may be referred to in your agreement with us as “payment policies.”

Charging Members

Additional Fees for Covered Services
You may not charge our members fees for covered services beyond copayments, coinsurance, or deductibles as described in their benefit plans. You may not charge our members retainers, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or otherwise comply with our protocols as required by your agreement with us, or based on our reimbursement policies and methodologies. This does not prevent you from charging our commercial members nominal fees for missed appointments or completion of camp/school forms. However, for Medicare Advantage members, CMS does not allow you to charge for “missed appointments” unless you have previously disclosed that policy to the member.

Charging Members for Non-covered Services
You may seek and collect payment from our commercial members for services not covered under the applicable benefit plan, provided you first obtain the member’s written consent. The consent must be signed and dated by the member prior to rendering the specific service(s) in question. Retain a copy of this consent in the member’s medical record. If you know, or have reason to suspect, the service may not be covered (as described below), the written consent also must include: (a) an estimate of the charges for that service; (b) a statement of reason for your belief the service may not be covered; and (c) in the case of a determination by us planned services are not covered services, a statement that we have determined the service is not covered and that the member, with knowledge of our determination, agrees to be responsible for those charges.

For Medicare Advantage members, in addition to first obtaining the member’s written consent as indicated, the following must also occur in order for you to seek and collect payment from our member for a non-covered service or item.

• If you know or have reason to believe that a service or item you are providing or referring may not be covered (as described below), you must request a pre-service organization determination from UnitedHealthcare prior to providing or referring for the service or item and UnitedHealthcare must issue a determination before you render or refer for the non-covered service or item.

• If after you request a pre-service determination, UnitedHealthcare determines that the service or item is not covered, UnitedHealthcare will issue an Integrated Denial Notice (IDN) to the member and you. The IDN informs the member of their liability for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment. Please be aware that when a Medicare Advantage member wishes to receive a non-covered service or item, CMS requires that the member be provided an IDN in order for the them to be held financially liable for the non-covered service or item unless the service or item is clearly excluded in the EOC or other related materials.

• A pre-service organization determination is not required in order to seek and collect payment from the member where the Medicare Advantage Member’s Evidence of Coverage (EOC) or other related materials is clear that a service or item is never covered.

A pre-service organization determination must be requested by submitting an advance notification request using UnitedHealthcareOnline.com > Notifications/Prior Authorizations.

You should know or have reason to believe that a service or item may not be covered if:

• We have provided general notice through an article in a newsletter or bulletin, or information provided on UnitedHealthcareOnline.com, (including clinical protocols, medical and drug policies) either that we will not cover a particular service or item, or that a particular service or item will be covered only under certain circumstances not present with the member; or

• We have made a determination that the planned service or item is not covered and have communicated that determination to you on this or a previous occasion.

• For Medicare Advantage benefit plans, CMS has published guidance, through National Coverage Determinations, Local Coverage Determinations, or other CMS guidance, indicating that the service or item may not be covered in certain circumstances. You are required to review the Medicare Coverage Center...
available at cms.gov. You must not bill our member for a non-covered service or item in cases in which you do not comply with this Protocol.

If, in accordance with the terms of this protocol, you requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the –GA modifier on your claim for the non-covered service. Including the –GA modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as member liability.

You must not bill a member for non-covered services in cases in which you do not comply with the terms of this protocol. Failure to comply with the terms of this protocol, including but not limited to failure to request a pre-service organization determination for a Medicare Advantage member or rendering the service to a Medicare Advantage member before we issue the pre-service organization determination, results in an administrative claim denial. You cannot bill the member for administratively denied claims.

**Balance Billing**
You may not balance bill the member for additional payment of covered services beyond their normal cost share amounts, (copayments, deductibles, or coinsurance) associated with their benefit plan.

For Medicare Advantage members who are eligible for Medicaid, you may not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage member, or their representative, or against the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, and coinsurance). You must either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost-sharing amount.

**Member Financial Responsibility**
Members are responsible for the copayments, deductibles, and coinsurance associated with their benefit plans. You should collect copayments at the time of service. To determine the exact member responsibility related to benefit plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) when billing patients who are our members.

However, if you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools on our website can help you determine member and health benefit plan responsibility, including Claim Estimator (UnitedHealthcareOnline.com > Claims & Payments > Claim Estimator) and the Patient Eligibility & Benefits function, which shows HRA balances. (Claim Estimator is available only for professional commercial claims).

Some claims may be adjudicated in real time while the member is still in your office. After services have been rendered, you can use the claim submission feature on UnitedHealthcareOnline.com. Within seconds you receive a fully adjudicated claim that shows the benefit plan's responsibility and the member's responsibility, based on contracted discounts and plan benefits. This helps promote accurate collections and avoid overpayment or underpayment situations.

In the event the member pays you more than the amount indicated on the medical claim EOB/remittance advice, you are responsible for promptly refunding the difference to the member.

**Preventive Care**
The Department of Health and Human Services has released regulations that require most benefit plans to include preventive care without any cost-sharing (copayments, coinsurance or deductible) requirements as long as services are rendered by participating physicians and other health care professionals.

UnitedHealthcare has updated its Preventive Care Services Coverage Determination Guideline (CDG) to help physicians identify and correctly code preventive services they deliver to members.

The CDG is updated when new guidance is received about services that should be covered as preventive services and whenever the applicable codes are revised. The United States Preventive Services Task Force is one of the primary references driving changes to the CDG. Items that have an “A” or “B” rating must be covered without cost-share by non-grandfathered benefit plans.

This preventive services provision applies to both fully insured and self-funded benefit plans. While grandfathered benefit plans are not required to implement these changes, some grandfathered benefit plans have chosen to cover preventive care services at no cost-share.

This provision does not apply to members enrolled in government health benefit plans (Medicare/Medicaid) including UnitedHealthcare Medicare Solutions Medicare Advantage benefit plans. For information on Medicare coverage of preventive services, please go to UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries > Preventive Health Services and Procedures. For more information please visit:

- Benefit Verification: You can verify the benefits and coverage of UnitedHealthcare members in the eligibility application on Link. Health care Reform: UnitedHealthcareOnline.com > Quick Links > Health Reform Resources > Providers > Health Reform for Providers > Preventive Services.
• Coverage Determination Guideline:
  UnitedHealthcareOnline.com > Tools & Resources
  > Policies, Protocols and Guides > Medical & Drug
  Policies and Coverage Determination Guidelines -
  Commercial > Preventive Care Services.

Provider Audits - Extrapolation

As part of our payment integrity responsibility to evaluate
the appropriateness of paid claims, we may conduct a
systematic review of paid claims. In cases where reviewing
all medical records for a particular code would be
burdensome on you, we may select and audit a statistically
valid random sample (SVRS) of claims, or a smaller
subset of the SVRS, in order to obtain an estimate of the
proportion of claims that were, in fact, paid in error. The
estimated proportion—referred to as the error rate—may
then be projected across the relevant universe of claims
to determine any overpayment, as permitted by law or
regulation. You may appeal the initial overpayment findings
or alternatively, if only a subset of the SVRS sample was
reviewed, cooperate by supplying the full sample of
medical records represented in the SVRS. Should you
request a more comprehensive audit, we will select a
larger sample of claims, re-estimate the error rate based
on the payments made in that sample, and extrapolate our
findings across the relevant universe of claims to determine
the amount of overpayment, if any. Any Overpayment
Disputes are handled as outlined in this guide and in your
agreement with us.

Hospital Audit Services

We use appropriate nationally recognized billing or coding
guidelines as the criteria for audits performed by our
internal auditors and/or external contracted vendors.
These coding guidelines are produced by the American
Association of Medical Audit Specialists, in partnership
with CMS, and other nationally recognized regulatory
agencies and can be located at: aamas.org > Resources
> Nat’l Audit Guidelines. Facility audits are designed to
identify billing and coding inaccuracy, and audits are
developed in response to identified contract risk. Facility
audits include a thorough review of critical claim elements
not submitted on the UB-92 or UB-04, such as medical
record, itemized bill, manufacturer invoices, etc. Audits may
be conducted on a pre-payment or post-payment basis,
depending on the federal and state regulations, national
guidelines and the terms of your agreement with us. These
audits may be conducted either onsite at the hospital/
care provider’s location, or offsite in cooperation with a
designated representative. In accordance with the National
Hospital Billing Audit Guidelines, UnitedHealthcare may
conduct other audits, or make other records requests, in
addition to the audits described in this guide.

Standard Percent of Charge Hospital Bill Audit

The scope of audit for our Standard Percent of Charge
Hospital Bill Audit includes review of medical records to
substantiate charges billed by the hospital. The process
below provides details on handling of inappropriate
charges identified during the course of an audit. Generally,
the auditor is expected to report their written findings to
the hospital representative upon completion of the audit.
Inappropriate charges may include, but are not limited to
an individual charge that appears to have been unbundled
from the more general charge in which it is commonly
included or a charge not supported by the medical
record. Post-audit claim reconsideration reconciles any
overpayments or underpayments identified as a result of
the audit process, in accordance with applicable law and
your agreement with us.

Hospital Requirements and Access

UnitedHealthcare’s internal auditors and/or external
contracted vendor notifies the hospital of the intent to audit
a claim by sending a communication to the appropriate
hospital representative.

The hospital provides the following:

• A copy of the itemized bill to our auditor and/or
  contracted vendor, within 30 calendar days of the date
  requested, and/or

• A copy of the bill breakdown to the auditor and/or
  contracted vendor at the time of the audit. (The hospital
  notifies the auditor and/or contracted vendor if a bill
  breakdown will be provided within 30 calendar days after
  we notify the hospital of our intent to audit.)

• The hospital must cooperate in a timely manner, so the
  auditor and/or contracted vendor can complete the
  audit scheduling process within 30 calendar days of the
  scheduling request.

• If there is a requirement for a valid authorization
  to release medical information, it is the hospital’s
  responsibility to obtain this release from the member, or
to waive the requirement if permitted under applicable
  law. In many cases, such authorizations are signed at the
  time of admission and may already be on file.

• If there is a hospital-imposed fee to audit the medical
  record, or a copy fee, such fee is waived unless specified
  in the hospital’s agreement with us.

• Audits are conducted either onsite or at the hospital in
  cooperation with the hospital representative.

• At the time of the audit, the hospital provides the auditor
  and/or contracted vendor with access to the medical
  record, all applicable department charge sheets
  and, if requested, any applicable hospital policy and
  procedures.

• The hospital gives our audit vendors the same level of
  access as our employee auditors, when those vendors
  are acting at our direction and on our behalf. Any vendor
authorized by us to conduct an audit on our behalf is bound by our obligations under the hospital’s agreement with us. This includes any confidentiality requirements regarding the hospital audit, and compliance with HIPAA requirements and use of Protected Health Information.

• The hospital may not impose any time limitation on our right or ability to audit, unless stated in the hospital’s agreement with us or permitted by applicable state or federal law.

Audit findings
At the completion of each audit, the auditor and/or contracted vendor may notify the hospital of our audit findings, which include overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed. Upon request, we provide the hospital representative with a copy of the audit findings. If the audit occurs at a location other than the hospital, a copy of the findings are supplied promptly.

Post-audit procedures
• Refund Remittance – In the event there is an undisputed overpayment, the hospital remits the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.

• Disputed Audit Findings – In the event the hospital wishes to dispute any audit findings, the hospital submits notification of its intent to dispute the audit findings to our auditor and/or contracted vendor within 30 calendar days of receipt of the audit findings per the terms outlined in our overpayment notification letter. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.

• Dispute Resolution – We respond to notification of disputed audit findings in writing within 60 calendar days of receipt.

• Escalated Dispute Resolution – In the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare as well as our Network Management staff. Escalated Dispute Resolution causes suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties.

• Unresolved Dispute – Either party may further pursue dispute resolution as outlined in this guide and in your agreement with us.

• Offsets – When a refund request has been issued in connection with an audit, we recoup or offset the identified overpayment, and/or disallowed charge amounts after the expiration of 35 calendar days from the date of the refund request provided by our auditor and/or contracted vendor, except under the following circumstances: (1) the hospital has remitted the amount due within the 35 calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the 35 calendar day repayment period; or (3) your agreement or state law indicates otherwise.

Technical Denials
In accordance with the Audit Findings and Post-Audit Procedures listed above, the hospital is required to submit, or provide access to, medical records upon UnitedHealthcare or UnitedHealthcare representative request. Failure to do so in a timely manner may result in a technical denial, resulting in an overpayment. Medical record requests that do not comply with the guidelines established by the Overpayments section of Chapter 8: Our Claims Process follow the technical denial process. In addition to the initial medical record request notification sent with all audited claims, technical denial claims include additional information, notifying care providers of the technical denial process, overpayment, and future actions.

Notice of Medicare Non-Coverage (NOMNC)
You must deliver required notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member’s services are expected to be fewer than two calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds two calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is incompetent. You must use the most current version of the standard CMS approved notice entitled, “Notice of Medicare Non-coverage” (NOMNC).

The standardized form and instructions regarding the NOMC may be found on the CMS website at cms.gov > Medicare > Beneficiary Notices Initiative (BNI) > MA ED Notices or contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text and all required elements must be present, including but not limited to instructions on how to contact the QIO and the member’s Medicare Advantage benefit plan.

Any appeals of such service terminations are called “fast track” appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of calendar day of the day that you are notified by us or the QIO if the member has requested a fast track appeal. (This includes, but is not limited to, weekends and holidays.)
Chapter 10: Medical Records Standards and Requirements

Access to Records
We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you provide copies of those records free of charge unless your participation agreement provides otherwise.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our members within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for confidentiality for 6 years or longer if required by applicable statutes or regulations. For example, for the Medicare Advantage benefit plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for services provided during the period in which the agreement was in place.

Operational Measure Related to Patient Hospitalization Experience
Without limiting any other data access rights set forth in your agreement with us, you must assist us or our designee in completing necessary chart reviews of Medicare Advantage medical records, specifically for the CMS required data submission related to the following operational measures:

- Plan All Cause Re-admission (PCR), and
- Medication Reconciliation Post-Discharge (MRP),

for all applicable UnitedHealthcare Medicare Advantage members.

Medical Record Standards
A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. Access medical record tools and templates and patient safety resources here: UnitedHealthcareOnline.com > Clinician Resources > Patient Safety Resources.

Additionally, our recommended medical record standards are published each November for commercial and Medicare Advantage benefit plans in the Network Bulletin found here: UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin.

Monitoring the Quality of Medical Care Through Review of Medical Records
In addition to other audits, we may conduct a medical record audit to review the quality of medical care, as reflected in medical records. A well-documented medical record reflects the quality and completeness of care delivered to patients.

Regular review of medical records can provide data that helps physicians and other health care professionals improve preventive, acute and chronic care rendered to patients. Accreditation and regulatory organizations, such as your state Department of Health and CMS, include review of medical records as part of their oversight activities. We require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.
Chapter 11: Health and Disease Management Programs

Clinical and Preventive Health Guidelines
UnitedHealthcare uses evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. We hope you will consider this information and use it, for our members when appropriate. A complete list of the clinical guidelines can be found at: UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Clinical Guidelines (in the left navigation pane). There have been significant changes to the guidelines listed below: A list of the clinical guidelines is also published each September in the Network Bulletin found here: UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin.

Health Management Programs
UnitedHealthcare offers case and disease management programs to support physicians’ treatment plans and assist members in managing their conditions. Using medical, pharmacy, and behavioral health claims data, our predictive model systems help us identify members who are at high risk and direct them to our programs. Patients can also be identified at the time of hospital discharge by a Health Risk Assessment, a NurseLine referral, or a member or caregiver referral. If you have patients who are UnitedHealthcare members who would benefit from case or disease management, you can refer them to the appropriate program by calling the number on the member’s health care ID card. Participation in these programs is voluntary. Upon referral, each member is assessed for the appropriate level of care for their individual needs. Programs vary depending on the member’s benefit plan.

Case Management
Our case managers are registered nurses who engage the appropriate internal, external or community-based resources needed to address member’s health care needs. When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, mental health, employee assistance and disability. Case management services are voluntary and a member can opt out at any time.

Transitional Case Management: Transitional Case Management (TCM) is the collaborative process of evaluating and coordinating post-hospitalization needs for members identified as being at risk of re-hospitalization or as frequent users of high-cost services.

General Condition Management: General Condition Management serves individuals with chronic conditions, those in need of longer-term support, or those who have unmet access, care plan, psycho-social, or knowledge needs.

More Information about health and case management programs can be found on UnitedHealthcareOnline.com > Tools and Resources > Health Resources for Patients.

Complex Medical Conditions programs
Transplant Resource Services: Members eligible for this program have access to the Optum Center of Excellence transplant network.

Congenital Heart Disease program: The Congenital Heart Disease (CHD) program offers members aged 18 and younger, with a clinical diagnosis of congenital heart disease specialized clinical management and supports them and their families throughout the process of facility selection, inpatient stay, and post-discharge management.

Bariatric Resource Services: The Bariatric Resource Services (BRS) program is designed to help facilitate optimal outcomes through the use of evidence-based guidelines, and access to a Centers of Excellence (COE)/designated care provider network of quality bariatric centers to help improve clinical and economic outcomes, and offer clinical case management by a dedicated nursing staff.

Women’s Health Services: We offer an integrated solution to rising costs related to complexities of pregnancy and childbirth. Within women’s health there are programs that focus on infertility, maternity and neonatal care.

Decision Support programs
NurseLine: A decision support solution that leverages a coaching call model and ICUE to help facilitate better health outcomes. Each call becomes an opportunity to not only address a symptom, but to connect members with the right care, right care provider, right medication and right lifestyle.

Treatment Decision Support: Treatment decision support (TDS) is a shared-decision making solution that leverages a predictive model to help identify and engage individuals who may be seeking care for certain conditions with highly variable treatment options, such as back surgery.

Wellness and Behavioral Health Programs
UnitedHealthcare offers multiple care coordination programs that may be available to our members depending on their health benefit plan. Many of the programs offered are focused on delivering skilled resources to assist members with improved self-management by helping them understand the care provider’s care plan, and helping them understand the medication instructions. In order to access these programs, please have members contact a UnitedHealthcare representative through the phone number listed on their health care ID cards.
Wellness programs

Healthy Back: The Healthy Back program is a consumer-based program that provides support and guidance to members to help them navigate the health care system with the goal of improving access to a high level of care. It includes a phone-based coaching program enhanced with online back pain management tools to maximize outcomes and control costs.

Healthy Weight: The Healthy Weight program is an intense weight management coaching solution focused on changing behaviors and lifestyles to achieve long lasting weight loss, reduced health risks, and an improved quality of life.

Tobacco Cessation: We offer a comprehensive tobacco cessation solution integrating industry and employer best practices. OurQuit Power program combines specialized tobacco coaching with nicotine replacement therapy.

Wellness Coaching: Wellness Coaching is a phone or mail-based program that helps members identify and prioritize unhealthy behaviors, and set personalized goals that focus on positive, healthy behavior change.

Behavioral Health Programs

UnitedHealthcare offers specialized mental health and substance use benefits delivered by our affiliate company United Behavioral Health, operating under the brand Optum™, which may be available to members depending on their health benefit plan. In order to access these programs, please have your patients contact their UnitedHealthcare representative through the phone number listed on the back of their health care ID card.

Full Care Management Programs: A mental health and substance use benefit helps members get help for problems, such as depression or a drug or alcohol use disorder. This program is available around the clock. Optum offers confidential, comprehensive services and arranges a wide array of treatment options from acute inpatient care to individual outpatient counseling.

When members call Optum for assistance, they speak directly to a specialist who can answer questions related to their mental health and substance use benefits. Working in strict confidence, trained professionals listen to each person carefully. Referrals are matched to specific needs using a nationwide network.

Employee Assistance Programs: Employee Assistance Program (EAP) benefits provide confidential support for a variety of everyday challenges. It is available to members and their families who have EAP benefits.

The EAP provides short-term counseling for individuals who may be struggling with stress at work, seeking financial or legal advice, coping with the death of a loved one, or just want to strengthen relationships with their family. EAP benefits also offer assistance, support or referral for other concerns such as depression, stress and anxiety, relationship difficulties, financial and legal advice, parenting and family problems, child and elder care support, dealing with domestic violence, substance use and recovery, and eating disorders.

Consumer Transparency Tools: MyHealthcareCostEstimator (myHCE)

The myHealthcareCostEstimator (myHCE) is an online cost estimator tool available in some markets to UnitedHealthcare commercial members at myUHC.com and is designed to assist them in making informed health care choices based on cost and quality. The tool displays care provider-specific cost estimates in conjunction with UnitedHealth Premium physician designations and Hospital Quality Ratings. Information about each program can be found on UnitedHealthcareOnline.com > Tools and Resources > Health Resources for Patients > Transparency (myHCE).

If you would like to review your cost data and a description of the methodology underlying myHCE please contact your UnitedHealthcare Network Management Representative or Hospital or Physician Advocate.

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<th>Topic</th>
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<tr>
<td>Chronic Obstructive Lung Disease*</td>
<td>Global Initiative for Chronic Obstructive Lung Disease (GOLD)</td>
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<td>Depression/Major Depressive Disorder</td>
<td>American Psychiatric Association</td>
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<td>Diabetes*</td>
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<td>Dietary Guidelines*</td>
<td>U.S. Department of Health and Human Services</td>
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<td>Heart Failure*</td>
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Behavioral Health Information

The U.S. Preventive Services Task Force (USPSTF) recommends screening patients for depression and alcohol misuse in primary care settings. If left untreated, these disorders can adversely affect quality of life and clinical outcomes. Screening for these disorders is critical to treatment since it can contribute to the patient’s readiness to change.

You can help by screening all patients, including adolescents, for depression and alcohol misuse. To assist, Optum and UnitedHealthcare recommend the following screening tools:

**Depression**
- Patient Health Questionnaire (PHQ-9)
- CPT 99420

**Alcohol Misuse**
- Alcohol Use Disorders Identification Test (AUDIT) or CAGE
- CPT 99420

When doing a screening for depression in adults, remember to include the 99420 Procedure (CPT) and the ICD-10-CM Z13.89 code.

Find these screening tools for free online. You may also email your request to Optum at BHInfo@uhc.com. For more information and resources on depression and alcohol-use disorders, members may access the Optum website, liveandworkwell.com.

To refer a member to an Optum network care provider for assessment and/or treatment, call the toll-free number on the back of the member’s health care ID card. A list of Optum care providers can be accessed at providerexpress.com.

The UnitedHealthcare Preventive Medicine and Screening Reimbursement Policy notes that counseling services are included in preventive medicine services. This policy is available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Reimbursement Policies - Commercial. The Preventive Care Services Coverage Determination Guideline is available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial. For information on coverage of mental health services and preventive health services for Medicare Advantage members, see the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, and the Medicare Advantage Coverage Summary for Mental Health Services and Procedures, available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries.

Depression, Alcohol and Drug Use Disorder and Addiction & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program Information

Optum has developed online preventive health resources that offer up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol and drug use disorder and attention-deficit/hyperactivity disorder (ADHD). A convenient, reliable and free source of pertinent health information, the preventive health website includes:

- A dedicated section for physicians and other health care professionals with articles addressing aspects of each condition;
- Information about co-morbid conditions;
- Links to nationally recognized practice guidelines;
- A self-appraisal that you can print, use or refer your patients to; and
- A listing of support resources for you, our members, and their families.

Physicians and other health care professionals may access the information on prevention.liveandworkwell.com.

Collaboration Between Primary Physicians and Behavioral Health Clinicians

A substantial number of patients with serious medical illnesses also have mental health or substance use health conditions. Continuity and coordination of care take on greater importance for patients with severe and persistent mental health and/or substance use problems. This is especially true when medications are prescribed, when medical/psychiatric symptoms co-exist and when patients have been hospitalized for a medical or psychiatric condition.

Please discuss with your patients the benefits of sharing essential clinical information. When applicable, we encourage you to obtain a signed release from each UnitedHealthcare member that allows you to share appropriate treatment information with the member’s behavioral health clinician.

Psychiatric Consults for Medical Patients

Please contact Optum if you would like to: 1) arrange a psychiatric consultation for a member in a medical bed, 2) are unclear whether a behavioral health consultation is warranted, or 3) want assistance with any needed behavioral health authorization. Optum can be reached by calling the pertinent phone number on the back of the member’s health care ID card.
Chapter 12: Quality Management Program

The Quality Management (QM) program focuses on helping to ensure access to the delivery of health care and services for all our members through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles.

The QM program activities include:

- Identification of the scope of care and services rendered
- Development of clinical guidelines and service standards by which clinical performance is measured
- Objective evaluation and systematic monitoring of the quality and appropriateness of services and medical care received from our network of care providers
- Assessment of the medical qualifications of participating physicians and other health care professionals
- Continued improvement of member health care and services
- Efforts to help ensure patient safety and confidentiality of member medical information
- Resolution of identified quality issues

The ultimate authority and oversight responsibility for our QM Program lies with our board of directors. Day-to-day QM operations are delegated to the Regional Quality Director and Senior Medical Director.

Quality Management Committee Structure

The Medical Advisory Committee (MAC) oversees, reviews, and provides recommendations on QM activities. Reviews may include, but are not limited to, clinical practice guidelines, medical policies, pharmacy updates, service standards, over-utilization and under-utilization of services by physicians and other health care professionals. This committee also makes recommendations regarding the selection of QM studies (based on identified high-volume, high-risk and problem-prone areas in their regions) and develops and implements regional components of the QM work plan.

The UnitedHealthcare Board of Directors has delegated responsibility for the oversight of health plan quality improvement activities to the Regional Quality Oversight Committee (RQOC).

The Regional Peer Review Committee (RPRC) provides a forum for qualified physicians to investigate, discuss and take action on member cases involving significant concerns about quality of care. The RPRC has been delegated decision-making authority by the National Peer Review Committee (NPRC).

The NPRC provides a forum for qualified physicians to discuss and take disciplinary action on member cases involving significant concerns about quality of care that were unresolved through Improvement Action Plan mechanism administered by the RPRC.

The National Provider Sanctions Committee (NPSC) provides a forum for qualified physicians to discuss and take action on sanction reports involving participating practitioners that raise issues regarding compliance with our credentialing plan, and/or patient safety concerns. Sanctions are monitored from government agencies and authorities including but not limited to CMS, Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG) that relate to Licensed Independent Practitioners (LIP).

Program Scope

- Identifying high-volume, high-risk and problem-prone areas of care and service affecting our population.
- Developing clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage, based on the availability of accepted national guidelines, the ability to monitor compliance and aspects of care.
- Undertaking quality improvement studies in clinical areas identified through careful claims data analyses; including frequency and cost breakdowns by member’s age, sex and line of business, episode treatment groups, major medical procedure categories, diagnosis, and diagnosis-related groups (DRGs).
- Utilizing population-based preventive health care audits to assess the level of preventive care rendered across our membership; separate studies are completed for special risk groups.
- Conducting regular surveys to assess member satisfaction, physician satisfaction, employer satisfaction, and reasons for voluntary physician disenrollment.
- Measuring adherence to physician service standards in areas such as wait times for appointments, in-office care and practice size and availability. To measure this we use complaint data, Consumer Assessment of Healthcare Providers and Systems survey information and GeoAccess analysis.
- Monitoring performance of QM-related functions for compliance with contract, including activities such as oversight of medical policies and procedures, reporting activities, encounter reporting, and regulatory compliance.
- Conducting routine medical record audits to assess physician compliance with the medical record review standards and preventive care guidelines, as well as...
monitoring coordination and continuity of care between PCPs and specialists.

Note: This is not the only reason we conduct such audits. Other audits may have different procedures and processes depending on their purpose and design.

• Helping to ensure medical record documentation provides the plan for your patients’ care, including continuity and coordination of care with other physicians, facilities and health care professionals; proper documentation in the medical record accurately and completely reflects the care provided to your patient and serves as both a risk management and patient safety tool.

• Reviewing and resolving member complaints regarding the provision of medical care and services; investigation may include verbal and written contact with the member and the physician or other health care professional, as well as a review of relevant medical records and responses to potential concerns identified.

Credentialing and Re-Credentialing

We are dedicated to providing our members with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our Provider Directory, and re-credential them at least every 36 months thereafter in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with and more extensive than the National Committee for Quality Assurance (NCQA) and CMS requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use CAQH ProView for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health benefit plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for re-credentialing are instructed on the proper method for accessing CAQH ProView.

Participating physicians and other health care professionals are responsible to verify licensure and other credentials, as applicable, of their clinical support staff.

Rights Related to the Credentialing Process

Care providers applying for the UnitedHealthcare network have the right to:

• Review the information submitted to support your credentialing application;
  Information from outside sources may be shared with the exception of personal or professional references or other information that is peer review protected.

• Correct erroneous information;
  The credentialing entity notifies the applicant in writing, by fax, within 30 days of identification of any information that varies substantially from the information provided by the applicant. Using the fax request form, the applicant must submit to the credentialing entity any corrections (using the fax number provided on the fax request form) within 30 days of the applicant’s notification of the discrepancy.

• Be informed of the status of your credentialing or re-credentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at 877-842-3210. Say or enter your TIN, respond to the prompts as follows: Other Professional Services > Credentialing > Medical > Get Status.

UnitedHealth Premium Designation Program (Commercial Plans)

The UnitedHealth Premium® physician designation program uses clinical information from health care claims and other sources to assist physicians in their continuous practice improvement and to help consumers make more informed and personally appropriate choices for their medical care. The program uses evidence-based, medical society, and national industry standards with a transparent methodology and robust data sources to evaluate physicians across 16 premium specialties which represent 47 sub-specialties.

The program works to advance safe, timely, effective, efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality, and with cost efficiency peer groups in the same geographic area.

Evaluation for quality compares a physician’s observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. Cost efficiency is assessed by comparing the case-mix adjusted cost of care attributed to the physician to a benchmark and applying a statistical test to determine if the difference is statistically significant. Quality is the fundamental measurement, demonstrating our commitment to evidence-based practice. The quality designation is separate from the cost efficiency
designation. The results are used together to determine the physician’s designation. Quality and cost efficiency evaluations each incorporate adjustments for the case mix of the physician and the level of the patient’s severity of illness where appropriate.

Your UnitedHealthcare Premium Designation is affected by referrals you make for our members to other care providers. This includes referrals for DME/orthotics, medical devices, and to care providers or facilities. For example, if you frequently refer to higher cost care providers or services, your inclusion or status in the Premium Designation program could be adversely affected.

Physicians receive one of the following designations:

- **Premium Care Physician**
  The physician meets UnitedHealth Premium program criteria for providing quality and cost-efficient care.

- **Quality Care Physician**
  The physician meets the UnitedHealth Premium program criteria for providing quality care.

- **Quality Not Evaluated**
  The UnitedHealth Premium program does not evaluate physicians in this specialty, or the physician's evaluation is in process; or
  The physician does not have enough health plan claims data to be evaluated for quality in the UnitedHealth Premium program. If the physician does not have enough data to assess quality, they are not eligible for the cost-efficiency designation.

- **Does Not Meet Quality**
  The physician does not meet the UnitedHealth Premium program criteria for providing quality care. If the physician does not meet the quality criteria, they are not eligible for the cost-efficiency designation.

Employers may also choose to offer their employees a tiered benefit plan, which may offer an enhanced benefit in the form of lower member cost share for using Premium Care Physicians. For more information on tiered benefits, go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services > Tiered Benefit Plans.

We strongly support transparency in our performance assessment criteria and methods. For more information regarding the UnitedHealth Premium physician designation program (including the measures, measurement methodology and how we use the results) - go to UnitedHealthcareOnline.com > Quick Links > UnitedHealth Premium, or call our toll-free number at 866-270-5588.

**Note:** The UnitedHealth Premium physician designation program does not apply to Medicare Advantage benefit plans.

**Star Ratings for Medicare Advantage and Prescription Drug Plans**

Several industry quality programs, including the programs for CMS Star Ratings, provide external validation of our Medicare Advantage and Part D benefit plan performance and quality progress. Quality scores are provided on a one to five-star scale, with one star representing the lowest quality and five stars representing the highest quality. Star Ratings scores are derived from four sources:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or patient satisfaction data,
2. HEDIS or medical record and claims data,
3. Health Outcomes Survey (HOS) or patient health outcomes data, and
4. CMS administrative data on benefit plan quality and member satisfaction.

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D benefit plans, go to the CMS consumer website at cms.gov.
Imaging Accreditation

If you perform outpatient imaging studies and bill on a – Form 1500 or the electronic equivalent, you must obtain accreditation from one of the accrediting agencies listed below.

- American College of Radiology (ACR) at acr.org
- Intersocietal Commission Accreditation of CT Labs (ICACTL) at icactl.org
- Intersocietal Accreditation Commission (IAC) at intersocietal.org
- Intersocietal Commission Accreditation of Magnetic Resonance Labs (ICAMRL) at icamrl.org
- Intersocietal Commission Accreditation of Echocardiography Labs (ICAEL) at icael.org
- Intersocietal Commission Accreditation of Nuclear Medicine Labs (ICANL) at icanl.org

Accreditation is required for the following procedures: CT scan, MRI, Nuclear Medicine/Cardiology, PET scan and Echocardiography, in order to avoid the potential reimbursement reductions described below. This requirement applies to global and technical service claims.

The accreditation process takes approximately six to nine months to complete. This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards. Once we notify you, failure to obtain accreditation affects your right to be reimbursed for care rendered using these procedures. As a result, we implement an administrative claim reimbursement reduction for global and technical service claims, in part or in whole.

Accreditation is obtained by submitting an application and fulfilling accreditation standards.

Additional details regarding this accreditation requirement are available on UnitedHealthcareOnline.com > Clinician Resources > Radiology > Imaging Accreditation.
Chapter 13: Member Rights and Responsibilities

UnitedHealthcare members have certain rights and responsibilities, all of which are intended to uphold the quality of care and services they receive from you. These rights and responsibilities are listed in the member materials for commercial and Medicare Advantage benefit plans.

- An online version of member rights can be found at UHC.com > Featured Links > About Us > Member Rights & Responsibilities in the left navigation menu. You can download a copy if needed.
- A copy of the Member Rights and Responsibilities can be obtained by calling your Provider Advocate at 877-842-3210.
- Member Rights and Responsibilities for Medicare Advantage Plan members can be found at uhcmedicaresolutions.com > Medicare Advantage Plans > What Do I Need to Know > Medicare Advantage Information and Forms > Other Resources and Plan Information.

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights. Information related to our privacy practices can be found at uhc.com > Featured Links > Privacy.

Advance Directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and care providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform members of state laws on advance directives through our member’s benefit material. We encourage these discussions with our members.
Chapter 14: Fraud, Waste and Abuse

The purpose of UnitedHealthcare’s Fraud, Waste and Abuse (FWA) Program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. The Program is comprised of two principle functions.

• The Payment Integrity functions are performed by UnitedHealthcare Payment Integrity, Optum entities and others. They help ensure reimbursement accuracy, keep up to date on new and emerging FWA schemes as well as new methodologies and technologies to combat FWA.

• Special Investigations Units ( SIUs) perform retrospective investigations of suspected of fraud committed against UnitedHealthcare health care benefit plans and programs.

This program is part of the UnitedHealthcare Compliance Program led by the UnitedHealthcare Chief Compliance Officer. Our Compliance Department works closely with internal business partners in developing, implementing and maintaining the program.

For CMS definitions of fraud, waste, or abuse, please refer to the Glossary at the back of this guide.

If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately. Please see the Resources and How to Contact Us section in Chapter 1 for contact information. UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

Medicare Compliance Expectations and Training

CMS requires Medicare Advantage ( MA) Organizations and Part D Plan Sponsors, including UnitedHealthcare, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their “first tier, downstream, and related entities” ( FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties. FDRs working on Medicare Advantage and Part D programs – including contracted care providers – must complete the two requirements below within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services. The required education, training, and screening requirements include the following:

Standards of Conduct Awareness

Provide a copy of their own code of conduct, or the UnitedHealth Group’s (UHG’s) Code of Conduct (at unitedhealthgroup.com > About > Ethics & Integrity > UnitedHealth Group’s Code of Conduct).

What You Need to Do

Provide your own or the UHG’s Code of Conduct as outlined above and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste, and Abuse and General Compliance Training

Provide Fraud, Waste, and Abuse (FWA) and General Compliance training.

As of Jan. 1, 2016, CMS no longer required the use of CMS published training materials to meet compliance training requirements. You have met CMS training and education requirements if you complete FWA certification through a fee-for-service Medicare program, or if as a DMEPOS provider you meet accreditation requirements through a fee-for-services Medicare program. FDRs must still complete the General Compliance Training available on the CMS Medicare Learning Network® at cms.gov.

You cannot alter the published CMS training material content. But you can download CMS training material and add information specific to your organization.

What You Need to Do

• Administer FWA and General Compliance training as outlined above.

• Maintain a record of completion ( i.e., method, training materials, dated employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for 10 years. UnitedHealthcare or CMS may request documentation from you to verify compliance with this requirement.

Exclusion Checks

Prior to hiring or contracting employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services.
Chapter 14: Fraud, Waste and Abuse

What You Need to Do
• Make sure that potential employees are not excluded from participating in federal health care programs as outlined above. 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) at oig.hhs.gov.
  › General Services Administration (GSA) System for Award Management at SAM.gov
• Review the federal and state exclusion lists on a monthly basis thereafter.
• Maintain a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

Examples of Potentially Fraudulent, Wasteful, or Abusive Billing
(Not an inclusive list)
**Back filling:** Billing for part of the global fee before the claim is received for the actual global code.
**Billing for services not rendered:** Billing for services or supplies that were not provided to the member.
**Billing for unauthorized services or equipment:** Billing for ancillary, therapeutic or other services without a required physician’s order.
**Billing while ineligible:** Billing for services after care provider’s license has been revoked/restricted or after debarred from a government benefits program for fraud or abuse.
**Double billing:** Billing more than once for the same service.
**Falsified documents:** Submitting falsified or altered claims or supporting claims with falsified or altered medical records and/or supporting documentation.
**Looping:** Claims are submitted for various family members when only one member is receiving services.
**Misrepresentation:** Misrepresenting the diagnoses and/or services provided for which they were based in order to obtain higher payment or payment for non-covered services.
**Patient brokering:** Care provider has “brokers” who offer money to subscribers for the use of their ID cards.
**Phantom billing:** Billing by a “phantom” or non-existent care provider for services not rendered.
**Unbundling:** Billing each component of a service when one comprehensive code is available.

**Up-coding:** Billing at a higher level of service than was actually provided.
**Waiver of copay:** Failure to collect copayments or deductibles as part of the payment agreement.

Prevention and Detection
Potential FWA is prevented and detected through various internal and external sources, which include but are not limited to the following:
• UnitedHealthcare Payment Integrity functions
• Optum Companies within UnitedHealth Group
• Health care providers
• Health plan members
• Federal and state regulators and task forces
• News media
• Professional anti-fraud and compliance associations
• CMS Web Sites: oig.hhs.gov/oei/reports
  oig.hhs.gov/exclusions
In addition, prevention and detection is monitored and audited through such mechanisms as:
**Prospective Detection:**
• Pre-Payment Data Analytics
• Data Mining Queries
• Abnormal Billing Patterns
• Other activities to determine if additional prospective activities are needed.
**Retrospective Detection:**
• Post-Payment Data Analytics
• Payment Error Analytics
• Industry Trend Analysis
• Care Provider Audits

Corrective Action Plans
As an additional part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may initiate and implement a formal corrective action plan if a care provider fails to comply with our billing guidelines or performance standards. We monitor the corrective action plan to confirm it is implemented effectively, and to help ensure any billing or performance problems are addressed and not repeated.
Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of HIPAA. The law makes it illegal to offer money, or services that a person knows or should know are likely to influence a member to select a particular care provider, practitioner, or supplier. Examples include offering gifts to induce members to come in for a consultation or treatment, or waiving copayments and deductibles to motivate members to receive services from a care provider. Care providers who violate this law are fined – up to $10,000 for each wrongful act. Fines may be assessed for up to three times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities: Items or services offered to members for free must be worth less than $10 and total less than $50 per year per beneficiary. You must never give cash or gift cards to members.
Provider Website

Our goal is to streamline and simplify the care provider experience by combining all UnitedHealthcare transactions into one location.

Link

Link is your gateway to our online tools and is accessible on UnitedHealthcareOnline.com. Link applications include claimsLink, eligibilityLink, My Practice Provider, UHC On Air, and much more.

Available benefit plan information varies for each of the applications. You can use Link to access information for UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, UnitedHealthcare Community Plan (as contracted by state), UnitedHealthcare West, UnitedHealthcare of the River Valley and UnitedHealthcare Oxford members.

Watch for the most current information on Link updates by email or in the Network Bulletin or on UnitedHealthcareOnline.com. You need an Optum ID to access Link and UnitedHealthcareOnline.com. To register for an Optum ID, go to UnitedHealthcareOnline.com > New User. For more information about Link, please visit UnitedHealthcareOnline.com > Tools and Resources > Health Information Technology > Link: Learn More.

Health Reform

The Patient Protection and Affordable Care Act (PPACA) includes several provisions designed to expand coverage, control health care costs, and improve the health care delivery system. To find out what these changes are and when they’re scheduled to take effect, visit the United for Reform Resource Center at UnitedHealthcareOnline.com > Quick Links > Health Reform Resources.

Free Medicare Education for Your Staff and Patients

Medicare Made Clear (MMC) is a UnitedHealthcare public service campaign that gives consumers the information they need to select the right Medicare benefit plan for their needs. Consumers can easily access important information on topics such as the parts of Medicare, enrollment timing, what’s covered (and what’s not) and what they need to know to make good choices on our reference website MedicareMadeClear.com.

Network Bulletin and Provider News

The fastest way to communicate with you is electronically. News or updates regarding policy, product, or reimbursement changes are generally posted in the Network Bulletin. The Network Bulletin alerts care providers to new, changed, or updated protocols, policies, programs and administrative procedures. It includes information across all UnitedHealthcare Commercial, Medicaid, and Medicare health benefit plans. The Network Bulletin is accessible online at UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin. Registration is not required.

From the same page, you can also sign up to receive the Network Bulletin by email. Email distribution is not limited to any one person in your office – anyone interested in receiving the Network Bulletin email can sign up. Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

In 2017, the Network Bulletin is available on UnitedHealthcareOnline.com and through email on the following dates:

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<th>Network Bulletin Edition</th>
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<td>January</td>
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Other news items can be found in the News section of the UnitedHealthcareOnline.com home page.
We also offer Really Simple Syndication (RSS) feeds. You must have an RSS reader to check subscription data feeds and download new information. Free RSS readers, as well as instructions on how to use them, are available through many browsers, such as Google and Yahoo! To subscribe to our RSS feeds, copy and paste any or all of the following URLs into your RSS Reader:

• General News Updates: UnitedHealthcareOnline.com/rss/news.xml
• Administrative Guide Updates: UnitedHealthcareOnline.com/rss/adminGuide.xml
• Medical Policy Updates: UnitedHealthcareOnline.com/rss/medical.xml

Medical Policy Update Bulletin

UnitedHealthcare publishes monthly editions of the Medical Policy Update Bulletin, a user-friendly online resource that provides notice to our network physicians and facilities of changes to our Medical Policies, Drug Policies, Coverage Determination Guidelines, Utilization Review Guidelines and Quality of Care Guidelines. It is posted on the first calendar day of every month and is accessible online at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines – Commercial > Medical Policy Update Bulletin. As a supplemental reminder to the detailed policy update summaries announced in the Medical Policy Update Bulletin, a list of recently approved, revised and/or retired policies is also included in the monthly Network Bulletin available at UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin.

Other Communications

We communicate with care providers throughout the year by mail, internet, email, phone, and fax to help ensure you are kept apprised of information that affects you. Physician and Facility Advocates are also available for you to talk to.
Applicability of this Supplement

All Savers Insurance Company (ASIC), a UnitedHealthcare company, offers off-Exchange health insurance to small employers, typically with 2-50 employees. All Savers may be on-Exchange but this supplement only applies to off-Exchange business. (See the section on Health Insurance Marketplaces (Exchanges) for more information).

Care providers are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement refer to appropriate chapter in the preceding guide.

How to Contact All Savers

<table>
<thead>
<tr>
<th>ASIC</th>
<th>Where you go</th>
<th>Requirements and Notes</th>
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</thead>
<tbody>
<tr>
<td>Notification</td>
<td>Call the number on the back of the member’s health care ID card or go to UnitedHealthcareOnline.com.</td>
<td>Prior authorization is required for certain services. Admission Notification is required for all inpatient services. UnitedHealthcare standard admission notification requirements for facilities apply.</td>
</tr>
<tr>
<td>Appeals - Urgent</td>
<td>Medical or Pharmacy, Fax: 920-661-9981</td>
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</tr>
<tr>
<td>Benefits, Eligibility, and Claims Status</td>
<td>Call the number on the back of the member’s health care ID card. myAllSaversProvider.com</td>
<td>To inquire about a member’s Eligibility, plan benefits or claims status, and other tools, such as access a Quick Reference Guide.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>myallsavers.com</td>
<td>For information on the Prescription Drug List (PDL).</td>
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Health care ID card

ASIC members receive health care ID cards containing information that helps you submit claims accurately and completely. Information varies in appearance or location on the card. However, cards display essentially the same information (e.g., claims address, copayment information, and phone numbers).

Be sure to check the member’s health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use ASIC electronic payer ID number 81400.

More detailed information on health care ID cards and a sample health care ID card, can be found in the Health Care Identification (ID) Cards section in Chapter 2: Provider Responsibilities and Standards.

Our claims process

We know that you want to be paid promptly for the services you provide. This is what you can do to help promote prompt payment:

1. Notify ASIC in accordance with the notification requirements set forth in this supplement.
2. Prepare a complete and accurate claim form.
3. For ASIC members - submit electronic claims using only Payer ID number 81400. This is the electronic claims routing number for ASIC members. Submit paper claims to the address on the member’s health care ID card.
4. For contracted care providers who submit electronic claims for ASIC members who would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at 877-620-6194. Select option 1 followed by option 1 again to speak with a representative. You can also log onto OptumHealthFinancial.com > Physicians & Health Care Providers > Electronic Payments and Statements.

Claim Reimbursement (Adjustments)

If you believe your claim was processed incorrectly, please call the number on the member’s health care ID card and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. If you or our staff identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination (see the following Claims Appeals section).
Claims Appeals
If you disagree with a claim payment determination, send a letter of appeal to the following address:

ASIC Members:
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: 317-715-7648
Phone: 800-291-2634

If you feel the situation is urgent, request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
3100 AMS Blvd.
Green Bay WI 54313
Fax: 920-661-9981
Phone: 800-291-2634

Your appeal must be submitted to ASIC within 180 calendar days from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes. The review process is available to provide a fair, fast and cost-effective resolution of disputes, in accordance with state and federal regulations.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your participation agreement.

Refer to Claim Reconsideration, Appeals Process and Resolving Disputes section in Chapter 8: Our Claims Process, for detailed information about the reconsideration and appeal process.

Notice to Texas Care Providers
To verify ASIC members’ benefits, please call the number on the back of the member’s health care ID card.

ASIC use tools developed by third parties, such as MCG (formerly Milliman Care Guidelines), to assist them in administering health benefits and to assist clinicians in making informed decisions in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As an affiliate of UnitedHealthcare, ASIC may also use UnitedHealthcare’s medical policies as guidance. These policies are available online at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides.

Notification does not guarantee coverage or payment (unless mandated by law). The member’s eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the phone number on the back of the member’s health care ID card.

Michigan Law Regarding Diabetes
Michigan has a law requiring insurers to provide coverage for certain expenses to treat diabetes. The law also requires insurers to establish and provide to members and participating care providers a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines published by the ADA.

The program for participating care providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations at care.diabetesjournals.org.

Subscription information for the American Diabetes Journals is available on the website or by calling 800-232-3472 and select option 1, 8:30 a.m. to 8 p.m. ET, Monday through Friday. Journal articles are available without a subscription at the website listed above.
Leased Network Supplement

(May apply to care providers in AK, HI, KY, ME*, MI, MN, ND, PR, SD, USVI, WI; reference your agreement for applicability.)

Applicability of this Supplement
The Leased Network Supplement (the “Leased Supplement”) applies to physicians, health care professionals, facilities and ancillary providers who participate with UnitedHealthcare through a leased network for certain products accessed by UnitedHealthcare in an area where UnitedHealthcare does not have a direct network.

Physicians, health care professionals, facilities and ancillary providers participating in UnitedHealthcare's network through a leased network are subject to both the preceding guide and this Leased Supplement. This Leased supplement controls if it conflicts with information in the preceding guide. For protocols, policies and procedures not referenced in this supplement refer to appropriate chapter in the preceding guide.

Leased Supplement
Any reference in the guide to a physician’s, health care professional, facility, or ancillary provider’s “agreement with us” refers to your participation agreement with the entity operating the leased network (your “Master Contract Holder”).

Several items that appear in the guide are covered by your agreement with your Master Contract Holder, not the provisions stated in the guide. Any reference to updating demographic information, submitting National Provider Identification information, credentialing or re-credentialing processes and appeal guidelines, should follow the processes as indicated in your agreement with your Master Contract Holder.

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*The Leased Network arrangement in ME is ending on 3/31/2017. Effective 4/1/2017, the ME network is directly contracted and credentialed through UnitedHealthCare.
Applicability of this Supplement
This Medicare Advantage Capitated Provider Supplement (this supplement) is intended for use by participating physicians, health care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Medicare Advantage products. This supplement applies to all benefit plans for members (1) who have been assigned to or who have chosen a care provider that receives a capitation payment from UnitedHealthcare for such member, and (2) who are covered under an applicable Medicare Advantage benefit plan insured by or receiving administrative services from UnitedHealthcare, as identified by a reference to “UHC” on the back of the member’s health care ID card.

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, you are paid a set amount for each member assigned to you per period of time, whether or not that person seeks care.

If you do not have a capitation agreement with us, this supplement does not apply to you. Refer to Chapter 4: Medicare Advantage Products.

“Medical group/IPA” as used in this supplement refers to any medical group/IPA participating, on a capitated basis, in the UnitedHealthcare Medicare Advantage network.

Note: Benefit structures may differ, and coverage is subject to eligibility, benefit design and medical necessity.

Member Eligibility
Member eligibility information using an electronic 834 file can be provided on a daily basis containing eligibility changes. A full eligibility file can be provided monthly. Initiation of electronic eligibility requires coordination with your software vendor and us.

Some of the advantages of receiving electronic eligibility are:
• An eligibility upload may reduce the administrative overhead by minimizing the effort currently required to maintain eligibility manually.
• Eligibility updates can be loaded into your system in a timely manner. Please contact your Physician Advocate for more information.

Eligibility files contain the following information:
• Member’s information, including full name, subscriber ID, Medicaid ID number (if applicable), Social Security Number, telephone number, address information (including ZIP code), date of birth, gender, marital status, handicap status, death date of subscriber or dependent, benefit status, Medicare benefit plan code, PCP, when selection is required by UnitedHealthcare
• Medicare eligibility reason code
• Group or policy number
• Additional information, including the Center for Medicare and Medicaid Services (CMS) contract number, BP code, language code, insurance line, coverage level, benefit begin and end dates, care provider effective date
• Care provider information, including name, care provider’s group number, NPI, gender and address (including ZIP code)
• COB begin date, COB insured group or policy number, COB end date, type of change to coverage

Referrals and Referral Contracting
PCP and Care Provider Responsibilities
Each member is assigned a PCP at the time of enrollment.

PCPs and specialty care practitioners (SCPs) not affiliated with a medical group/IPA that is delegated for medical management must follow our Medical Management processes for referrals. Refer to the Medical Management section of this supplement.

Referral and/or Authorization Procedure
The delegated medical group/IPA may be responsible to initiate the referral and/or authorization request when referring a member to another health care provider. The following capitated medical services are examples where a referral and/or authorization may be necessary:
• Outpatient services
• Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA’s facility)
• Specialty consultation/treatment

The medical group/IPA, PCP and/or other referring physician is responsible for verifying eligibility and participating care provider listings on all referral and/or authorization requests, to make sure the referral is to the appropriate network care provider. The medical group/IPA must comply with the following procedure:
• When a member requests specific services, treatment or referral to a physician, the PCP or treating physician shall review the request for medical necessity.
• If there is no medical indication for the requested treatment, the physician shall discuss an alternative treatment plan with the member.
• If the treatment option selected by the member requires referral or prior authorization, the PCP or treating physician must submit the member’s request to the medical group/IPA Utilization Management Committee or its designee for determination. The PCP or treating physician should include appropriate medical information and commentary on the referral and/or regarding why
they believe the requested treatment is or is not indicated and alternative treatments as appropriate.

• If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare) must issue a denial letter to the member, specific to the requested services, treatment or referral and which complies with the applicable federal requirements.

Possible referral and/or authorization determinations include:

• Approved as requested – No changes.
• Approved as modified – Services were approved, but the original requested care provider or treatment plan was modified. Denial letter for the originally requested service, including rationale for denial, must be sent if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic services, approved physical therapy).
• Extension – Delay of decision for a specific service (e.g., need additional documentation or information, or requires consultation by an expert reviewer).
• Delay in Delivery – The authorizing entity requires a postponement of access to an approved service for a specified period of time or until a specified date.

To facilitate timely processing of claims, the medical group/IPA referral and/or authorization process should include claims processing guidelines for the referral care provider.

Referral and/or Authorization Form
The medical group/IPA may design its own request for referral and/or authorization form, without approval by UnitedHealthcare; however, the font of the form must be at least 12-point, with "Times New Roman" being the preferred style. In addition, the form shall, at a minimum, include all of the following components:

• Member identification (e.g., member ID number and birth date)
• Services requested for authorization including appropriate ICD-10-CM and/or CPT codes
• Authorized services (including appropriate ICD-10-CM and/or CPT codes)
• Proper billing procedures (including the medical group/IPA address)
• Verification of member eligibility

Within two business days of the decision, the medical group/IPA shall provide copies of the referral and/or authorization form to the following:

• Referral care provider
• Member
• Member’s medical record
• Managed care administrative office

If UnitedHealthcare is financially responsible for the services, the medical group/IPA shall submit the referral and/or authorization information to us.

Direct Access Services
Women’s Health Specialists
Female members may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means they may receive these services without prior authorization or a referral from her PCP. In all cases however, the physician must be affiliated with their assigned medical group/IPA and participating with UnitedHealthcare.

Flu Vaccine
Each member has direct access to a network physician for an annual flu vaccine. The medical group/IPA shall educate each member about annual flu vaccine care providers and the availability of flu vaccines through the member’s PCP.

Medical Management
With limited exceptions, physicians and health care providers are not reimbursed for services determined to be not medically necessary, or for which correct procedures have not been followed (e.g., notification requirements, prior authorization, or verification guarantee process).

NCQA Accreditation standards require that all health care organizations, health benefit plans and medical group/IPAs, delegated for utilization/medical management, distribute a statement to all members, physicians and health care providers and employees who make utilization management (UM) decisions affirming the following:

• UM decision-making is based only on appropriateness of care and service and existence of coverage
• Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or service
• Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization

Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and the attending physician.

If you and member decide to go forward with the medical service once UnitedHealthcare or the delegated medical group/IPA has denied prior authorization, (and issued a denial notice to the member and physician as appropriate), no physician, hospital, or ancillary services are reimbursed by UnitedHealthcare or the delegated medical group/IPA. Medical directors are available to discuss their decisions and our criteria with you. Medical policies are also available on UnitedHealthcareOnline.com or from the delegated medical group/IPA as applicable.
Provider Requirements
You are required to participate, cooperate and comply with UnitedHealthcare Medical Management policies. All physicians and health care providers must render covered services at the most appropriate level of care, based on nationally-recognized criteria.

UnitedHealthcare may delegate medical management functions to a medical group/IPA that demonstrates compliance with UnitedHealthcare’s established standards (refer to the Delegated Medical Management section of this supplement). If you are associated with a delegated medical groups/IPA you must use the medical group/IPA’s medical management office and protocols.

In addition, we may retain responsibility for some medical management functions, such as inpatient admissions and outpatient surgeries. If you are not associated with a delegate or where UnitedHealthcare retains responsibility for the specific medical management function, you are required to comply with the UnitedHealthcare Medical Management procedures.

Details of our pre-service, concurrent review, case management, post-service/retrospective review, and medical claim review protocols are available online at UnitedHealthcareOnline.com.

Provider Responsibilities under UnitedHealthcare’s Medical Management Program
You are required to confirm a request for services has been authorized prior to rendering services for a specified member. If a prior authorization has not been requested, you must request one for services within three business days prior to providing or ordering the covered service except in the case of emergent or urgent services.

Use our website to confirm a prior authorization has been approved for a particular date of service, at UnitedHealthcareOnline.com > Notifications/Prior Authorizations. If the member is assigned to a delegated medical group/IPA, check with this medical group/IPA’s medical management department for confirmation.

You must notify us of urgent or emergent cases within 24 hours of services being rendered or an admission. Failure to obtain prior authorization or to notify us within the appropriate timeframe may result in a denial of payment.

In no event shall UnitedHealthcare or the member be held responsible to reimburse physicians and health care providers for medical services, admissions, inappropriate hospital days, and/or not medically necessary services if required prior authorization was not obtained. Receipt of an authorization does not affect the application of any applicable payment policies in determining reimbursement. The delegated medical group/IPA sets its own policies regarding the responsibilities of physicians and health care providers.

Determining Medical Necessity
For Medicare Advantage members, we use Medicare guidelines, including National Coverage Determinations and Local Coverage Determinations to determine medical necessity of services requested.

If other nationally-recognized criteria contradict MCG, UnitedHealthcare and delegated medical group/IPAs follow the Medicare guidelines for Medicare Advantage members. Individual criteria is provided to you upon request.

Emergency Services and/or Urgent Hospital Admissions
Some admissions cannot be scheduled. In these cases, you are required to contact UnitedHealthcare of an admission as soon as possible on the same day (but no later than 24 hours from admission). You must work with our medical management department to obtain authorization. Send the admission notification to the medical management department at:

Phone: 800-799-5252
Fax: 800-274-0569 (24 hours/day, seven days/week)

You should verify the member’s eligibility before any after-hours or weekend admission whenever possible. The UVR confirmation eligibility system is available 24 hours per day, seven days per week.

The delegated medical group/IPA sets its own policies regarding notification and authorization for these services.

Emergency Medical Conditions
Retrospective denial of services for what appears to the “prudent layperson” to be an emergency is prohibited. If a physician or other representative affiliated with the medical group/IPA instructs the member to seek emergency services, the medical group/IPA is responsible for payment for medically necessary emergency services regardless of the prudent layperson standard. The definition of an Emergency Medical Condition is found in the Glossary of this guide under “Medical Emergency”.

Post Stabilization Care
CMS defines post-stabilization care as services:

- Related to an Emergency Medical Condition,
- Provided after a member is stabilized, and
- Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the enrollee’s condition.

UnitedHealthcare or our delegates must:

- Have a process to respond to requests for post-stabilization care
- Respond to requests for authorization of post-stabilization services within one hour

If UnitedHealthcare or our delegate does not respond within one hour, care is deemed authorized until:
• The medical group/IPA shall notify UnitedHealthcare's
• The delegated medical group/IPA remains responsible
• Services provided outside of your defined service
• UnitedHealthcare retains the ultimate accountability
• Your efforts shall include, but are not limited to:
  › The member’s PCP or identified specialist speaks with
  › The member’s PCP, or identified specialist, determines
  › The member’s PCP or identified specialist determines
• You must arrange for a bed at the accepting network
• If an accident or illness occurs within your contracted
• Travel dialysis is not considered an out-of-area medical

Medical Observation
UnitedHealthcare, or its respective designee, authorizes hospital observation status when medically indicated. Hospital observation status is generally designed to evaluate a member’s medical condition to determine the need for inpatient admission, or to stabilize a member’s condition. Typically, observation status is used to rule out a diagnosis or medical condition that responds quickly to care. A member’s outpatient admission status may later be converted to an inpatient admission if medically necessary and if appropriate criteria have been met.

Out of Area (OOA) Medical Services
OOA medical and hospital services are those emergent or urgently needed services to treat an unforeseen illness or injury that arises while a member is outside of the medical group/IPA’s (your) contracted service area. These OOA services are services that would have been the financial responsibility of the medical group/IPA had the services been provided within their service area.

• UnitedHealthcare retains the ultimate accountability for the management of OOA cases, unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your participation agreement to determine financial risk for OOA.
• Services provided outside of your defined service area and arranged and/or authorized by you as the member’s medical group/IPA are your responsibility, and are not considered OOA medical services. This includes those out-of-network (OON) services referred by a practitioner affiliated with the delegated medical group/IPA, whether or not that practitioner obtained appropriate authorization. In such cases, it remains your responsibility to perform all delegated medical management activities, including issuing appropriate authorization and denials.
• The delegated medical group/IPA remains responsible to issue appropriate denials for member-initiated non-urgent, non-emergent medical services provided outside of the medical group/IPA’s defined service area.
• The medical group/IPA shall notify UnitedHealthcare’s OOA department of all known OOA cases no later than the first business day after receiving member notification of an OOA admission, procedure and/or treatment. Failure to notify us within this timeframe may result in UnitedHealthcare holding the medical group/IPA financially responsible for the OOA care and service.
• Once a UnitedHealthcare member is deemed stable for transfer, you must work actively and collaboratively with UnitedHealthcare on the return of the member to a network care provider and facility in a timely fashion.
• You shall facilitate the return of the member to network care provider by making sure that the following process occurs in a timely fashion.

Out of Area (OOA) Medical Services
Trauma Services
Trauma services are defined as medically necessary covered services rendered at a state-licensed, designated trauma hospital or a facility designated to receive trauma cases. Trauma services must meet identified county or state trauma criteria.

You shall review and authorize care and trauma services using the applicable provision review criteria. UnitedHealthcare may retrospectively review trauma service claims and medical records in order to verify that the services met trauma criteria and that trauma services were delivered. UnitedHealthcare may also confirm that the trauma facility has an active trauma license. Contracts for trauma services may vary and definitions and reimbursement methods specified therein apply.
The following provision criteria shall be considered when authorizing trauma services:

- Trauma team activated
- Trauma surgeon is the primary treating physician
- Member’s clinical status meets the county’s current EMS protocols for designating a trauma patient.
- Trauma services, once rendered, shall apply to the first 48 hours post-facility admission, unless there is documented evidence of medical necessity indicating that trauma level services are continuing to be delivered.
- Trauma service status shall no longer apply when, based on medical necessity, the member is determined to be hemodynamically stable and/or medically appropriate for transfer out of the critical care arena.
- Clinical management of a member by the trauma team shall not be the sole criteria used to determine and authorize continued trauma services care.

Transplant Services/Case Management
For medical groups/IPAs that have risk for transplant services, we request that you notify the case management department when a member is referred for evaluation, authorized for transplant and admitted for transplant and/or may meet criteria for service denial.

For medical groups/IPAs that do not have risk for transplant services members must be referred into the UnitedHealthcare transplant case management program if they are identified as:

- Requiring evaluation for a bone marrow/stem cell or solid organ transplant
- Undergoing transplant evaluation
- Receiving a transplant
- Being within the first year post-transplant

The transplant case manager works in conjunction with the member’s transplant team, PCP, and other clinicians to complete an assessment of their healthcare needs, develop, implement and monitor a care plan, coordinate services and re-evaluate the care plan for them.

- Participating physicians and health care providers must obtain prior authorization for transplant evaluations and transplant surgery, regardless of financial risk.
- Transplant evaluations and surgery must be performed at one of Optum’s Centers of Excellence, or facility approved by UnitedHealthcare/Optum’s Medical Directors.
- We shall be responsible for the authorization and management for all transplant-related care and services from the evaluation through one year post-transplant, unless otherwise dictated by the member’s benefit.
- We shall be responsible for the authorization and management of donor care and services directly related to transplant services from date of initiation of the stem cell/bone marrow collection, or 24 hours prior to solid organ donation surgery, until 60 calendar days post-transplant date, unless otherwise dictated by the member’s benefit.
- We shall be responsible for authorization and reimbursement of all travel expenses as covered under the member’s benefit plan.
- Authorization and management of all non-transplant-related, medically necessary, covered services (including services needed to treat the member’s underlying disease and maintain the member until transplant can be completed) for the member and donor remain the financial responsibility, of the delegated medical group/IPA, as described in the DOFR.
- Medical group/IPA is required to comply with our transplant protocols, policies and procedures. We may, at our sole discretion, modify these protocols, policies and procedures from time to time.

Referrals may be made to Optum as follows:

Phone: 866-300-7736 or
Fax: 888-361-0502

Elective and Urgent Services Prior Authorization Requirements

The list of services requiring prior authorization can be found at UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements

A minimum notification of three business days is required for elective services to complete a thorough clinical analysis prior to a member’s proposed elective procedure date. Procedures are not considered scheduled, and should not be communicated as being scheduled, until they have been authorized. An authorization or notification number with the approved date range is returned by fax to your office within appropriate regulatory guideline requirements.

For services considered to be urgent and scheduled to be provided within two calendar days, Medical Management replies by fax within appropriate regulatory guideline requirements, but not to exceed three calendar days/72 hours. You must identify urgent care services so we may appropriately prioritize them.
Authorization of Acute Inpatient Rehabilitation Facilities (AIR) or Long Term Acute Care Facilities (LTAC)

For shared risk groups, you are strongly encouraged to consult with a benefit plan medical director prior to authorizing a member transfer to Acute Inpatient Rehabilitation (AIR) and/or Long Term Acute Care (LTAC).

Prior Authorization Protocol

For any service which requires a prior authorization, the admitting care provider initiates an authorization request by fax at least three business days prior to the scheduled date of service.

- You must complete and submit the appropriate prior authorization request forms. Incomplete forms are not accepted. You may find the list of forms at UnitedHealthcareOnline.com > Tools & Resources > Forms.

- Our Medical Management team documents the information, respond to the authorization request, and provide a decision within the required regulatory timeframes. If approved, an authorization number is issued to the care provider. If denied, the reason for denial is forwarded to you and the member.

- In the case of a denial, you are offered the opportunity to speak with UnitedHealthcare’s Medical Director to discuss the case.

- The authorized care provider delivers care to the member. Documentation of the recommended treatment plan should be shared with the member’s PCP.

The authorized care provider submits a claim with the authorization number in the usual manner to the appropriate address.

Medical Management Denials/Adverse Determinations

A denial/adverse determination may be issued when there is no apparent medical necessity for a health care service, a non-covered benefit is requested, or when no information or insufficient information is provided. If you disagree with a Medical Management decision to deny requested health care services, you may request an appeal as outlined in this section. Our reviewers are available to discuss denial cases with the treating or attending practitioner. Reviewers may be a physician, pharmacist, chiropractor, dentist or other licensed practitioner type, as appropriate to the case.

Denials, Delays or Modifications

Decisions to approve, modify or deny requests for authorization of health care services, or to delay delivery of services, based on medical necessity or benefit coverage, must be made and communicated in a timely manner appropriate for the nature of the member’s medical condition, and in accordance with the applicable federal law.

All authorization decisions must be based on sound clinical evidence such as review of medical records, consultation with the treating practitioners, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

All information to support decision-making shall be consistently gathered and documented. Disclosure of such criteria is made in accordance with applicable state and federal law.

Referral requests not meeting the criteria for immediate authorization must be reviewed by the Medical Director or the Utilization Management Committee (UMC) designated physician or presented to the collective UMC or subcommittee for discussion and a determination.

Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may determine to delay, modify or deny authorization of benefits to a member for reasons of medical necessity. Board-certified licensed physicians from appropriate specialty areas must be utilized to assist in making determinations of medical necessity, as appropriate:

- Physicians may not review their own referral requests.

- Referral requests being considered for denial are reviewed by physicians qualified to make an appropriate determination.

- Where the medical necessity or the proposed treatment plan is not clear, the referral is clarified and discussed with the requesting physician. Complex cases may be brought to the UMC/Medical Director for further discussion and decision.

- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision making regarding payment or denial of a service.

- Possible request for authorization determinations include:

  - Approved as requested – No changes.

  - Approved as modified – Referral approved, but the requested care provider or treatment plan was modified. Denial letter must be sent if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy).

  - Extension – Delay of decision regarding a specific service (e.g., need additional documentation or information or requires consultation by an expert reviewer).
Delay in Delivery – Access to an approved service must be postponed for a specified period of time or until a specified date. This is not the same as a modification. A written notification in the denial letter format is required.

Denied – Non-authorization of a request for health care services. Examples of reasons for denials include:

1. Not a covered benefit – the requested service(s) is a direct exclusion of benefits under the member’s benefit plan - specific benefit exclusion must be noted
2. Not medically necessary or benefit coverage limitation – specify criteria or guidelines used in making the determination as it relates to the member’s health condition
3. Member is not eligible at the time of service
4. Benefit exhausted - include specific information as to what benefit was exhausted and when it was exhausted
5. Not a participating care provider – a participating care provider/service is available within the medical group/IPA network
6. Experimental or investigational procedure/treatment
7. Self referred/no prior authorization (for non-emergent post-service)
8. Services can be provided by the PCP

UnitedHealthcare has aligned its “Professional Reimbursement Policy on Wrong Surgery” or “Other Invasive Procedure Events” to be consistent with CMS. We do not reimburse for a surgical or other invasive procedure when the physician erroneously performs:

- A different procedure all together,
- The correct procedure, but on the wrong body part, or
- The correct procedure, but on the wrong patient.

Additionally, we do not provide reimbursement for facilities or provider services related to these wrong surgical or other invasive procedures.

Written Denial Notice

The written denial notice serves many purposes and is an important component in the member’s chart and your records. The denial letter serves to document member and practitioner notification of:

- The denial, delay, partial approval or modification of requested services
- The basis of denial, delay, partial approval or modification, including medical necessity, benefits limitation or benefit exclusion
- The appeal rights
- An alternative treatment plan, if applicable
- Benefit exhaustion or planned discharge date

CMS requires the use of the standard Integrated Denial Notice (IDN) known as the Notice of Denial of Medical Coverage/Payment (NDMCP) for Medicare Advantage plan members. Medicare Marketing Guidelines require that templates have appropriate, benefit plan-specific Medicare Marketing ID numbers and CMS approval (OMB) numbers and revision dates.

Minimum Content of Written or Electronic Notification

Written or electronic notice to deny, delay in delivery, or modify a request for authorization for health care services shall include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved
- The specific reference to the benefit plan provisions to support the decision
- The reason the service is being denied, delayed in delivery, modified, or partially approved including:
  - Clear and concise explanation of the reasons for the decision, in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision,
  - Description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based, and
  - How those criteria were applied to the member’s condition.
- Notification that the member’s physician can request a peer to peer review
- Clinical reasons for decisions regarding medical necessity
- Contractual rationale for benefit denials
- Alternative treatment options offered, if applicable (not applicable for retrospective review)
- A description of any additional material or information necessary for the member to “perfect” the request, and why that information is necessary
- If the request is for an experimental or investigational treatment, an explanation of the scientific or clinical judgment for making the determination
- Appeal and grievance processes, including:
  - Information regarding the member’s right to appoint a representative to file an appeal on their behalf.
  - Member’s right to submit written comments, documents or other additional relevant information
  - Information notifying the member and their treating practitioner of the right to an expedited appeal for
the time-sensitive situations (not applicable for retrospective review).

› Information regarding the member’s right to file a grievance or appeal with the applicable state agency including information regarding the independent medical review process (IMR), as applicable.

› Envelopes containing organization determination letters should state “Important Plan Information” in a minimum of 12-point font.

› The requesting care provider should include the name and direct phone number of the health care professional responsible for the decision.

Facility Denial Process
When the medical group/IPA is delegated for authorization and concurrent review, we expect them to issue a facility denial letter to the contracted facility when the facility’s medical record or claim fails to support the level of care or services rendered. This may be determined through concurrent or retrospective review.

There are three types of facility denial letters:
• Delay in inpatient services
• Delay in change of level of care within the same facility
• Delay in facility discharge

The delegated medical group/IPA must comply with our protocols, policies and procedures for denials, including turn-around times for issuing, delivering and submitting facility denial letters to UnitedHealthcare. Facility denials are not sent to the member and specifically exclude them from liability for the denied level of care and/ or services.

Experimental and Investigational Services Denials
We will provide the opportunity for an independent, external review whenever an authorization for any drug, device, procedure, or other therapy deemed experimental or investigational is denied to a member who has either a life-threatening or seriously debilitating disease or condition, as defined below.

› Life threatening is defined as:
  › Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or
  › Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.

› Seriously debilitating is defined as diseases or conditions that cause major irreversible morbidity.

› Experimental or investigational therapies are any drug, device, treatment, or procedure that meets one or more of the following criteria:
  › It cannot be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
  › It is the subject of a current investigational new-drug or new-device application on file with the FDA.
  › It is being provided pursuant to Phase I or Phase II clinical trial or as the experimental or research arm of Phase III clinical trial, as the Phases are defined by regulations and other official actions and publications issued by the FDA and HHS.
  › It is being provided pursuant to written protocol that describes among its objectives determinations of safety and/or efficacy as compared with standard means of treatment.
  › It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and HHS.
  › The predominant opinion among experts as expressed in the published authoritative literature is that the usage should be substantially confined to research settings.
  › The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
  › It is not investigational or experimental in itself, as defined above, and would not be medically necessary, except for the provision of a drug, device, treatment, or procedure that is investigational or experimental. UnitedHealthcare does not delegate utilization management activities related to requests for authorization of experimental/ investigational therapies. The delegated medical group/IPA must not issue a denial for experimental/ investigational therapies/ service(s) requests.

The practitioner denial notice also includes the experimental/ investigational information packet. If a UnitedHealthcare Medical Director determines the member’s condition does not meet the experimental/ investigational criteria, we shall notify the delegated medical group/IPA. The delegated medical group/IPA shall then make a coverage determination in accordance with established utilization management procedures.
Cancer Clinical Trials

The member’s treating participating practitioner must recommend participation in a cancer clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the member. We do not delegate utilization management activities related to requests for authorization of cancer clinical trials, and as such, the delegated medical group/IPA must forward referral requests for cancer clinical trials and all relevant case documentation to us for review and determination.

We issue a written determination notice to the member and the requesting care provider.

Clinical trials are not a benefit of UnitedHealthcare Medicare Advantage benefit plans and may not be approved by UnitedHealthcare or our delegated IPA/medical group. Care providers should bill Medicare, as Medicare directly pays care providers for Medicare qualified clinical trial services furnished to a UnitedHealthcare Medicare Advantage member. Members may be directed to 800-MEDICARE for additional information on clinical trials.

Delegated Medical Management

We may delegate medical management to a medical group/IPA that demonstrates compliance with their established standards for the medical management function. This function may also be referred to as utilization management. Physicians associated with these delegated groups must use the medical group/IPA’s medical management office and protocols for all authorizations for which they are delegated.

A delegated medical group/IPA may have processes and forms that differ somewhat from those outlined in this section. Please contact your Physician Advocate, as applicable, if you have questions concerning medical management delegation.

If a medical group/IPA is delegated for medical management, it may also be delegated for case management and/or disease management, as documented in its participation agreement with us. In such cases, the delegated medical group/IPA (“delegate”) is also held responsible for meeting the NCQA standards for complex case management, unless the contract states otherwise.

We perform an initial audit to measure compliance of the delegate with our standards for delegation of medical management. At least annually thereafter, we audit the delegate to make sure of continued compliance. We may initiate a focused audit based on specific activity that warrants such an audit. The delegate is required to provide specific documents/evidence to the auditor as applicable.

Based on the compliance audit findings, we may require the delegate to develop and implement a corrective action plan designed to bring the care provider back into compliance. Delegates who do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance.

Medical management is a delegated function that is subject to revocation. Sanctions may consist of delegation with a corrective action plan or revocation. There are costs to the delegate should the function be revoked.

Semi-Annual Reporting

The delegate provides UnitedHealthcare with reports a minimum of semi-annually and as outlined in the delegation agreement. Reporting should include an analysis/explanation of any variances or trends.

Capitation Processing and Payment

Refer to the Division of Financial Responsibility (DOFR) grid or other applicable exhibit in your participation agreement, for a detailed listing of capitated services. Services not specifically excluded from capitation are included in the capitation payment made to the medical group/IPA or hospital, as applicable.

Capitation Reports

We run capitation reports by process month for its Medicare Advantage products. Typically, all current activity and retroactivity up to the standard six month system window are reflected in each month’s capitation reporting and payment. The participation agreement may define a non-standard eligibility window for less than the standard 48 month system window. This non-standard eligibility window overrides the standard 48 month system window. The nonstandard eligibility retro window does not limit the retroactivity related to premium increases/decreases from CMS.

Capitation reports and first-of-the-month eligibility reports are run from the same snapshot of our membership data. The actual date of this snapshot varies, but typically occurs during the last week of the prior month. As an example: the membership snapshot for November capitation is taken during the last week of October.

15/30 Rule

The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not at all. If the effective date of a change falls between the first and 15th of the month, the change is effective for the current month, and capitation is paid for that month. However, if the effective date falls on the 16th or later, the change is reflected the first of the following month and capitation is paid for the following month.

For purposes of calculating capitation payments, members are added on the first day of the month or terminated on the last day of the month.
Retroactive Add
A member added retroactively between the first and the 15th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment for that month, even though they would be considered eligible for services.

Retroactive Term
A member retroactively terminated between the first and 15th of the month would generate a capitation recoupment entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 16th or later, would not generate a capitation recoupment entry for the capitation previously paid for the entire month.

The Medicare Advantage capitation process uses the member’s date of birth (DOB), as reported by CMS, as a basis for capitation calculations driven by member age.

Capitation Payments
We make monthly capitation payments to the medical group/IPA and capitated hospital as payment for providing and arranging covered services to our members.

Capitation payments are delivered by electronic funds transfer or by check on the date specified in the participation agreement. If the due date falls on a non-business day, the capitation payment is delivered the next business day.

Electronic Funds Transfer (EFT)
In order to receive capitation payments using EFT, we require a signed Authorization Agreement Electronic Funds Transfer (EFT) Payments form, detailing the bank account and bank routing information. The EFT initial set-up, or a change in business information, requires three weeks processing time to take effect.

EFTs are deposited by the end of the banking day on the date specified in the participation agreement. Most financial institutions charge a per transaction fee on electronic funds transfers.

CMS Premium
The Medicare Modernization Act payment methodology for Medicare Advantage organizations such as UnitedHealthcare, defines a competitive bid process. CMS compares the bid from each organization against the CMS benchmark and modify the payment made to Medicare Advantage organizations accordingly.

The CMS premium we receive is based on several member-specific variables, including:
- Age
- Gender
- State and county code
- Plan benefit package selection and benefit configuration
- Health status
- The Medicare Advantage benefit plan’s competitive bid
- The Medicare Advantage benefit plan’s member premium
- Risk-adjusted factors based on the member’s Hierarchical Condition Category (HCC), based on inpatient and outpatient encounter data.

We use the premium reported on the Monthly Membership Report (MMR) from CMS as the first step in development of the premium that is used for the percent of premium calculation. The algorithm, methodology-blend percentage and rates/factors are posted on the CMS website at cms.gov for all periods.

Unpaid CMS Premium
If we do not receive payment from CMS for a particular member, we do not pay capitation for that member. Typically unpaid CMS premiums occur in the first month of eligibility and the payment is usually received within 60 calendar days.

If the medical group/IPA has unpaid premiums, it must continue to arrange for the member’s medical care and pay for services accordingly.

If CMS does not retroactively pay the premium within 120 calendar days, the medical group/IPA should notify its Physician Advocate with specific information for that member so the non-payment can be pursued with CMS.

Out-of-Area Premium
We receive premium from CMS based, in part, on the member’s State and County Code (SCC) as reported by CMS. We use the premium reported by CMS as a basis for percent of premium capitation.

CMS may report a member in a different state than the state their assigned medical group/IPA is located. As an example, CMS may report a member’s SCC as Washington, yet their assigned medical group/IPA is in Oregon.

Once the SCC is updated by the CMS system, CMS pays the correct SCC going forward. Typically, CMS does not retroactively adjust premium for changes in SCC.

End Stage Renal Disease (ESRD) Premium
ESRD premiums are paid using a Risk-Adjusted model. The model provides a 3-tier approach: (1) dialysis status, (2) receiving a transplant, and (3) functioning graft status.

CMS communicates these tiers using the Customer’s Risk-Adjusted Factor Type Code.

In addition to the ESRD flag, the flat file reports the member-level Risk-Adjusted Factor Type code to aid the medical group/IPA with identifying their ESRD patient who is our member. The risk-adjusted factor type code is not reported on the image reports. Additional information on
Delegated Claims Process

We may delegate claims processing to medical groups/IPAs and facilities (collectively referred to as “delegated entities” in this section) that have requested delegation and have shown through a pre-delegation assessment that they are capable of processing claims that are compliant with applicable federal regulatory requirements.

Delegated entities are required to develop and maintain claims operational and processing procedures that allow for accurate and timely payment of claims - taking into consideration proper application of benefit coverage, eligibility requirements, appropriate reimbursement methodology, etc. and which meet all applicable federal regulatory requirements.

Claims Processing

Medicare Advantage contracted care provider claims must be processed in accordance with the agreed upon contract rates and within applicable federal regulatory requirements. Claims are to be adjudicated within 60 calendar days of receipt.

Medicare Advantage non-contracted care provider claims should be reimbursed in accordance with, but not limited to, the current established locality-specific Medicare Physician Fee Schedule, DRG, APC, and other applicable pricing published in the Federal Register. Non-contracted, clean claims must be adjudicated within 30 calendar days of receipt. Non-clean claims are to be adjudicated within 60 calendar days of receipt.

Interest Payment Requirements

Delegated entities are required to automatically pay applicable interest penalty on claims according to established federal and/or state regulatory requirements. For Medicare Advantage, CMS requires the payment of interest for non-contracted care provider clean claims not paid within 30 calendar days from the first date stamp. Interest is paid at the current rate for the period beginning on the day after the required payment date and ending on the date the check is mailed. CMS updates the interest rate twice annually, in January and July. This information can be found in the Federal Register or on the official CMS website.

Timely Filing

Timely filing limit for contracted care provider claims should follow the contractual arrangements that the delegated entity has with its downstream care providers.

Medicare Advantage - The timely filing requirement for non-contracted care provider claims should follow the CMS guidelines for original Medicare claims, i.e. claims received more than one calendar year beyond the date of service are denied as being past the timely filing deadline.

Please also refer to the official CMS website at cms.gov, for additional rules and instructions on timely filing limitations.

Commercial - The timely filing requirements are different from state to state. Reference the applicable state requirements.

Service Area

The financial responsibility for providing covered medical and/or medical facility services within a designated service area is determined by your participation agreement. Refer to your participation agreement for your specific service area definition.

Out-of-Area (OOA) Urgent or Emergent Claims

Urgent or emergent services provided within the delegate’s service area are typically the financial risk of the delegate regardless of whether services were in or out of their network of care providers. Refer to your Division Of Financial Responsibility.

In most contractual arrangements, however, UnitedHealthcare has financial responsibility for OOA medical and facility services provided on an urgent or emergent basis. We follow federal regulations regarding payment of claims related to access to medical care in urgent or emergent situations. If we determine the claims are not emergent or urgent, we forward the claims to the delegate for further review. Medical services provided outside of the delegate’s defined service area and arranged and/or authorized by the member’s medical group/IPA are the delegate’s responsibility and are not considered OOA medical services.

The delegate remains responsible to issue appropriate denials for member-initiated, non-urgent/non-emergent medical services outside of the delegate’s defined service area.
Misdirected Claims
In order to meet CMS regulatory timeliness standards, it is important that misdirected claims are forwarded to the proper payer in accordance with applicable federal regulations. Claims that are misdirected to us rather than to the appropriate delegated claims service are identified, batched and forwarded in accordance with federal regulations to the delegate responsible for processing the claim. We send health care service provider a notice that the member’s claim has been forwarded to another entity for processing.

All claims received in error at the delegated entity must be identified and tracked (manually or systematically). Tracking must include the name of the entity where the claims were sent and the date mailed. Claims must be forwarded to the appropriate payor immediately upon receipt, in accordance with federal regulatory timeframes. To prevent forwarding delays, the delegated entities are held accountable to forward misdirected claims within 14 calendar days of receipt. If it is determined that the member had been assigned to another medical group/IPA on the date of service, you should forward the claim to the appropriate delegated entity or health benefit plan to ensure compliance with federal regulatory timeframes for processing. Likewise, claims you receive from another delegated entity or health benefit plan with prior date stamp should be fast tracked to help ensure prompt pay requirements. The delegated entity must, however notify you, the care provider of service, of the correct payor name, if known, on the Explanation of Payment (EOP) provided to you when the claim is adjudicated.

Reporting
Delegated entities are responsible for submitting all required information to us and appropriate regulatory agencies as indicated in federal regulations. Delegated entities are required to submit regulatory and benefit plan reporting requirements timely including, Monthly/Quarterly CMS Part C, reporting requirements deemed by UnitedHealthcare to be necessary to conduct the proper level of oversight monitoring, and the Claims Quarterly Reports (CMS Part C Reporting Requirements) as stated in federal regulations.

Compliance Audits
We have established policies and procedures specifically designed to monitor the delegated entities’ compliance with federal claims processing requirements. Our auditors conduct claims processing compliance audits of each delegated entity on a regular basis. Delegated entities with compliant results are audited at minimum annually. Additional audits are performed for other circumstances such as:
- Audit results indicate non-compliance
- Self-reported timeliness reports indicate non-compliance for two-three months
- Non-compliance with reporting requirements
- Lack of resources or staff turnover
- Overall performance warrants an audit (claims appeal activity, claims denial letters, or member and care provider claims-related complaints)
- Allegations of fraudulent activities or misrepresentations
- Changes to or conversion of information systems
- New management company or change of processing entity
- Established Management Service Organization (MSO) acquires new business
- Significant increase in membership or volume of claims
- Significant increase in claims-related complaints
- Regulatory agency request
- Significant issues concerning financial stability

Delegated entities are required to comply with and submit all audit requirements including timely and complete submission of claims universe reports, and all required audit materials necessary to conduct and successfully complete the audit.

Delegated entities found to be non-compliant will be placed on Improvement Action Plan and will be required to correct any identified deficiencies including, but not limited to, the following:
- Processing timeliness issues
- Failure to pay interest or penalties
- Provider Remittance Advice content fails to meet regulatory requirements
- Canceling audits
- Failure to submit all audit requirements
- Failure to provide access to canceled checks or bank statements

Delegated entities that do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance. Claims processing is a delegated function subject to revocation. Sanctions may consist of additional/ enhanced auditing, on-site claims management, revocation, and enrollment freeze. There may be costs to the delegated entity depending on the sanction put in place.

Claim Denials
When a claim is received for a Medicare Advantage member, the delegated entity must assess the claim for the following components before issuing a denial letter:
- Member’s eligibility status with UnitedHealthcare on the date of service
- Responsible party for processing the claim (forward to proper payer)
• Contract status of the health care provider of service or referring care provider
• Presence of sufficient medical information to make a medical necessity determination
• Covered benefits
• Authorization for routine or in-area urgent services
• Maximum benefit limitation for limited benefits
• Prior to denial for insufficient information, the delegated entity must document their attempts to obtain necessary information to make a determination.

There are two types of claim denial letters outlined below. In both instances, the party that holds the financial risk is responsible for providing the notification.

**Member Denial Letter**
In instances when a member is financially responsible for a denied service, UnitedHealthcare or the delegated entity (whichever holds the risk) must provide the member with written notification of the denial decision in accordance with federal regulatory standards.

The delegated entity must use the most current CMS-approved Integrated Denial Notice (IDN) known as the Notice of Denial of Medical Coverage/ Payment (NDMCP) template to accurately document and issue a claim denial letter to a Medicare Advantage benefit plan member. The denial letter must be sent out within the appropriate regulatory timeframes. At a minimum, the member denial letter must include the following:

• Applicable member information
• The entity issuing the letter
• The date of denial
• The claim amount
• The date of service
• The health care provider of service
• 12-point font
• The envelope must state “Important Plan Information” in a minimum of 12-point font.
• The proper appeal rights
• CMS approval (OMB) numbers and revision dates
• The denial code and the reason for the denial must be clear, accurate, and based on appropriate criteria.
• The delegated entity must make correct claim determinations, which include developing the claims for additional information when necessary to determine possible urgent or emergent services.

Each member denial letter must meet the necessary criteria to be considered compliant. All claims denial letters issued to members are subject to audit by us. All delegated entities will receive instructions as to their denial letter audit status and oversight process. A compliance audit of each delegated entity’s member denial letters will be conducted on a regular basis as described in the Compliance Audits section above.

The delegated entity remains responsible to issue appropriate denials for member-initiated, non-urgent/ non-emergent medical services outside of the delegated entity’s defined service area.

**Provider Denial Letter**
In instances when the member is not financially responsible for the denied service, it is not necessary to notify them of the denial. You, as the care provider, must be notified of the denial and your financial responsibility (i.e., writing the charges off or claims payment). When the member has no financial responsibility for the denied service, the denial letter or EOP issued to any participating care provider of service must clearly state that the member is not to be billed for the denied or adjusted charges. In addition, you must be notified of your right to dispute the decision. The denial notice (letter or EOP) must also specify the member is not to be balance billed.

**CMS Non-Contracted Provider Payment Dispute Resolution Process**
The care provider payment dispute resolution (PDR) process includes any decisions where a non-contracted health care provider contends that the amount paid by the delegated entity for a covered service is less than the amount that would have been paid under original Medicare. This process also includes instances where there is a disagreement between a non-contracted care provider and the delegated entity about the entity’s decision to pay for a different service than that billed, for example, bundling issues, disputed rate of payment, DRG payment dispute. The timeframe for submitting a payment dispute is 120 calendar days from the original claim determination. At a minimum, the delegated entity must adhere to the following requirements when handling Medicare non-contracted care provider claim payment disputes:

• Well-defined internal payment dispute process in place, including a system for receiving PDRs.
• Proper identification of payment disputes in place. (Non-contracted health care providers must clearly state what they are disputing and why, supply relevant information that will help support their position, including description of the issue, copy of submitted claim, supporting evidence to demonstrate what original Medicare would have allowed for the same service).
• Well-defined internal dispute process in place, including a system for tracking disputes and monitoring of PDR claims inventory.
• Timeframe for submitting a payment dispute (timely filing limit of 120 calendar days from the original claim determination) accurately established and communicated to the non-contracted care provider at time of claim payment.
• Information on how to submit an internal claim payment dispute to the organization is communicated to the non-contracted care provider at time of claim payment, including the organization’s mailing address where disputes are to be submitted and other appropriate information for disputes (i.e., email addresses, phone numbers).

• Timeframe of 30 calendar days from the PDR claim received date to process and respond (i.e., to finalize the PDR claim) to the non-contracted care provider is in place and being met.

• Make sure correct calculation of interest payments on overturned PDRs is made. Interest is required on a reprocessed non-contracted care provider clean claim if the delegated entity made an error on the original organization determination. Interest is only applied on the additional amount paid; it is calculated from the oldest receive date of the original claim until the “check mail date” of the additional amount paid.

• Complete and clear rationale provided to the non-contracted care provider for upheld PDRs.

• Information contained in the PDR Acknowledgement Letter, Provider Remittance Advice (PRA) or Explanation of Payment (EOP), and upholds PDR Determination Letter is appropriate and met requirements.

• Information given within the care provider notice on upheld or overturned payment disputes on how to contact the organization if the non-contracted care providers have additional questions.

• Process in place to update the organization’s claims system, if needed, if the root-cause of overturned PDRs is identified to be system-related so that future claims from non-contracted care providers will reimburse appropriately.

• Process in place to identify similar claims for that contract year for the non-contracted care provider who submitted a payment dispute to help ensure that they are paid correctly.

• Ongoing training program in place for any component of the internal claim payment dispute process. Training to include educating all areas of the organization, including, but not limited to member service, claims and appeals.

• Internal compliance monitoring conducted on a consistent basis to confirm CMS requirements are met on non-contracted care provider disputes.

• End-to-end quality review process in place, from the time a dispute is received from the non-contracted care provider to the time when the dispute decision is sent to the non-contracted care provider.

Requirements for Submission of Encounter Data

We require the submitting entity to submit all professional and institutional claims and/or encounter data for Medicare Advantage members:

• To comply with regulatory requirements of the Balanced Budget Act (BBA)

• To submit to CMS for risk adjustment reporting and accurate Medicare reimbursement

• To comply with NCQA-HEDIS reporting requirements

• To provide the submitting entity with comparative data

• To produce the Provider Profile and Quality Index

• To facilitate utilization management oversight

• To facilitate quality management oversight

• To support Services 75 FR 19709-Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B

• To comply with CMS regulation 42 CFR 422.111(b)(12) which requires an EOB for Part C benefits

• To facilitate settlement calculations, if applicable

To comply with the CMS regulation 75 FR 19709 to report member cost share as well as out-of-pocket maximums, we require contracted care providers to submit current, complete and accurate encounter data, including member cost share/revenue, to us within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned Medicare Advantage members.

To comply with the CMS regulation 42 CFR 422.111(b) (12) which requires an EOB for Part C benefits, all encounter submissions from contracted providers must include all data fields contained in an ANSI ASC X12N 837 Health Care Claims transaction and follow guidance specified in the technical report document for the ANSI ASC X12N 837 Health Care Claims transaction implementation guide. In addition, UnitedHealthcare requires that all encounter data submitted via EDI should be sent to payer ID 95958. We continuously monitor encounter data submissions for quality and quantity for Medicare Advantage. Submission levels below the current established thresholds as defined by the Capitation/Encounter Data Collection Team are considered non-compliant. The capitated medical group/IPA, or other submitting entity, must correct any encounter errors identified by a clearinghouse or trading partner at least on a monthly basis. As a capitated delegated entity processing claims on our behalf, it is our expectation that all encounter submissions are an accurate reflection of the original claim received without exception.

All encounter data submitted to UnitedHealthcare is subject to federal audit. We have the right to perform routine medical record chart audits on any or all of the medical group’s/IPA’s participating care providers at such
time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD and CPT coding. The medical group/IPA shall be notified in writing of audit results pertaining to coding accuracy. As outlined in your participation agreement, the medical group/IPA may be subject to financial consequences if it or another submitting entity fails to submit or meet the encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart audit of its participating physicians with notice from UnitedHealthcare.

Hierarchical Condition Category (HCC) reporting
CMS mandates that services are paid based on Hierarchical Condition Category (HCC) Reporting. This payment methodology requires physicians and health care providers to be accurate in chart documentation and diagnosis reporting, through claims and encounter data submissions to all health insurance carriers. CMS reimburses all Medicare Advantage benefit plans based on the member’s health status. CMS uses the diagnosis codes from the Medicare Advantage claims and/or encounter data (inpatient, outpatient and physician) to establish each member’s health status or HCC. The HCC is used by CMS to calculate Medicare reimbursement payments for each member.

As a result, we are required to send all adjudicated claims and capitated encounter data for Medicare Advantage members to CMS. These claims and encounters must pass all the edits that CMS applies to its fee-for-service HIPAA 5010 837, Form 1500, and UB-04 submissions.

In order to minimize rejected claims and encounter data, you must process your Medicare Advantage claims and encounters in the same manner as your Medicare fee-for-service bills, as outlined in our submission instructions and other requirements stated in this supplement.

If you are a capitated medical group/IPA, or other submitting entity, you must correct any encounter errors identified by a clearinghouse or trading partner at least on a monthly basis. As a capitated delegated entity processing claims on our behalf, we expect that all encounter submissions accurately reflect the original claim and there are no exceptions. CMS may audit our submissions at any time. The billing and member medical information must be able to be tracked back to the medical record.

Member Grievance and Appeals
Delegated entities are required to comply with the following requirements when there is a member grievance and appeals:

- Immediately forward all member grievances and appeals (complaints, appeals, quality of care/service concerns) in writing for processing to:
  - **West Region**
    - (AK, AZ, CA, CO, HI, ID, MT, NM, NV, UT, WA, WY)
    - UnitedHealthcare
    - P.O. Box 6106
    - Cypress, CA 90630
  - **Other States**
    - UnitedHealthcare Provider Appeals
    - P.O. Box 6106
    - Salt Lake City, UT 84130-0575

- Respond to our requests for information relevant to the member’s appeal or grievance within the designated timeframe. You must supply records as requested within two hours for expedited appeals and 24 hours for standard appeals. This includes, but is not limited to, weekends and holidays.

- Comply with all final determinations made by us regarding member appeals and grievances.

- Cooperate with us and the external independent medical review organization, including but not limited to, promptly forwarding to the external review organization copies of all medical records and information relevant to the disputed health care service in the medical group/IPA’s possession, as well as any newly discovered relevant medical records or any information in the participating medical group/IPA’s possession that is requested by external review organization.

- Provide us with proof that reversals of adverse determinations were carried out within the stated time frames. Care providers must supply proof within:
  - Expedited appeals, two hours of overturn notice
  - Standard appeals, 24 hours of overturn notice.

This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).
Physician/Provider Complaints and Member Appeals, Grievances or Complaints
We maintain a centralized system of logging, tracking and analyzing issues received from members and from physicians and other health care providers to measure and improve member and provider satisfaction. This system operates to assist us in fulfilling the requirements and expectations of our members and our participating physicians. In addition, we support compliance with CMS, the National Committee for Quality Assurance (NCQA), the Joint Commission, and other accrediting and/or regulatory requirements. Information regarding care provider and member complaints is important to the re-credentialing process because it helps us attract and retain physicians and health care providers, employer groups and members.
All written complaints are entered into the complaint database. If a potential quality of care issue is identified within the complaint (using pre-established triggers), an acknowledgement letter is sent and the case is forwarded to the Quality of Care Department to investigate the care elements. If the complaint involves an imminent and serious threat to the health of the member, the case is referred to the Quality Intervention Services group for immediate action. Quality of care complaints are investigated by identifying and requesting relevant medical records/information necessary to make a determination. Case review findings are reflected in assigned severity levels and data collection codes to objectively and systemically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our members.
When complaints are received they are tracked and trended by physician/provider and the information is utilized at the time of physician/provider’s recredentialing. An annual analysis of the complaint data is performed to identify opportunities for improvement.
Members have the right to appeal the determination of any denied services or claim by filing an appeal with UnitedHealthcare. Timeframes for filing an appeal is 60 calendar days of the denial notice.

Delegate Performance Management Program
UnitedHealthcare and Catalyst Health Network coordinate evidence-based care, ensuring that primary care physicians, specialists and facilities are aligned with the Institute for Healthcare Improvement’s (IHI’s) “Triple Aim” objective:
1. Increase patient satisfaction,
2. Improve the health of the population and
3. Reduce the cost of health care.
As part of our effort to support the goals of Triple Aim© delegate performance will be evaluated. An analysis of clinical, quality and health outcomes will be conducted to identify potential variations in care delivery in order to support the best quality care and outcomes for our members. By comparing data, that is risk-adjusted when appropriate, to identify variations from peer benchmarks and sharing that information with you, we can work collaboratively to improve value for our members.

Performance Measurement
Performance measurement supports practice improvement and provides delegates with access to information regarding how their group compares to peer benchmarks for specific measures. This information provides a starting point for an ongoing dialog regarding how we can best support your efforts in providing high quality, cost-effective care to our members.
Delegate performance measurements include, but are not limited to, the following areas of focus:
• Clinical utilization management
• Clinical quality including STARS, HEDIS and patient satisfaction
• Encounter data performance management
• Credentialing performance management
• Financial performance management
• Compliance with UnitedHealthcare, Federal and State requirements.
Performance measurements are evaluated on a regular basis, compared to peer benchmarks, and communicated to the delegate in the form of performance reports.

Improvement action plans
Based on delegate performance findings, we may require the delegate to develop an improvement action plan designed to bring the delegate into compliance with performance standards.
Delegates who do not achieve compliance within the established timeframes may require continued oversight until they achieve compliance.
Delegation is a function that is subject to revocation for continued noncompliance with our standards. Failure to meet performance requirements may be cause for revocation of delegated services.
Applicability of This Supplement
This Mid-Atlantic Regional Supplement applies to services provided to members enrolled in:
• MD-Individual Practice Association, Inc. ("M.D. IPA") and M.D. IPA Preferred, or
• Optimum Choice, Inc. ("Optimum Choice"), and Optimum Choice Preferred, and Optimum Choice Small Business Health Options Program (SHOP).

(May apply to care providers in DE, DC, MD, PA, VA, WV; reference your agreement for applicability)

Care providers are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. For protocols, policies and procedures not referenced in this supplement refer to appropriate chapter in the preceding guide.

A complete list of Mid-Atlantic Healthplan Protocols pertaining to M.D.IPA, M.D.IPA Preferred, Optimum Choice, and Optimum Choice Preferred can be located on UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols.

The term “prior authorization” referenced in this supplement is also referred to as “preauthorization”. You will notice both terms used throughout this supplement, both are the same.

Product Summary
This table provides information about M.D. IPA and Optimum Choice products for the Mid-Atlantic Region.

<table>
<thead>
<tr>
<th>Attributes</th>
<th>M.D. IPA and Optimum Choice</th>
<th>M.D. IPA Preferred and Optimum Choice Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do members access physician and health care professionals?</td>
<td>Members choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care.</td>
<td>Network benefits: Members choose a PCP who arranges or coordinates care, with the exception of emergency services, network OB/GYN and routine eye refraction care. Out-of-network benefits: Members are not required to have care arranged or coordinated by a PCP.</td>
</tr>
<tr>
<td>Does a PCP have to write a referral to a specialist?</td>
<td>Yes; except for visits to a network OB/ GYN routine eye refraction care, or emergency services.</td>
<td>Network benefits: Yes, except for visits to a network OB/ GYN, routine eye refraction care, or for emergency services. Out-of-network benefits: No referral needed.</td>
</tr>
<tr>
<td>Is the treating physician required to obtain prior authorization for procedures or services?</td>
<td>Yes, please view section on Prior Authorizations process located within this supplement. A complete list of codes requiring prior authorization can be located on UnitedHealthcareOnline.com &gt; Tools and Resources &gt; Policies, Protocols and Guides &gt; Protocols &gt; Mid-Atlantic Protocols.</td>
<td>Yes; please view section on Prior Authorizations process located within this supplement. A complete list of codes requiring prior authorization can be located on UnitedHealthcareOnline.com &gt; Tools and Resources &gt; Policies, Protocols and Guides &gt; Protocols &gt; Mid-Atlantic Healthplan Protocols &gt; Prior Authorization Code List.</td>
</tr>
</tbody>
</table>

UnitedHealthcare Optimum Choice Small Business Health Options Program (SHOP)
Health Insurance Marketplaces, also known as Exchanges, are tools to help small groups research, compare and enroll in quality health benefit plans from health insurers. Products offered on and off the Exchange follow the same policies and protocols as outlined within this supplement, except as otherwise required by your agreement. Your agreement with us determines if you are participating in these products. If a member presents a health care ID card with a product name with which you are not familiar, call UnitedHealthcare at 877-842-3210. This product list is provided for your convenience and is subject to change.

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Optimum Choice Small Business Health Options Program (SHOP) Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Name</td>
<td>Optimum Choice, Inc.</td>
</tr>
<tr>
<td>How do members access physicians and health care professionals?</td>
<td>For each covered family member, members choose a network primary care physician, or are assigned a PCP, to manage the member’s care and generate referrals to network specialists when required.</td>
</tr>
<tr>
<td>Is a special referral required?</td>
<td>Yes, on selected procedures. See guidelines in the referral requirements section of Mid-Atlantic Supplement.</td>
</tr>
<tr>
<td>Are treating physicians and/or facilities required to request prior authorization when providing certain services?</td>
<td>Yes, on selected procedures. See guidelines in the Prior Authorization List located on UnitedHealthcareOnline.com.</td>
</tr>
</tbody>
</table>
UnitedHealthcare Optimum Choice Health Savings Account (HSA) Plan

The Optimum Choice and Optimum Choice Preferred HSA benefit plans are high-deductible medical benefit plans that combine our traditional gated HMO benefit plans with an HSA option. All expenses under this benefit plan are the member’s responsibility until their deductible is reached. HSA benefit plans require that reimbursement for services rendered to members are based on a fee-for-service reimbursement methodology.

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Optimum Choice, Inc. Health Savings Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Requirement</td>
<td>The Optimum Choice HSA product requires each UnitedHealthcare member to choose a primary care physician.</td>
</tr>
<tr>
<td>PCP Referrals to Network Specialists</td>
<td>The member’s PCP generates referrals for specialty care and facility care.</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Services for members enrolled in Optimum Choice HSA are excluded from your capitation payment and are paid on a fee-for-service (FFS) basis per the All Payer Payment Appendix included in the UnitedHealthcare physician agreement.</td>
</tr>
<tr>
<td>OCI HSA Member Health Care ID Card</td>
<td>The Optimum Choice HSA product name and member’s PCP are indicated on the member’s health care ID card. Specialist referral requirements are on the back of the health care ID card. When confirming eligibility, please use the eligibility application on Link.</td>
</tr>
</tbody>
</table>

Provider Responsibilities

For detailed information and instructions on verifying eligibility, the choice and role of the PCP and other care provider requirements, refer to Chapter 2: Provider Responsibilities and Standards.

Eligibility and Health Care ID Cards

M.D.IPA and Optimum Choice members receive health care ID cards that include information needed for you to submit claims. Information on the ID cards may vary by health benefit plan. For example, some members may have health care ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits. An image of the health care ID card can be seen when you verify the member’s eligibility. For more detailed information on ID cards and to see a sample health care ID card, refer to the Health Care Identification (ID) Cards section of Chapter 2: Provider Responsibilities and Standards.

Please check the member’s health care ID card at each visit, and keep a copy of both sides of the health care ID card for your records. Possession of a health care ID card is not proof of eligibility. Prior to seeing a member, it is important you verify eligibility and benefits, as well as the member’s PCP selection, to avoid payment issues. Go to UnitedHealthcareOnline.com > Patient Eligibility & Benefits.

The following unique features on located on M.D.IPA and Optimum Choice health care ID cards:

1. Laboratory provider information is located on the front of the cards; please see the following Laboratory Requirements section of this supplement.
2. Radiology county information is located on the front of the cards; please see the following Radiology Services section of this supplement.
3. Information regarding the necessity of referral and prior authorization requirements is now listed on the back of the cards.

Laboratory Requirements

M.D. IPA and Optimum Choice members must use the medical laboratory noted on their health care ID card for medical laboratory services. Any specimens collected in the office MUST be sent to the laboratory indicated on the member’s health care ID card. Depending on where the member lives, the health care ID card shows:

- LAB = LABCORP (Laboratory Corporation of America).
- LAB = PAR (may use any participating outpatient commercial medical laboratory). Our online directory of health care professionals is available at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory.

Refer to UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols > Laboratory Services for more information.

Radiology Services

M.D. IPA and Optimum Choice members must use the radiology county noted on the health care ID card. Depending upon the member’s Primary Care Provider’s office location, the health care ID card shows:

- RAD = PAR (may use any office based participating provider) A complete list of these providers may be found at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory.
- RAD = County (the name of a county, i.e., “MONT (Montgomery County)” is listed on the card)

Specific vendors are available for referral based on the county listed on the health care ID card. A complete list of county specific radiology vendors is found at UnitedHealthcareOnline.com > Tools and Resources > Policies, Protocols and Guides > Mid-Atlantic Healthplan Protocols > Radiology Services.

PCP Requirements for Members

A PCP is defined as a physician specializing in family practice, internal medicine, pediatrics, or general practice. Other care providers will be included as primary physicians.
as required by state mandates. Members are required to see their PCP or a covering physician at the address location that shares the same TIN listed on the Patient Eligibility screen. Some PCPs have multiple TINs but may not participate under each of those TINs for the member’s benefit plan. Prior to scheduling appointments, it is important to verify the member’s assigned PCP and the TIN listed on the Patient Eligibility screen is the same TIN for the address location where the member will be seen. You may submit your address corrections through the Provider Data Management application on Link, or call the phone number on the back of the member’s health care ID card prior to seeing the member.

UnitedHealthcare of the Mid-Atlantic region may close any PCP panel if a member complains about access, or if UnitedHealthcare of the Mid-Atlantic region identifies a quality related issue.

For all requests relating to panel status (i.e., Open/Closed to New/Existing Patients), please contact your Network Account Representative 30 calendar days prior to any action. To locate your Network Account Representative, please go to UnitedHealthcareOnline.com > Contact Us > Network Contacts are located near the bottom of the page. Members are required to select a network PCP or a PCP is auto assigned.

Discharge of a Member from Physician’s Care
If, after reasonable effort, you are unable to establish and maintain a satisfactory relationship with a member, you may request the member be discharged from your care and transferred to an alternate physician. You must notify us to have the member removed from your panel. This number is on the back of the member’s health care ID card. Reasons for discharge may include:

• Disruptive behavior
• Physical threats/abuse (this warrants immediate action which must be documented. Please notify the proper authorities)
• Verbal abuse
• Gross non-compliance with the treatment plan

You must provide adequate documentation in the member’s medical record of the verbal and written warnings. The physician is obligated to provide emergency care to the member for 30 calendar days from the member’s receipt of the dismissal letter. For more information go to: UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols > PCP Selection, Panel Closure & Member Dismissal.

Referrals
For information on the following, refer to the Mid-Atlantic Health Plan Referral Protocol located on UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols > Referral Process (PDF):

• Referral Submission Requirements
• Maximum Referral Visits
• Exceptions for specific specialists or treatments

Referrals are not required when M.D. IPA or Optimum Choice is the secondary carrier.

Forms and specific referral processes for some treatments can be found on UnitedHealthcare.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols.

Copays
Please verify the member’s copayments when verifying eligibility.

Prior Authorizations
How to Submit
Multiple submission options are available to submit requests for prior authorizations to UnitedHealthcare, including electronic methods. To avoid duplication, once a prior authorization is submitted and confirmation is received, please do not resubmit.

• Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations or, if logged into Link, by using the Prior Authorization & Notification application. Radiology services should also be submitted using these tools.

• Phone: 877-842-3210. The Clinical Services staff is available during the business hours of 8 a.m. to 8 p.m. ET.

• Fax: Fax your requests for prior authorization by using the Universal Prior Authorization Request Form located at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Mid-Atlantic Healthplan Protocols to:

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Outpatient</td>
<td>866-255-0959</td>
</tr>
<tr>
<td>Infertility</td>
<td>866-369-4119</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>866-362-6101</td>
</tr>
<tr>
<td>Homecare</td>
<td>877-269-1045</td>
</tr>
<tr>
<td>Radiology</td>
<td>866-589-4848</td>
</tr>
<tr>
<td>Transplant</td>
<td>866-537-9371</td>
</tr>
<tr>
<td>Inpatient &amp; Acute Rehabilitation</td>
<td>866-892-4582</td>
</tr>
</tbody>
</table>

The forms referenced below can be found on the Mid-Atlantic Healthplan Protocols webpage.
Radiology Prior Authorization Requests and Prior Authorization List

Although prior authorization requests for radiology can be submitted electronically using our online prior authorization system. M.D. IPA and Optimum Choice are not part of the United Healthcare Radiology Prior Authorization Program. Refer to the Preauthorization List located at Mid-Atlantic Healthplan Protocols > Pre Authorization Code List.

Outpatient Rehabilitation (Physical, Occupational, and Speech Therapy) Prior Authorization Request

Prior authorization requests for physical, occupational, speech, and other therapy-related services cannot be submitted electronically. Fax your requests for prior authorization to the Clinical Care Coordination Department at 888-831-5080 by using the Rehab Extension Form located at Mid-Atlantic Healthplan Protocols.

Chiropractic Services Prior Authorization Request

Prior authorization requests for chiropractic services cannot be submitted electronically. Fax requests for prior authorization to the Clinical Care Coordination Department at 888-831-5080 by using the Chiropractic Services Extension Form located at Mid-Atlantic Healthplan Protocols > Chiro Extension Form along with a copy of the current Consultant Treatment Plan (PCP Referral).

Please allow two business days for extension request decisions. Missing information may result in a delayed response. Decisions are based on the member’s plan benefits, progress with the current treatment program, and documentation submitted.

Exception Requests

All exceptions to our policies and procedures must be preauthorized by faxing a request to Outpatient Services at 866-255-0959. The most common exception requests are:

• Immunizations (outside the scope of health benefit plan guidelines)
• Referral of an HMO member out-of-network to a nonparticipating physician, health care practitioner or facility

Prior authorization is required for the listed elective outpatient services. It is the physician’s responsibility to obtain relevant prior authorization. However, the facility should verify that prior authorization has been obtained prior to rendering the service. Payment may be denied to the facility for services rendered in the absence of prior authorization. All final decisions concerning coverage and payment are based upon member eligibility, benefits and applicable state law.

If you have a question about a pre-service appeal, please see the section on Pre-Service Appeals under Chapter 6: Medical Management.

Inpatient Admission Notification

It is the responsibility of the facility to notify UnitedHealthcare within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5 p.m. local time on the next business day.

For emergency admissions when a member is unstable and not capable of providing coverage information, the facility, should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances.

Prior authorization is required for all elective inpatient admissions for all M.D. IPA and Optimum Choice members; it is the admitting physician’s responsibility to obtain the relevant prior authorization. However, the facility should verify that prior authorization has been obtained prior to the admission. Payment may be denied to the facility and attending physician for services rendered in the absence of prior authorization. Please remember prior authorization does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon member eligibility, benefits and applicable state law.

Skilled Nursing Facility (SNF) placements no longer require prior authorization. You must verify available benefit and notify us within one business day of SNF admission.

Maryland State-Specific Variations from the Standard Notification Requirements for Facilities

For information specific to members residing in Maryland, please refer to UnitedHealthcareOnline > Clinical Resources > Advance and Admission Notification Requirements, and scroll to the bottom of the web page.

Admission Notification Requirements

Phone: 800-962-2174 or Fax: 800-352-0049.

As a participating facility you are required to notify us of an admission of our member within 24 hours or the next business day following a weekend or federal holiday, whichever comes first. When we receive your notification we begin a case review. If notification is not provided in a timely manner, we may still review the case and request additional medical information. We may retroactively deny one or more days based upon the case review. If a member receiving outpatient services needs an inpatient admission, you must notify us as noted above. Emergency room services that result in a covered admission are payable as part of the inpatient stay as long as you have notified us of the admission as described above.

Delay in Service

Facilities that provide inpatient services must maintain appropriate staff resources and equipment to make sure that covered services are provided to members in a timely manner. A delay in service is defined as any delay in medical decision-making, test, procedure, transfer, or
discharge that is not caused by the clinical condition of the member. Services should be scheduled the same day as the physician’s order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day, unless emergent treatment was required. A delay in service may result in sanctions of the facility and non-reimbursement for the delay day(s), if permissible under state law.

A clinical delay in service is assessed for any of the following reasons:

- Failure to execute a physician’s order in a timely manner that results in a longer length of stay.
- Equipment needed to execute a physician’s order is not available.
- Staff needed to execute a physician’s order is not available.
- A facility resource needed to execute a physician’s order is not available.
- Facility does not discharge the patient on the day the physician’s discharge order is written.

**Concurrent Review**

Review is conducted on-site at the facility or by phone for each day of the stay using nationally-accepted criteria. You must cooperate with all requests from us for information, documents or discussions including, but not limited to, clinical information on patient status and discharge planning. If criteria are not met, the case is referred to a medical director for assessment. We deny payment for facility days that do not have a documented need for acute care services. We require that physicians’ progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the facility and the physician.

**Facility Post-Discharge Review**

When a member has been discharged before notification to UnitedHealthcare can occur or before information is available for certification of all the days, a post-discharge review is conducted. A UnitedHealthcare representative will request the member’s records from the Medical Records Department or assess a review by phone, and review each non-certified day.

Inpatient days that do not meet acuity criteria are referred to a medical director for determination and may be retrospectively denied. Delays in service or days that do not meet criteria for level of care may be denied for payment.

**Facility to Facility Transfers**

The facility must notify us of a request for facility-to-facility transfer. In general, transfers are approved when there is a service available at the receiving facility that is not available at the sending facility, the member would receive a medically appropriate change in the level of care at the receiving facility, or the receiving facility is a network facility and has appropriate services for the member.

If any of the conditions above are not met, coverage for the transfer is denied. Services at the receiving facility will be approved if:

- Medical necessity criteria for admission were met at the receiving facility, and
- There were no delays in providing services at the receiving facility.

**Injectable Medications**

Drugs that require both prior authorization and the use of a specific vendor: This protocol applies when you obtain specialty medications specialty medications, including prescription ordering and purchase. You must use a participating specialty pharmacy in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. The specialty pharmacy bills us for the medication. You only need to bill us for administration of the medication and not for the medication itself. The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for the collection of any payment prior to dispensing the medication to the physician’s office. Refer to the following resources:

- The Preauthorization Code List located in the Mid-Atlantic Healthplan Protocols.
- A listing of specialty drug codes that also require procurement through a designated specialty pharmacy.
- UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources > Specialty Pharmacy Program. Note: You may be required to include specific diagnosis for payment.

Requests for prior authorization can be faxed to 866-537-9371. Please include clinical notes and name of specialty pharmacy vendor. We will call you within three business days if conditions are not met for prior authorization of the drug. If authorized, Pharmacy Services provides a written authorization number and coverage dates.

This authorization must be submitted to the specialty pharmacy vendor along with the medication order.

Specialty pharmaceutical vendor information is available at: UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources.
Clinical Appeals
To appeal an adverse decision (a decision by us not to prior authorize a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter that includes your intent to appeal, justification for the appeal and include supporting documentation. The denial letter will provide you with the filing deadlines and the address to use to submit the appeal.

Urgent Appeal Submissions:
Medical fax: 801-994-1083,
Pharmacy fax: 801-994-1058

Direct Access Services
Female members may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means the member may receive these services without prior authorization or a referral from her PCP. In all cases however, the physician must be affiliated with the member’s assigned medical group/ IPA and participating with UnitedHealthcare.

Claims Process
Please refer to Chapter 8: Our Claims Process for detailed information about our claims process. Please refer to the Referral Process Policy discussed earlier, which can be found on UnitedHealthcareOnline.com.

All claims that can be submitted electronically must be submitted to payer ID 87726.

Reconsideration and Appeals Processes
For claim reconsiderations for M.D. IPA and Optimum Choice, please submit your request online using the claim reconsideration application on Link.

Specific instructions for claims reconsideration, including a quick reference guide, can be found on UnitedHealthcareOnline > Help > Claims & Payments.

For information on the appeal process, please refer to the Claim Reconsideration, Appeals Process and Resolving Disputes section in Chapter 8: Our Claims Process.

Capitation
Capitation payment will be paid to the practice for covered services on a per member per month (PMPM) basis. The PCP receives separate capitation payments for members of M.D. IPA and Optimum Choice monthly on the fifth day of the month.

The PMPM is calculated by multiplying the fixed monthly rates (detailed in the Capitation Rate Schedule contained in your agreement) times the number of members who have selected or been assigned to a PCP within the practice.

Payment Rules
The capitation payment for a given month is calculated based on the 15/30 rule. This rule is used to determine whether a capitation payment is made for the full month or not at all. If the effective date of member change falls between the first and 15th of the month, the change is effective for the current month. If the effective date of the member change falls on or after the 16th of the month, the capitation adjustment is reflected on the first of the following month. As such, retroactive adjustments to capitation payments may be made based on the members eligible on the 15th of the month.

<table>
<thead>
<tr>
<th>15/30 Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retroactive Add:</td>
<td>A member added retroactively on the 14th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment, even though the member would be considered eligible for services. To help you identify these members, the member’s standard services capitation is reported as $0.</td>
</tr>
<tr>
<td>Retroactive Term:</td>
<td>A member retroactively terminated between the first and 14th of the month would generate a capitation recoup entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 16th or later would not generate a capitation recoup entry for the capitation previously paid for the entire month.</td>
</tr>
</tbody>
</table>
UnitedHealthcare of the Mid-Atlantic region provides Capitation Reports to PCPs, as described below:

<table>
<thead>
<tr>
<th>ECap Report Name</th>
<th>ECap Report Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>7030-A01: Capitation Analysis Summary – Provider Medical Group Report</td>
<td>High-level capitation information by current and retro periods for each care provider.</td>
</tr>
<tr>
<td>7010-A02: Capitation Paid ECap – Primary Care Provider Report - Detail</td>
<td>A PCP-level report that summarizes the capitation paid by current and retro periods. The three sections of the report include amounts for: 1. Standard services 2. Supplemental benefits and capitated adjustments 3. Non-capitated adjustments and withholds</td>
</tr>
<tr>
<td>7210-A01: Capitation Details – Primary Care Provider Report for Standard Services-(PMG)</td>
<td>Detailed capitation information for each current member assigned to a PCP.</td>
</tr>
<tr>
<td>7240-A01: Member Changes Capitation Details – Primary Care Provider Report for Standard Services-(PMG)</td>
<td>Detailed retroactive change information on added, changed and terminated members. The three sections of the report include information on: 1. Member adds 2. Member demographic changes 3. Member terms</td>
</tr>
<tr>
<td>7290-A01: Capitation Adjustment Details – Primary Care Provider Report-(PMG)</td>
<td>Capitation adjustment details for Member and provider-level guide adjustments. The two sections of the report include information on: 1. Current period 2. Retro period</td>
</tr>
</tbody>
</table>

The PCP practice should reconcile the capitation payment and report upon receipt. Any requests for an adjustment or reconciliation of the capitation payment must be made within 60 calendar days of receipt. If the PCP/medical group (practice) does not request reconsideration of the capitation payment within 60 days, the capitation payment provided is accepted as payment in full (as per contract). Copies of the reports above can be obtained by calling Provider Services at 877-842-3210.
Applicability of This Supplement
This Neighborhood Health Partnership (“NHP”) Supplement applies to covered services provided to members enrolled in NHP benefit plans when those covered services are provided by participating care providers in either of the following categories:

Your participation agreement with UnitedHealthcare includes a reference to the NHP protocols or Guides, or they have directly contracted with NHP to participate in networks maintained for NHP members;

OR

The participating care provider is located in the NHP Service Area. The “NHP Service Area” is the following Florida counties:

Broward, Flagler, Hernando, Highlands, Hillsborough, Lake, Lee, Martin, Miami Dade, Orange, Osceola, Pasco, Palm Beach, Pinellas, Polk, Sarasota, Seminole, and Volusia.

NHP Flex Benefit Plans: This supplement does not apply to care providers located outside the NHP Service Area.

NHP participating care providers are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the preceding guide.

The term “prior authorization” referenced in this supplement is also referred to as “pre-certification”. You will notice both terms used throughout this supplement.

Online and Platform Migration
To help streamline processes for care providers, UnitedHealthcare Neighborhood Health Partnership (NHP) transitions to new administrative and claims systems beginning June 1, 2016. Employer groups with an NHP health benefit plan moves to our core UnitedHealthcare systems on their renewal date beginning on or after June 1.

Members will not transition all at once; instead, they will transition on their employer group’s renewal date. All members will have transitioned to the core UnitedHealthcare systems by May 31, 2017. Please review the back of the health care ID card to determine how to verify the member’s eligibility.

Health Care ID Cards
Members who have transitioned receive new member health care ID cards with new member ID numbers. Starting June 1, please follow these steps to determine if a member has transitioned. Please be sure to check a member’s eligibility each time they visit your office.

• If the member has a new health care ID card, please follow the “For members who have transitioned” processes.

• If the member does not have a new health care ID card:
  › Check to see if the member is listed on myNHP.com. If they are, they have not yet transitioned to the core UnitedHealthcare systems. Please follow the “For members who have not transitioned” processes.
  › If the member is not listed on myNHP.com, check to see if they are listed on UnitedHealthcareOnline.com. If they are, they have transitioned to the core UnitedHealthcare systems. Please follow the “For members who have transitioned” processes.
  › If you are unable to confirm eligibility for an NHP member using either website, please call Provider Services at 877-842-3210.

For Members who Have Transitioned
The new health care ID card has a new member ID number, and the phone number, website and claims address for our core UnitedHealthcare systems are listed on the back. Please use the new member ID numbers for claims with dates of service on or after the member transition date.
For Members who Have Not Transitioned

- The health care ID card has a member ID number that begins with “JD,”
- On the back it lists the NHP website, phone number and claims address.

Please check eligibility online each time a member visits your office in case a member who has transitioned presents their old member health care ID card.

If the information in this supplement does not specify a difference the process in place applies to both types of members. If you are unable to confirm whether a member has transitioned to the new system, please call 877-842-3210 to check member eligibility.

How to Contact NHP

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Website</td>
<td>Mynhp.com/Providers</td>
</tr>
</tbody>
</table>
| For members that have not transitioned | • Claims submissions  
|                    | • Eligibility                                    |
|                    | • Forms                                          |
|                    | • Request referrals                               |
| Provider Website  | Link and UnitedHealthcareOnline.com              |
| For members who have transitioned | Same as above and more;  
|                    | • Medical Policies, Drug Policies and Coverage Determination Guidelines  
|                    | • Provider news and updates, such as the Medical Policy Update Bulletin  
| Note: You must register to access some of the features available to you. Go to UnitedHealthcareOnline.com and select “New User” to begin registration. |
| Provider Services | Phone: 877-972-8845  
| For members who have not transitioned |  
|                    | Phone: 877-842-3210  
| Appeals            | Address: Neighborhood Health Partnership  
| For members who have not transitioned | Attn: Appeals Dept.  
|                    | P.O. Box 5210  
|                    | Kingston, NY 12402-5210  
|                    | Fax: 801-994-1106  
| For members who have transitioned | UnitedHealthcare Appeals  
|                    | P.O. Box 30432  
|                    | Salt Lake City, UT 84130-0432  
|                    | Fax: 801-938-2100  
| Urgent Appeals     | Medical appeals fax: 801-994-1083  
|                    | Pharmacy appeals fax: 801-994-1058  

In an emergency go to nearest emergency room or call 911.

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website www.myNHP.com or call.

For Members: 877-972-8845  
Mental Health: 800-817-4705  
NurseLineServices847  
TDD 711  
Medical Claims: PO Box 5210, Kingston, NY 12402-5210  
877-972-8848

For Pharmacists: 855-816-6616  
www.myNHP.com 877-972-8845  
PO Box 5210, Kingston, NY 12402-5210  
Medical Claims: PO Box 30432, Salt Lake City, UT 84130-0432  
Fax: 801-938-2100  
Pharmacy appeals fax: 801-994-1058  
Note: You must register to access some of the features available to you. Go to UnitedHealthcareOnline.com and select “New User” to begin registration.
<table>
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<tr>
<th>Resource</th>
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</tr>
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</table>
| **Cardiology**: Prior Authorization of cardiology services as described in the Cardiology Notification/Prior Authorization Protocol section of this guide. | Online: [evicore.com](http://evicore.com)  
Phone: 866-889-8054  
Online: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Notifications/Prior Authorizations > Cardiology  
Phone: 866-889-8054 |
| For members who have not transitioned |  |
| For members who have transitioned |  |
| **Chemotherapy** (outpatient injectable) | Phone: 866-889-8054  
Online: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Notifications /Prior Authorizations  |
| **Chiropractic Services Information** | Quality Managed Healthcare, Inc.  
Phone: 954-236-3143  
Fax: 954-236-3254 |
| **Claims (Electronic)** |  |
| For members who have not transitioned | Payer ID: 95123 or 96107  
Payer ID: 87726  
The ERA Payer ID number is also changing to 87726. If you would like to receive 835 ERA files for NHP, or if you currently receive 835 ERA files for NHP under Payer ID 95123 or 96107, please contact your vendor to enroll under Payer ID 87726. The health care ID card for members who have transitioned indicates payer ID 87726. |
| For members who have transitioned |  |
| **Claims (Paper)** |  |
| For members who have not transitioned | Neighborhood Health Partnership  
P.O. Box 5210  
Kingston, NY 12402-5210  
UnitedHealthcare  
P.O. Box 740800  
Atlanta, GA 30374-0800  |
| For members who have transitioned |  |
| **EDI Support** | Phone: 866-509-1593 |
| **Eligibility Verification** | Online: [myNHP.com](http://myNHP.com)  
Phone: 877-972-8845  
For the hearing impaired, please call the National Relay Center: (800) 828-1120  
Customer Service hours: 8 a.m.- 6 p.m. ET  
IVR/Automated Referral Line: 877-972-8845  
As members renew beginning April 1, 2016, the new Provider Services number is 877-842-3210. Please refer to the back of the health care ID card to help ensure the appropriate provider services department is contacted. |
| **Home Health Care, Durable Medical Equipment and Home Infusion, Respiratory Services, Insulin Pumps and Supplies and Breast Pumps** | Online: [myNHP.com](http://myNHP.com) > Providers > Durable Medical Equipment (DME), Home Health, Home Infusion, Respiratory Services, Insulin Pumps and Supplies and Breast Pumps |
| **Intensity Modulated Radiation Therapy (IMRT)** | Phone: 800-550-5568  
Fax: 800-731-2515 |
| **Mental Health Services Prior Authorization** | Phone: 800-817-4705 |
| United Behavioral Health (UBH), operating under the brand Optum. |  |
| **Pharmacy** (OptumRx) | Prior Authorization: 800-711-4555  
Customer Service: 888-739-5820  
Fax: 800-837-0959 |
| **Physical, Occupational and Speech Therapy** (OptumHealth) | Phone: 800-873-4575  
Fax: 248-733-6070 |
<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
</tr>
</thead>
</table>
| **Podiatry**                     | Foot and Ankle Network (FAN)  
|                                  | Phone: 305-558-0444  
|                                  | Fax: 305-557-3810                                                                                                                                 |
| **Radiology/Advanced Outpatient Imaging Procedures:** | Prior Authorization of radiology services as described in the Outpatient Radiology Notification/Prior Authorization Protocol section of this guide  
|                                  | For members who have not transitioned  
|                                  | Online: evicore.com  
|                                  | Phone: 866-889-8054                                                                                                                                 |
|                                  | For members who have transitioned  
|                                  | Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations  
|                                  | Phone: 866-889-8054                                                                                                                                 |
| **Routine Referrals**            | For members who have not transitioned  
|                                  | Online: myNHP.com  
|                                  | Phone: 800-550-5568 (urgent requests only)  
|                                  | Fax: 800-731-2515                                                                                                                                 |
|                                  | For members who have transitioned  
|                                  | Online: UnitedHealthcareOnline.com  
|                                  | Phone: 800-731-2515  
|                                  | Fax: 800-731-2515  
|                                  | **Note:** Open referrals that span the member’s transition date are moved to the core UnitedHealthcare system and can be viewed on UnitedHealthcareOnline.com. |
| **Substance Use Services**       | United Behavioral Health (UBH), operating under the brand Optum  
|                                  | Phone: 800-817-4705                                                                                                                                 |
| **Case Management**              | For members who have not transitioned  
|                                  | • Congenital Heart Disease: 800-550-5568  
|                                  | • Kidney Resource Services: 800-550-5568  
|                                  | • Ventricular Assist Devices: 800-550-5568  
|                                  | • Transplant Resource Services fax: 855-250-8157                                                                                                    |
|                                  | For members who have transitioned  
|                                  | • Congenital Heart Disease: 877-842-3210  
|                                  | • Kidney Resource Services: 800-550-5568  
|                                  | • Ventricular Assist Devices: 877-842-3210 or fax 855-282-8929  
|                                  | • Transplant Resource Services: 877-842-3210 or fax 855-250-8157                                                                                     |
| **Prior Authorization / Pre-Certification** | For members who have not transitioned  
|                                  | You may also request urgent pre-service appeals on behalf of a member. Be sure to include the place of service and CPT codes for your request.  
|                                  | Online: MyNHP.com > Providers > Forms  
|                                  | Phone: 800-550-5568 (Urgent requests only)  
|                                  | Fax: 800-731-2515 or 800-729-1574  
|                                  | Obstetrical fax: 800-731-7954  
|                                  | Facility Admissions fax: 800-731-2430  
|                                  | For members who have transitioned  
|                                  | We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. Be sure to include the CPT codes for your request.  
|                                  | Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations  
|                                  | Phone: 877-842-3210, Option 3, or the number on the back of the member’s ID card.  
|                                  | Fax: 866-756-9733 – using the prior authorization form found at UnitedHealthcareOnline.com > Tools & Resources > Forms > Clinical/Pharmacy |
Discharge of a Member from Participating Provider’s Care

If, after reasonable effort, the PCP is unable to establish and maintain a satisfactory relationship with a member, the PCP may request that the member be discharged from care and transferred to an alternate participating care provider. The PCP must submit the request in writing to NHP Member Care. Reasons for discharge may include:

• Disruptive behavior
• Physical threats/abuse (This warrants immediate action which must be documented. Please contact NHP Member Care and notify the proper authorities).
• Verbal abuse
• Gross non-compliance with the treatment plan

The PCP must provide adequate documentation in the member’s medical record of the verbal and written warnings. The PCP is obligated to provide care to the member until it is determined that the member is under the care of another physician.

Laboratory Services

All NHP members should be directed to LabCorp, Inc. service centers for outpatient laboratory procedures. If a participating care provider draws the specimen in the office the specimen should be sent to LabCorp, Inc.

Home healthcare agencies are responsible for “drop off” of drawn specimens at one of the LabCorp, Inc. service centers.

Claims for clinical laboratory services performed by a participating care provider that is a facility for following services: (i) emergency room services; (ii) chemotherapy; (iii) ambulatory surgery; (iv) transfusions; or (v) hemodialysis is paid in accordance with your agreement. Clinical laboratory specimens drawn at a skilled nursing facility must be processed by LabCorp, Inc.

You may perform clinical laboratory services in the office as listed on the NHP Clinical Laboratory Services (protocol II), located on myNHP.com > Providers > References. Laboratory procedure lists I & II have specific protocols outlined there.

Procedures on list I may be performed by any physician in the office in accordance with state and federal guidelines. Procedures on list II may be performed by a specialist as listed in list II. When these clinical laboratory services are performed in the office, then claims for those services are paid in accordance with your participation agreement.

Use of Non-Participating Laboratory Services

This protocol applies to all participating care providers, and it applies to all laboratory services, clinical and anatomic, ordered by any practitioner.

This protocol does not apply to laboratory services approved to be provided by physicians in their offices (as described above) or facilities (as described above). You are required to refer laboratory services to participating laboratories, except as otherwise authorized by NHP. To get more information on participating laboratories, you can:

• Go to myNHP.com to view a complete list of participating laboratories; or
• Go to LabCorp.com or call 888-LABCORP (522-2677), option #3 to determine how to conveniently access their services.

Call Provider Services at 877-972-8845. As members renew beginning April 1, 2016, the new Provider Services number is 877-842-3210. Please refer to the back of the member health care ID card to help ensure the appropriate Provider Services department is contacted.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact NHP UM at 800-550-5568. LabCorp requires the following to make sure accurate testing and billing:

• Member’s NHP health care ID number
• LabCorp requisition forms with all required fields completed specific test orders using test codes
• Diagnosis codes

Administrative Actions for Non-Participating Laboratory Services Referrals

To see details regarding administrative actions we take for utilizing non-participating laboratory services, refer to myNHP.com > Providers > References > Use of Non-Participating Laboratory Services (protocol I-A)

Additional information is also found in Chapter 7: Specific Protocols.
Referrals
The PCP is responsible for determining when they should refer the member for “specialty care”. Initial referrals can only be initiated by the PCP. All referrals must be made to participating care providers. Claims for services rendered without a proper referral are denied and the member may not be billed for those services unless prior to receiving the service the member, with knowledge that a referral is not in place or that the service is not a covered service, agrees in writing to be financially responsible for the cost of the service. Referrals to a specialist may be necessary:

• When a member fails to respond to current medical treatment,
• To confirm or establish a member’s diagnosis and/or treatment modality,
• To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP. PCPs may make referrals to specialist according to the three levels below.

The following specialty services do not require referral:
› Chiropractic (subject to benefit limitations)
› Dermatology (five visits per calendar year)
› Gynecology
› Podiatry*
› Substance use treatment*
› Mental health*

When submitting a referral:
• Use 12-digit PCP and specialist numbers printed in the IVR listing and member’s seven-digit ID number.
• PCPs require a password and can only refer to a specialist.
• Referrals entered through the IVR System within the last 180 calendar days can be verified.
• Referral letter is generated and mailed to the specialist and member within 24 hours.

Out-of-Network Referrals
Out-of-network referrals are only approved when the services required are not available from a participating care provider. Out-of-network referrals may be requested by calling NHP at 800-550-5568. Upon receipt of the referral by NHP, the data is reviewed and, if approved, entered into the system to help ensure payment of the specialist claims.

Specialty Referral Guidelines
• Once the specialty services have been properly authorized, the member or PCP may schedule an appointment with the specialist.
• Please submit specialist referrals for transitioned members online at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Referral Submission
• Faxed or mailed referrals are date-stamped by NHP and processed in the order received and/or severity of the request as defined below. Urgent referrals are handled on a priority basis.
• If there is a question or concern regarding the referral, such as eligibility, coverage or medical necessity, the NHP UM staff notifies the PCP’s office staff.
• An authorization letter is mailed to the specialist for the member’s medical record.
• Specialist claims are not paid without a referral.
• The specialist should re-verify the member’s eligibility at the time of visit by calling Provider Services at 877-972-8845. As members renew beginning April 1, 2016, the new Provider Services number is 877-842-3210. Please refer to the back of the member’s health care ID card to help ensure the appropriate Provider Services department is contacted.
• IVR system cannot be used for referrals to physicians in the following specialties:
  › Hematology
  › Oncology
  › Plastic & reconstructive surgery
  › Behavioral health
  › Perinatology
  › Neonatology
  › Ophthalmology Sub-specialties (Retinal, Corneal, Oculoplasty)
  › Reproductive Endocrinology/Infertility

With the exception of Behavioral Health Services, requests for these specialties can be sent to NHP UM at 800-550-5568 or faxed to 800-731-2515 or 800-729-1574. Paper referrals may result in certification delays. For Behavioral Health Services, requests can be obtained by calling 800-817-4705.

The PCP may choose to complete the Participating Provider Referral Form, available on myNHP.com > Forms, for those specialties or services not available through the IVR.

All fields on the form must be completed in their entirety. Be sure to include any documentation of pertinent clinical summary information (including diagnosis) which would be helpful to the specialist or NHP Utilization Management. The PCP must sign and date the referral form and fax to: 800-731-2515 or 800-729-1574.

*(See the Prior Authorization section of this supplement)*
All NHP HMO members require a referral before scheduling appointments for specialty services. PCPs must request one of the following referral types:

- **Level I** - Consult: PCP is authorizing a consultation only. The PCP requires a written or verbal communication prior to authorizing additional services. This level certifies a specialist to see the member for one visit during a 60-day period.

- **Level II** - Consultation & Diagnostics: PCP is authorizing a consultation and diagnostic tests that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostic tests identified on the Prior Authorization List are not covered as part of this referral. This level certifies a specialist to see the member three times during a 90-day calendar period.

- **Level III** - Consultation, Diagnostics & Treatment: PCP is authorizing a consultation, diagnostic tests and any treatment that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostics and treatments identified on the Prior Authorization List are not covered as part of this referral. This level certifies a specialist to see the member three times during a 90-day period.

- **Chronic care** - PCP is authorizing three or more visits, diagnostic tests and/or treatments over a course of more than 90 calendar days that will be performed by the specialist in the office and billed by the specialist. The referral needs to include a written plan of care. Specialized diagnostic tests and treatments identified on the Prior Authorization List are not covered as part of this referral.

**Additional Specialist Visits**

If the PCP determines that the member requires continued specialty visits or treatments by the specialist, the PCP may request additional visits by submitting a Prior Authorization Form (treatment plan) available on myNHP.com to NHP UM. The prior authorization form may be faxed to NHP UM: 800-731-2515 or 800-729-1574. The treatment plan must include the following information:

- Date of request;
- PCP name;
- Member name, health care ID number, and date of birth;
- Specialist name, phone number, and specialty;
- Medical information substantiating the need for additional visits;
- Number of additional visits requested and the time frame for the visits.

**Obstetrical Referrals:**

For members who have not transitioned, the obstetrician completes the Global OB Care Notification Form (available on myNHP.com) for pregnant members to obtain referral for total OB Care. The referral for total OB Care includes all prenatal care, one ultrasound between 13 and 24 weeks of gestation, and delivery. During a member’s pregnancy, the obstetrician acts as a PCP for the member and may issue referrals.

Prior authorization for the maternity inpatient admission is required at the time of delivery. Total OB care should be billed at the time of delivery along with the facility authorization number of the delivery.

The following procedures are not included in the referral for total OB Care and require prior authorization:

- Amniocentesis, fetal echo, biophysical profiles, consultation with a specialist, non-stress tests, venipuncture outside the Obstetrician’s office, and any additional ultrasounds. LabCorp must be used for all laboratory services, including any genetic testing.

For members who have transitioned, the Global OB Care Notification Form is not used. Female members/customers may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by NHP as providing OB/GYN physician services. This means the member may receive these services without prior authorization or a referral from her PCP. In all cases however, the physician must be affiliated with the member’s assigned medical group/ IPA and participating with NHP.

**Obstetrics**

A member may self-refer to a NHP obstetrician who is a participating care provider for routine obstetrical (OB) care. If the member is referred to a non-participating specialist, the specialist must notify us through UnitedHealthcareOnline.com or by fax at the number designated on the top of the Prior Authorization Form to make sure accurate claims payment for ante- and postpartum care.

- Routine OB care includes office visits and two ultrasounds.
- Plain film radiography that is performed by a NHP participating care provider or in the obstetrician’s office in support of an authorized visit, do not require prior authorization.
- Routine labs performed in the obstetrician’s office, or are provided by a participating care provider in support of an authorized visit, do not require prior authorization.
- Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician’s office that do not require prior authorization may be performed.
Utilization Management

Transited Members
Please submit your request at UnitedHealthcareOnline.com > Notifications/Prior Authorizations. We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. Be sure to include the place of service and CPT codes for your request.

If you do not have electronic access, you can submit prior authorization requests by phone or fax:

Phone: 877-842-3210, option 3, or the number on the back of the member’s ID card.
Fax: 866-756-9733

Prior Authorization Requirements
All NHP members require prior authorization for the services listed on the Prior Authorization List located on UnitedHealthcareOnline.com > Clinician Resources > Advance & Admission Notification Requirements > Neighborhood Health Partnership Advance Notification guide.

Except as otherwise provided, NHP requires prior authorization prior to the following admissions:

- All hospital admissions*
- Inpatient rehabilitation facility
- Skilled nursing facility
- Long term acute care facility
- Special care unit

You must provide clinical information to support the medical necessity of the admission and/or observation stay, by the next business day following the admission. Final determinations are made by a Medical Director as appropriate.

Concurrent Review
The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, you must submit to NHP or its delegated entities, by phone, or fax, sufficient clinical information to certify the continued stay, to allow the review of the member’s medical status during an inpatient stay, extend the member’s stay, coordinate the discharge plan, determine medical necessity at an appropriate level of care, and to perform quality assurance screening.

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including OB care. If the diagnosis or treatment of a member is delayed secondary to the inability of the facility to provide a needed service, payment for these days is denied, including but not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

Reimbursement for continued stay that does not meet NHP medical necessity criteria is denied. The member cannot be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services. The member is held harmless in these proceedings.

Drug Prior Authorization
In order to promote appropriate utilization, NHP requires a prior authorization for certain medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician’s service (medical benefit) to be eligible for coverage. For a member to receive coverage for a medication requiring prior authorization, the participating care provider must provide clinical information to OptumRx (if the medication is to be dispensed by a participating pharmacy), or to NHP UM (if the medication is to be provided incidental to a physician’s service). Prior authorization does not guarantee coverage.

<table>
<thead>
<tr>
<th>Pharmacy Drug PA Requests</th>
<th>NHP Medical Drug PA Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 800-711-4555</td>
<td>Phone: 877-488-5576</td>
</tr>
<tr>
<td>OptumRx Fax (non-specialty meds): 800-527-0531</td>
<td>Fax: 800-731-6984</td>
</tr>
<tr>
<td>OptumRx Fax (specialty meds): 800-853-3844</td>
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For a full description of our clinical programs on medications dispensed through the outpatient pharmacy benefit, please refer to UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources > Clinical and Specialty Programs. To determine medications available through the Pharmacy benefit and check prior authorization requirements, please consult the NHP Prescription Drug List Consumer Reference guide at MyNHP.com > Members > Pharmacy.

All infusions and chemotherapeutic agents administered through the medical benefit require prior authorization, regardless of the indication. In addition, for the most current and complete list of medical drugs requiring prior authorization for NHP members as well as the requirements for the outpatient medications listed above, go to myNHP.com > Providers > Pharmacy.

*Admissions from the emergency room, to the ICU/CCU, or admission for emergency surgery must be Post-certified by the next business day following admission.
Claims Reconsiderations and Appeals

Claim Reconsideration
For members who have transitioned, please refer to Claim Reconsideration, Appeals Process and Resolving Disputes section located in Chapter 8: Our Claims Process for detailed information about the reconsideration process.

For members who have not transitioned, contact: Provider Services at 877-972-8845 or submit your request online at myNHP.com. (Documentation should clearly explain the nature of the review request.)

Claim Appeal (Post Service)
For members who have transitioned: Please refer to Claim Reconsideration, Appeals Process and Resolving Disputes section located in Chapter 8: Our Claims Process for detailed information about the appeal process. Mail or fax appeal forms to:

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432
Fax: 801-938-2100

For members who have not transitioned: Claim appeals must be requested in writing. Please use the Provider Appeal Request Form available on myNHP.com. Claim appeal forms, along with all accompanying documentation, should be mailed or faxed to:

NHP Provider Claims Appeals
P. O. Box 5210
Kingston, NY 12402-5210
Fax: 801-994-1106

You have one year from the date of occurrence to file an appeal with the NHP. You will receive a decision in writing, within 60 calendar days from the date appeal is received by us.

If you have a question about a pre-service appeal, please see the section on Pre-Service Appeals section in Chapter 6: Medical Management.

Capitated Health Care Providers
If you participate in our network under a capitation agreement with us, you may receive two monthly capitation checks and statements from UnitedHealthcare – one for members who have transitioned and one for members who have not yet transitioned. The capitation reports attached to your check are different for members who have transitioned.

EPS is not available to care providers who participate under a capitated arrangement. However, you can now enroll in EFT for members who have transitioned. To enroll, please contact your Physician Advocate to request an EFT enrollment form.

You can access and download a capitation detail file for members who have transitioned. To learn how to access the report and view instructions for using it, go to UnitedHealthcareOnline.com > Tools & Resources > Reports > Capitation Detail File User guide.
Applicability of This Supplement
OneNet PPO, LLC (OneNet) is a wholly owned subsidiary of UnitedHealthcare Insurance Company, a part of UnitedHealth Group, Incorporated. The OneNet supplement (this supplement) is a supplement to this UnitedHealthcare Guide, both of which must be followed by OneNet health care providers. This supplement may also be referred to as the OneNet Physician, Health Care Practitioner, Hospital and Facility Guide or the “OneNet Guide”.

OneNet health care providers are participating physicians, health care practitioners, hospitals and facilities whose agreement with UnitedHealthcare includes participation in networks offered by OneNet, including but not limited to, the OneNet PPO Medical Network and the OneNet Workers’ Compensation Network. This may include health care providers within the OneNet service area, as well as health care providers in other areas such as providers in states adjacent to the OneNet service area, and those in any future OneNet network expansion areas.

As of March 16, 2016, the OneNet PPO Medical Network product is no longer offered, and only the OneNet PPO Workers’ Compensation Network continues to operate. (See the Discontinuation of the OneNet PPO Medical Network Product section.)

This supplement describes operational procedures and information that specifically apply to services provided to OneNet Customers and OneNet Clients. Care providers are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the preceding guide.

Because OneNet is not a payer but a Preferred Provider Organization only, certain provisions of the UnitedHealthcare guide apply to OneNet, but with some variation. This supplement identifies the principal variations and in the event of a conflict between this supplement and the UnitedHealthcare Guide, the OneNet supplement controls.

As of the date this supplement was published, the OneNet service area includes Delaware, Maryland, North Carolina, Pennsylvania, Virginia, Washington D.C., and West Virginia with additional care providers in Florida, Georgia, South Carolina and Tennessee.

Terms Used in the OneNet Supplement
OneNet Client: OneNet Clients include insurance carriers, third party administrators (TPA), union health and welfare funds, workers’ compensation administrators, workers’ compensation insurance carriers, and others. OneNet Clients may be a OneNet Payer or any entity that provides administrative services to a OneNet Payer (e.g., a TPA).

OneNet Customer: A OneNet Customer is a person authorized by OneNet PPO, LLC to access OneNet participating health care providers under the terms of their agreement. If your UnitedHealthcare contract has the definition of “Customer” or “Member”, the term OneNet Customer as used by OneNet and as used in this supplement is intended to have the same meaning. OneNet Customers include:

• Primary Participants: The qualifying subscriber, employee, insured, policyholder or other person who through their direct or indirect agreement with OneNet is eligible to access network health care providers.

• Participants: As used by OneNet and in this supplement, Participants refers to all Primary Participants and their spouses and dependents (including domestic partners, if applicable) who are authorized by OneNet to access network health care providers.

OneNet Payer: A OneNet Payer is a person or entity that has an obligation to pay for services rendered by a OneNet participating health care provider to a OneNet member. OneNet Payers may include insurance carriers, workers’ compensation carriers, self-funded health benefit plans and others. OneNet Payers may use the services of a TPA or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing claims payment on behalf of OneNet Payers. References in the health care provider agreement to “participating entity”, “Payer” or “Payor” also apply to OneNet Payers. Neither OneNet nor UnitedHealthcare and its affiliates are OneNet Payers.

Claim Pricing or Repricing: The process of applying the OneNet contracted rates to claims submitted by participating health care providers to OneNet or to third party payers or other entities who have contractually based authority to access OneNet networks for themselves or their clients. This process includes the application of clinical edits, reimbursement policies and standard coding practices. In the case of workers’ compensation, it includes the application of state or federal fee schedule rates, or other government-authorized pricing methodology or schedule, when applicable. The terms “claim pricing” and “repricing” are used interchangeably.
Discontinuation of the OneNet PPO Medical Network Product

As of March 16, 2016, the OneNet PPO medical network product is no longer offered to OneNet Clients. There are no Participants with access to the OneNet PPO medical network. Information concerning the OneNet PPO medical network product is included in this supplement to assist in the processing of claims with dates of service prior to March 16, 2016. Claims submitted with dates of service after March 15, 2016 are not processed through the OneNet PPO medical network product.

The OneNet PPO Workers’ Compensation Network continues to operate, but access is limited to employers and administrators contracted with Procura Management, Inc. (Procura). Procura is an Optum company and UnitedHealth Group affiliate. Access to the OneNet PPO Workers’ Compensation Network has ended for all other OneNet Clients. However, some employers and groups who formerly accessed the OneNet PPO Workers’ Compensation Network directly or through another administrator may now access the network through Procura.

These changes impact OneNet participating care providers in the following ways:

• OneNet provides run out pricing on claims for the OneNet PPO medical network through March 15, 2017. To be considered valid for claim pricing, claims must be received within 12 months from the date of service, and the claim must be within the group’s OneNet effective dates. While OneNet applies pricing to these claims, payment of these claims by the OneNet Payer may be subject to the OneNet Payer's timely filing requirements or other limitations set by the Participant’s benefit plan.

• OneNet is no longer accepting medical run out claims through EDI. Submit any valid medical claims to OneNet using the OneNet claims address on the Participant’s health care ID card.

• Medical claims with dates of service after March 15, 2016 should not be sent to OneNet. Contact the payer or TPA listed on the Participant’s health care ID card if you have questions about where to direct claims for services after the group’s access to OneNet ended.

• Medical claims received after March 15, 2017 will be returned to the submitter without pricing, even if the dates of service occurred while the Participant had access to the OneNet PPO medical network. We will not be able to make adjustments to any medical or non-Procura workers’ compensation claims after this date.

• All workers’ compensation claims should be submitted to the injured worker’s employer, workers’ compensation carrier or TPA. Do not submit workers’ compensation claims directly to OneNet or to Procura.

Additional guidelines and policies applicable to OneNet medical run out claim pricing, including pricing appeals and adjustments, are included in other sections of this supplement.

About OneNet PPO

OneNet PPO maintains the OneNet PPO Workers’ Compensation Network, a network of physicians, health care practitioners, hospitals and ancillary facilities used for work-related illness and injury. The network serves workers’ compensation programs administered by employers and TPAs contracted with Procura, an Optum Company.

Procura’s clients are responsible for the administration of workers’ compensation benefit programs accessing the OneNet PPO Workers’ Compensation Network. These responsibilities include, but are not limited to, determining claim compensability, providing explanation of benefit (EOB) statements or remittance advice, and paying compensable claims.

Similarly, OneNet Clients who accessed the OneNet PPO medical network for a self-funded health benefit plan prior to the product closure are responsible for determining the eligibility, final claim adjudication, and claims payment for their Participant’s run out claims.
# How to Contact OneNet PPO

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
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</thead>
<tbody>
<tr>
<td><strong>Customer Care</strong></td>
<td>For OneNet PPO medical claims and workers’ compensation claims for past clients other than Procura, please contact OneNet Customer Care:</td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td>800-342-3289 (Please provide your TIN when you call)</td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td><a href="mailto:maprofessionalservices@uhc.com">maprofessionalservices@uhc.com</a></td>
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</tbody>
</table>
| For workers’ compensation claims for an employer or third party administrator (TPA) accessing the OneNet PPO Workers’ Compensation Network through Procura: | **Phone:** 877-461-3750  
**Fax:** 484-804-6034  
**Email:** proppo@procura-inc.com |
| The Procura name appears on the EOB / remittance advice of Procura clients. | Employers and groups who formerly accessed the OneNet PPO Workers’ Compensation Network directly or through another administrator may now access the network through Procura. |
| **Website:**                     | Information about OneNet PPO and OneNet workers’ compensation claim pricing sheets for Procura are available on UnitedHealthcareOnline.com. > Claims & Payment > Claim Status > OneNet PPO Pricing Status. |
| **Claim Submission**             | **OneNet Medical Run out Claims**  
**OneNet is no longer accepting medical run out claims through EDI.** These claims must be submitted on paper to the OneNet claims address on the Participant’s ID card.  
There are no groups with access to the OneNet PPO medical network as of March 15, 2016. Claims with an earliest date of service after March 15, 2016 should not be sent to OneNet. Contact the OneNet Payer for information on where to direct these claims.  
All pricing services for medical run out claims ends on March 15, 2017. Claims received after this date will be returned without pricing. Submit these claims to the OneNet Payer. Do not submit these claims to Procura.  
**Workers’ Compensation Claims**  
Submit all workers’ compensation to the injured workers’ employer, workers’ compensation carrier or third party administrator (TPA). Do not submit workers’ compensation claims directly to OneNet or to Procura. |
| **Our Standard Medical Claims Mailing Address** | OneNet PPO/MAPS1 Claims  
P.O. Box 934  
Frederick, MD 21705-0934  
**This mailbox will be closed after March 15, 2017.** All items directed to this mailbox after its closure will be returned to the sender. |
| **Claim Pricing Appeals**        | OneNet Appeals  
Attention: CRA  
P.O. Box 934  
Frederick, MD 21705-0934  
**This mailbox will be closed after March 15, 2017,** and we will no longer be able to provide adjustments to OneNet medical claims or non-Procura workers’ compensation claims.  
All items directed to this mailbox after its closure will be returned to the sender.  
Send pricing appeals for OneNet PPO Workers’ Compensation claims for employers and TPAs contracted with Procura to: proppo@procura-inc.com or call 877-461-3750. |
| **Claim Payment Appeals**        | **OneNet is not the Payer and does not adjudicate or pay claims.** Please direct payment appeals to the OneNet Client at the telephone number found on the Participant’s health care ID card or on the OneNet Client’s EOB / remittance advice. |
| **Questions About Your UnitedHealthcare Contract** | Please contact your UnitedHealthcare Provider Representative. |
| **OneNet Information and Updates** | UnitedHealthcareOnline.com > Network Bulletin |
OneNet General Provider
Administrative Requirements

OneNet care providers follow Chapter 2: Provider Responsibilities and Standards described in the UnitedHealthcare guide with the noted exceptions:

• As part of transitions under continuity of customer care, participating care providers should notify current patients who are OneNet Participants of an effective date of termination of their participation agreement at least 30 calendar days prior, or as required under applicable laws. OneNet does not maintain Participant names and addresses and cannot notify Participants on your behalf.

• Additional exceptions related to benefits, eligibility, online tools and health care ID cards are described in other parts of this supplement.

Health Care ID Cards and Participant Eligibility

There are no longer any groups or Participants with access to the OneNet PPO medical network. Any health care ID card bearing the OneNet name or logo is no longer a valid card. OneNet Clients were responsible for printing their own health care ID cards and for maintaining Participant benefits and eligibility information. Please contact the OneNet Client listed on the Participant’s health care ID card, or EOB or remittance advice, if you have a question about the Participant’s benefits or eligibility at the time of service.

ID cards are not issued or used for workers’ compensation Participants, and you should not expect Participants accessing the OneNet PPO Workers’ Compensation Network to present an ID card. Workers’ compensation insurers, workers’ compensation administrators and employers of the injured worker are instructed to advise you of network access when you call to verify employment. You may wish to ask if the injured worker’s employer if they or their workers’ compensation carrier or administrator are contracted with Procura to provide workers’ compensation network access.

Online Services at UnitedHealthcareOnline.com

View workers’ compensation claim pricing sheets for employers and administrators accessing the OneNet Workers’ Compensation Network through Procura by using the OneNet PPO Pricing Status tool on UnitedHealthcareOnline.com > Claims & Payment > Claim Status > OneNet PPO Pricing Status. Pricing sheets show the allowed amount of your claims after the application of OneNet claim pricing. Pricing sheets do not show the final claim adjudication by the OneNet Payer, and may include billed charges that are determined to be non-compensable. These charges are detailed on the workers’ compensation EOB or remittance advice.

OneNet medical claim pricing sheets and workers’ compensation claim pricing sheets for past workers’ compensation clients other than Procura are no longer available on UnitedHealthcareOnline.com. Please call OneNet Customer Care if you wish to receive a copy of a pricing sheet that falls into either of these categories.

Because OneNet Participant benefits, eligibility and other information is not stored on any UnitedHealthcare member system, many of the web tools available at UnitedHealthcareOnline.com for other commercial products cannot be used for OneNet Participants.

Examples of unavailable tools include:
• Determining workers’ compensation eligibility or benefits
• View patient personal health records
• Submit advance notifications
• View your OneNet fee schedule
• Claim Estimator
• Claim submission
• Reprint EOBs
• Electronic Payments and Statements

Similar limitations exist for other UnitedHealthcare systems designed to utilize or verify benefits and eligibility information, such as the United Voice Portal.

Referrals

UnitedHealthcare’s requirements for care provider referrals do not apply to the OneNet PPO Workers’ Compensation Network, and you do not use the Referral Submission system on UnitedHealthcareOnline. However, in some states the injured worker may be required to use certain care providers in order to receive workers’ compensation benefits. Please contact the injured worker’s case manager or adjuster for guidance and use your best efforts to recommend to another participating care provider if requested. For assistance locating participating workers’ compensation care providers, please call Procura at 877-461-3750.

Air Ambulance, Fixed-Wing Non-Emergency Transport

UnitedHealthcare’s requirement to refer non-emergency fixed-wing air ambulance to a participating care provider does not apply to OneNet PPO Workers’ Compensation Network. However, the injured worker may not receive workers’ compensation benefits unless an authorized care provider is used. Please contact the injured worker’s case manager or adjuster for guidance and use your best efforts to recommend a care provider based on the information provided.
Laboratory Services
UnitedHealthcare’s requirement that participating laboratory providers must be used does not apply to OneNet PPO’s Workers’ Compensation Network. However, the injured worker may not receive workers’ compensation benefits unless an authorized laboratory is used. Please contact the injured worker’s case manager or adjustor for guidance and use your best efforts to refer to a laboratory based on the information provided. The OneNet PPO Workers’ Compensation Network includes national, regional and local care providers of laboratory services. Self-referral and anti-kickback provisions of laboratory services protocols apply to OneNet care providers.

Pharmacy Services
The OneNet network does not include a pharmacy network.

Specialty Pharmacy and Home Infusion
UnitedHealthcare’s requirements on Designated Specialty Pharmacy or Home Infusion Providers for Specialty Medications, and Specialty Pharmacy Requirements for Certain Specialty Medications do not apply to, and are not supported by, the OneNet PPO Workers’ Compensation Network, with the exception of provision on Administration of Xolair in a Health Care Setting. Please contact the injured worker’s case manager or adjustor for the name of a specialty pharmacy provider, as the injured worker may be required to use certain care providers to received benefits.

Behavioral Health Services
If you believe an injured worker would benefit from mental health / substance use services due to their job-related injury, and you would like to refer them to a behavioral health care provider, contact the injured worker’s case manager or adjustor for more information. The OneNet PPO Workers’ Compensation Network includes behavioral health care providers.

Utilization Review Components for Workers’ Compensation
Procura clients may use Case Management services for injured workers. You are required to use your best efforts to comply with the Case Management programs utilized by Procura and its clients. Individual states where OneNet PPO Workers’ Compensation care providers participate may also have specific regulations related to Case Management for injured workers.

Claims Process
Whether submitting medical run out claims to OneNet, or workers’ compensation claims to an employer or administrator accessing the OneNet PPO Workers’ Compensation Network through Procura, it is important to submit complete claims and to accurately code all diagnoses and services in accordance with national coding guidelines.

Complete claims include the information listed under the Complete claims requirements section below. We may require additional information for particular types of services, or based on particular circumstances or state requirements.

If you have questions about submitting claims to us, please contact OneNet Customer Care.

Complete Claims Requirements
Your medical run out or workers’ compensation claims may not be processed if you omit any of the following items. While OneNet is no longer accepting medical run out claims through EDI, some EDI-specific requirements are included below in the event you submit workers’ compensation claims to a workers’ compensation carrier electronically.

• Items identified under the Claims and Encounter Data Submissions section of the UnitedHealthcare Guide

• Taxonomy Code (if submitting workers’ compensation claims electronically)

• Description of service (Paper claims)

Additional requirements for the CMS 1450 form:
• Items identified under the Additional Information Needed for a Complete UB-04 (or CMS-1450) Form section the UnitedHealthcare guide.

• When billing late charges, bill type 115 or 117 (inpatient), or 135 or 137 (outpatient), should be indicated in form locator 4 of the CMS-1450/UB-04.

• Bill all outpatient surgeries with the appropriate revenue and CPT codes if reimbursed according to ambulatory surgery groupings.

Submit all claims for professional services or facility services to OneNet on a Form 1500 or CMS-1450 /UB-04 claim form or their electronic equivalents (if submitting workers’ compensation claims electronically) and include all standard code sets that apply.

Participating health care providers must mark all claims “OneNet PPO” (physician and health care practitioners use Box 9D on Form 1500; hospitals and facilities use Box 9D on Form 1500 or Box 50 on CMS-1450/UB-04).

Non-workers’ compensation claims should be mailed to the OneNet claims address listed on the Participant’s health care ID card. All workers’ compensation claims should be sent directly to the applicable employer, workers’ compensation administrator or insurance carrier.
When submitting hospital or facility claims:

- OneNet may request copies of medical records in order to comply with audits required by external accreditation agencies, the state, OneNet Clients, or for cause.
- OneNet Payers and OneNet Clients may conduct independent hospital or facility claims audits and may also request copies of medical records as part of the process of ensuring quality care.
- You must provide medical records when requested by OneNet or OneNet Clients at no cost to OneNet, the OneNet Client, or the Participant. UnitedHealthcare’s Hospital Bill Audit Protocol does not apply to such audits or requests for medical records.

**Additional Complete Claims Requirements for OneNet Medical Run Out Claims**

Obtain the following from the Participant:

- Name, address, date of birth and Social Security Number or Unique Identifier Number
- Primary Participant’s name, address and Social Security Number or Unique Identifier Number
- Group name and group number from the health care ID card
  - Always include the Participant’s group name and number on the claim form. Do not submit a claim that only includes the Participant’s Social Security Number or unique identifier number. OneNet cannot price a claim without the group number.

**Electronic Data Interchange (EDI)**

OneNet no longer accepts professional and institutional medical claims through EDI.

All workers’ compensation claims should be sent directly to the applicable employer, workers’ compensation carrier or administrator.

**Claim Review Procedures**

OneNet claim reviews identify and correct coding errors. Our coding review procedures allow corrections of coding errors and coding irregularities, and provide consistency in our claims processing.

**Other Tips to Expedite Claim Processing:**

- OneNet claims cannot be estimated using the UnitedHealthcareOnline.com Claim Estimator.
- Submit claims on a red Form 1500 or a CMS-1450/UB-04 form, using 11 or 12 point font size and black laser jet ink.
- Do not use a highlighter on the claim form or any attachments.
- Line up forms to print in the appropriate boxes.
- Submit claims on original forms, not photocopies.
- Complete all required fields on standard claim forms.
- Make sure attachments are complete and legible.
- Make sure information such as the care provider’s name, telephone number, NPI, and other information is accurate.
- Remember to sign and date all necessary forms; an electronic signature is acceptable.

**Claim Submission**

**Applicable to OneNet Medical Run Out Claims and Workers’ Compensation Claims**

OneNet does not pay claims and does not have an obligation to pay for services rendered by a OneNet provider. The pricing of OneNet claims includes reviews for completeness and accuracy, and application of claim pricing in accordance with your contracted fee schedule. The priced claim is sent to the appropriate OneNet Client for adjudication and payment determination. You are required to accept the OneNet contracted amount as payment in full for covered services.

Claims must be submitted within the time frame identified in your contract and in accordance with any applicable state laws. Failure to submit claims correctly results in the rejection and return of claims.

A health care provider may not bill Participants for non-professional services including, but not limited to, charges for overhead, administration fees, malpractice surcharges, membership fees, fees for referrals, or fees for completing claim forms or submitting additional information. If OneNet rejects or denies a claim because a health care provider failed to follow policies and procedures, the Participant may not be billed.

OneNet Clients are required to adjudicate and pay clean claims within 30 days of claim pricing, or within applicable state or federal guidelines. If the OneNet Payer fails to adjudicate and pay a claim within this time period, the care provider may, at their discretion, request full billed charges (or the state or federal maximum in the case of a workers’ compensation claim). In these instances, the OneNet Payer pays the claim as it was priced by OneNet. After receiving payment, the care provider must notify the OneNet Payer that payment of full billed charges is requested due to late claim payment. Exceptions to the right to request full billed charges for failing to offer timely payment is as follows:

- When OneNet notifies the care provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied, missing required information or is deficient in some way.
- When a OneNet Client notifies the care provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied, deficient or being held to determine workers’ compensation compensability.

The OneNet Client must send you an EOB advice with itemized explanations of reimbursement amounts for services. The EOB outlines: the billed charges for
services rendered; the OneNet contracted amount; the reimbursement amount; and the amount that was adjusted based on the contract or benefit plan. For medical claims, the EOB will include Participant payment responsibility, such as applicable copayments, deductibles and/or coinsurance. For Workers’ Compensation claims, the EOB includes services found to be non-compensable.

Applicable to OneNet Medical Run Out Claims
For all covered services, the Participant is responsible for payment of copayments, deductibles or coinsurance as described in the Participant’s health benefit plan. A health care provider may bill Participants for applicable copayments, deductibles, coinsurance and non-covered services.

You are required to accept the OneNet contracted amount as payment in full for covered services, with the exception of the participating care provider’s right to collect from the Participant any applicable copayment, deductible, or fee for any services deemed to be non-covered services under the participant’s health benefit plan. You are prohibited from balance billing OneNet Participants for services covered by the OneNet Payer’s health benefit plan and for amounts in excess of their copayments, deductibles, or coinsurances as described in their health benefit plan.

Applicable to OneNet PPO Workers’ Compensation Claims
For workers’ compensation related services, there are no copayments, deductibles, or coinsurance and balance billing is prohibited for all services covered by a workers’ compensation benefit plan.

Submit all workers’ compensation claims to the injured worker’s employer, workers’ compensation carrier or administrator. Do not submit workers’ compensation claims directly to OneNet for pricing.

You receive a notice from the workers’ compensation carrier or administrator in the event that your submitted claims are being held while compensability is being determined.

Claims determined to be non compensable should be submitted to the injured worker’s health benefit plan. You should not assume that because the injured worker is accessing you through the OneNet PPO Workers Compensation Network that UnitedHealthcare is the injured worker’s health insurer. You can get information on the worker’s health insurer by calling their employer or from the worker directly if he or she is not insured through their employer.

Pricing of OneNet Medical Claims
Reimbursement to you by the applicable OneNet Client for covered services rendered to OneNet Customers pursuant to a OneNet PPO, LLC benefit program (other than a OneNet PPO Workers’ Compensation benefit program), shall be the least of: (i) the OneNet PPO, LLC payment rate set forth in your agreement; (ii) your billed charges for such services; or (iii) (a) the applicable state’s workers’ compensation fee schedule, (b) the applicable federal workers’ compensation schedule, or (c) other state, federal or government-authorized methodology or schedule.

Application of this reimbursement comparison is generally at the claim line (service code) level, unless state or federal regulations applicable to the job-related injury specify comparisons must be done at claim-level aggregate values.

Workers’ Compensation Claims Subject to Claim Edits
For workers’ compensation 837P and Form 1500 (formerly HCFA-1500) claims subject to code edits or line bundling and unbundling, the claim pricing resulting from these edits is allocated back to the original submitted claim lines and codes. Priced claims do not display the lines or codes added or deleted by these claim edits. This is intended to assist physicians and OneNet’s workers’ compensation clients in claims reconciliation by having priced claims match originally submitted claims.

Allocation of Global Pricing to the Claim Line Level
Certain claims are subject to global pricing, including, but not limited to, case rates, flat rates and per diems. In these cases, the global contracted rate may be allocated proportionately to the applicable lines of the claim. How the contracted rate is distributed across claim lines depends on the type of global rate and the payment methodology. A fixed percentage of the global contracted rate is applied to each line in most cases.

Example 1: Percentage of Global Pricing Distributed Across Lines – Medical Claims
Health care provider has billed lines totaling $100 that are subject to a global rate of $80. A portion of the global contracted rate is allocated to each line.

<table>
<thead>
<tr>
<th>Line</th>
<th>Billed Charges</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 1</td>
<td>$50.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>Line 2</td>
<td>$30.00</td>
<td>$24.00</td>
</tr>
<tr>
<td>Line 3</td>
<td>$20.00</td>
<td>$16.00</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$100.00</strong></td>
<td><strong>$80.00</strong></td>
</tr>
</tbody>
</table>
Example 2: Percentage of Global Pricing Distributed Across Lines – Workers’ Compensation Claims

Health care provider has billed lines totaling $100 that that are subject to a state fee maximum of $90 and a contracted global rate of $80. A portion of the global rate is allocated to each line as a percentage of the state fee charges.

<table>
<thead>
<tr>
<th>Line</th>
<th>Billed Charges</th>
<th>State Fee</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$50.00</td>
<td>$45.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>2</td>
<td>$30.00</td>
<td>$27.00</td>
<td>$24.00</td>
</tr>
<tr>
<td>3</td>
<td>$20.00</td>
<td>$18.00</td>
<td>$16.00</td>
</tr>
<tr>
<td>Total</td>
<td>$100.00</td>
<td>$90.00</td>
<td>$80.00</td>
</tr>
</tbody>
</table>

Other distributions may also be used to help ensure that line level allowed amounts add up to the correct global level, such as allowing up to the billed amount (or up to the state fee schedule, federal fee schedule or other government-authorized fee as applicable on workers’ compensation claims) on each line until the total global pricing amount is reached. Whenever such allocations occur, OneNet Clients are instructed that individual lines where global pricing has been distributed cannot be processed separately. Remark codes on the claim indicate when individual lines of a claim-level rate cannot be processed separately.

Claim Inquiries

OneNet can only verify the receipt, pricing, and mail date of a claim from participating physicians, health care practitioners, hospitals and facilities. Other claims inquiries, including those about adjudication or payment status, should be made directly to the applicable OneNet Payer or OneNet Client.

The fastest way to check for a claim pricing sheet for a Participant accessing the OneNet PPO Workers’ Compensation Network through Procura is through UnitedHealthcareOnline.com, > Claims & Payments > OneNet PPO Pricing Status. Pricing sheets show the allowed amount of your claims after the application of OneNet claim pricing. Pricing sheets do not show the final claim adjudication by the payer and may include billed charges that are determined to be non-compensable, ineligible or the Participant’s responsibility. Any such charges are detailed on the EOB or Remittance Advice.

If you do not have Internet access, or if you cannot find the claim information for the Procura client you need on UnitedHealthcareOnline, please call 877-461-3750.

If you are looking for information on a OneNet medical claim, or a workers’ compensation claim for a former OneNet Client other than Procura, please call OneNet Customer Care at 800-342-3289. Be prepared to provide the following information:

- Tax Identification Number and National Provider Identifier
- Participant identification number, Social Security Number or Unique Identifier Number
- Date(s) of service for the claim

Please direct your inquiries about claims payment to the applicable OneNet Client. To do so, you may be asked to provide the Social Security Number (or Unique Identifier) and group number of the OneNet Participant.

Claim Appeals (Post Service)

OneNet claims appeals cannot be submitted for reconsideration using the UnitedHealthcareOnline.com Claim Reconsideration tool. Follow the procedure below for appeals on OneNet claims.

Payment Appeal Procedures

OneNet PPO is not a Payer and does not pay claims. Direct appeals regarding payment to the appropriate OneNet Client at the telephone number listed on the Participant’s health care ID card (medical claims only) or to the contact information listed on the OneNet Client’s EOB or remittance advice (medical claims or workers’ compensation claims). You may also call OneNet Customer Care for assistance identifying the appropriate client.

When resubmitting information, include all applicable documentation, including any additional information requested and a copy of the EOB.

Overpayments

All questions or refunds of overpayments should be directed to the applicable OneNet Client at the phone number listed on the OneNet Participant’s health care ID card (medical claims only), or contact information listed on the OneNet Client’s EOB or remittance advice (medical claims or workers’ compensation claims).

If you identify a claim for which you were overpaid by a OneNet Payer, or if OneNet or one of our OneNet Payers informs you in writing or electronically of an overpaid claim that you do not dispute, you must send the OneNet Payer the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request.

Please include appropriate documentation that outlines the overpayment, including Participant’s name, health care ID number, date of service, and amount paid. If possible, please also include a copy of the EOB that corresponds with the payment.

If you disagree with a request for an overpayment refund, you should notify the OneNet Payer in writing as to why you do not believe overpayment occurred and why a refund is not merited.

If the OneNet Payer still believes a refund should be provided, the OneNet Payer forwards the information to OneNet for further review, and OneNet works with you and the OneNet Payer to resolve the issue.
If a OneNet Participant pays you more than the amount indicated on the EOB or Remittance Advice, you are responsible for promptly refunding the difference to the OneNet Participant within 30 days of identifying the overpayment, or within applicable state and federal timeframes.

**Claim Pricing Appeals for Medical Claims and Non-Procura Claims**

Send all appeals regarding claim pricing in writing to:

OneNet Appeals  
P.O. Box 934  
Frederick, MD 21705-0934  
Attention: OneNet CRA

Please include all applicable documentation, including a copy of the original claim and EOB. If appropriate, be sure to submit office/clinical notes and the corrected claim. Always include a clear explanation of the reason for the appeal. Claim pricing appeals must be submitted within 12 months of the date of the EOB, or within applicable state and federal timeframes.

**OneNet pricing appeal services for medical and non-Procura claims ends on March 15, 2017.** After that date, we are no longer able to consider pricing appeals or adjust medical claims or workers’ compensation claims from former clients other than Procura, even if the date of service occurred when the Participant had access to a OneNet network.

**Claim Pricing Appeals for Procura Claims**

Pricing appeals for Procura claims should be directed to Procura at proppo@procura-inc.com, or by calling 877-461-3750. Claim pricing appeals must be submitted within 12 months of the date of the EOB, or within applicable state and federal time frames.

Do not send OneNet medical claims to Procura. Forward any OneNet medical claims to the applicable OneNet Payer listed on the Participant’s health care ID card.

**Claim Pricing Adjustments of $5.00 or Less**

OneNet strives to accurately re-price all claims, and gladly makes adjustments when a claim that has been re-priced inaccurately results in significant underpayment or overpayment for services.

To help ensure administrative costs for our health care providers, OneNet Clients and OneNet do not exceed the amount being appealed, claim pricing that resulted in either an overpayment or underpayment of five dollars ($5.00) or less is not adjusted.

**Resolving Disputes**

If you have a concern or complaint about a OneNet Client, please use your best efforts to resolve the issue directly with the OneNet Client.

If the issue is not resolved to your satisfaction, please follow the resolution processes outlined in *Resolving Disputes - Concern or Complaint* section of the UnitedHealthcare guide.

**Compensation**

Follow UnitedHealthcare’s protocols on compensation for care provided to OneNet Participants with the following exceptions:

- Under processes for charging members for non-covered services, in the cases where you know that services may not be covered, the Participant’s written consent should include a statement that the OneNet Payer has determined that the services are not covered and that the Participant, with knowledge of the Payer’s determination, agrees to be responsible for those charges.

- For health benefit plans, coverage of services is determined by the Participant’s health benefit plan. OneNet Client health plans may cover services that are not covered under UnitedHealthcare health benefit plans, and vice versa. For workers’ compensation, coverage of services is determined by the workers’ compensation carrier or administrator based on claim compensability.

- The online Claim Estimator available on UnitedHealthcareOnline.com cannot be used to estimate OneNet claims. Likewise, OneNet claims cannot be submitted for real time processing through the claim submission feature on UnitedHealthcareOnline.com.

- For Hospital Audit Services, OneNet or OneNet Clients may conduct their own reasonable audits of hospital claims and may follow their own procedures, subject to mutual agreement of the OneNet Client and the audited facility. These procedures may vary from those of UnitedHealthcare’s Hospital Audit Service Department. OneNet Payers must pay the claims first before requesting an audit.

**Medical Records Standards and Requirements**

Standards and requirements described in *Chapter 10: Medical Records Standards and Requirements* extend to OneNet and OneNet Clients.
Quality Management and Health Management Programs

The following exceptions apply to the Health and Disease Management procedures in how they apply to OneNet and OneNet Participants:

• UnitedHealthcare Case Management, Behavioral Health and Disease Management programs do not apply to OneNet.

• OneNet Participant information should not be reported to the UnitedHealthcare Cancer Registry.

• OneNet encourages the use of the Clinical and Preventive Health Guidelines published by UnitedHealthcare when treating OneNet Participants.

• While OneNet encourages the use of resources available at UnitedHealthcareOnline.com related to mental health / substance use, the processes described for behavioral health consults do not apply for OneNet. If you believe a Participant accessing you through the OneNet PPO Workers’ Compensation Network would benefit from mental health / substance use services due to their job-related injury, please contact the workers’ compensation case manager or adjuster for guidance.

Participant Rights and Responsibilities

A copy of current OneNet Participant Rights and Responsibilities, which vary from UnitedHealthcare's Member Rights and Responsibilities, can be obtained by calling OneNet Customer Care. The current version pertains to workers’ compensation Participants only, but a copy of our medical Participant Rights and Responsibilities document may also be available for reference.

Advance Directives

For OneNet Customers, follow the advance directive requirements provided in the UnitedHealthcare guide. OneNet does not produce benefit materials for OneNet Participants and cannot inform OneNet Participants of state laws on advance directives. This is the responsibility of the OneNet Client.

Participant Appeals, Grievances or Complaints

OneNet Participants direct appeals or grievances to their Payer or administrator, and do not use the Appeals and Grievance Form used by UnitedHealthcare members. You are required to support the Payer’s appeals process by providing records as requested and complying with final determinations. In the case of complaints or grievances related to a participating care provider, the Payer or administrator refers the information to UnitedHealthcare and OneNet.
Information Regarding the Oxford Provider Website Transition

Our goal is to streamline and simplify the care provider administrative experience by consolidating all UnitedHealthcare transaction capabilities. During 2017, the platform that supports the Oxford products changes. This change impacts many online applications including: Claim Reconsideration (with or without attachments), Benefits & Eligibility, and Claims Management. As we continue to build functionality, the way you access what you need online will change. As these changes occur, we will communicate them through the UnitedHealthcare Network Bulletin and through online and/or written updates. Watch for the most current information by email, the Network Bulletin, on OxfordHealth.com or on UnitedHealthcareOnline.com. For more information on how to register for online access, please go to OxfordHealth.com or UnitedHealthcareOnline.com.

Applicability of this Supplement

This supplement applies to all covered services that you provide to members insured by or receiving administrative services from UnitedHealthcare Oxford. Oxford offers commercial products under the names of Freedom, Liberty, Metro, and Garden State, as follows:

- Freedom products are offered in Connecticut, New Jersey and New York
- Liberty products are offered in New Jersey and New York
- Metro Products are only offered in the New York state counties of: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester. The service area is limited to those New York State counties listed (except for emergency services).
- Garden State Products are only offered in New Jersey. The service area is limited to New Jersey (except for emergency services).

Care providers are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the preceding guide.

Benefit Plans not Subject to the Requirements in this Protocol

- UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic, and UnitedHealthcare Medicare Advantage brands on the Oxford Health Plan platform.
- UnitedHealthcare Oxford Navigate individual benefit plans underwritten by Oxford Health Insurance, Inc.

Oxford Commercial Product Overview

Oxford offers commercial gated or non-gated products as described below.

Gated benefit plans – These are products in which all covered services* performed by network physicians and/or other network health care professionals, other than those covered services performed by the member’s PCP or OB/GYN, require: (a) a referral from the PCP to a network care provider; or (b) prior authorization from the benefit plan, obtained by the PCP, approving an in-network exception,* ** for the member to receive covered services from an out-of-network care provider at the member’s network level of benefits. Members of gated benefit plans have “In-Network Referral Required” printed on the back of their health care ID card.

- For gated benefit plans with network only benefits, covered services obtained without the required referral or network exception are denied.
- For gated benefit plans with out-of-network benefits, covered services obtained without the required referral or in-network exception are covered, but subject to the member’s out-of-network benefits and cost sharing requirements.

Non-gated benefit plans - These are benefit plans in which all covered services performed by network physicians and/or other network health care professionals do not require a referral from the member’s PCP to a network care provider. Non-gated benefit plans do require prior authorization from the benefit plan, obtained by the member’s PCP, approving an network exception, for the member to receive covered services from an out-of-network care provider at the member’s network level of benefits. Members of non-gated benefit plans have “No Referral Required” printed on the back of their health care ID card.

- For non-gated benefit plans with network only benefits, covered services obtained from an out-of-network care provider without an approved network exception are denied.
- For non-gated benefit plans with out-of-network benefits, covered services obtained from an out-of-network care provider without an approved network exception are covered, but subject to the member’s out-of-network benefits and cost sharing requirements.

*Emergency services and urgent care services never require a PCP referral or prior authorization.
**Please see Referrals and Prior Authorization section for additional information regarding the in-network exception process for circumstances where the plan does not have a network Provider available to provide covered services to a Member.
How to Contact Oxford Commercial

OxfordHealth.com

OxfordHealth.com > Provider > Tools and Resources offers instructions, quick reference guides, access to forms and medical policies, and many other resources, without a requirement to be registered.

For step-by-step instructions to using our website transactions, go to OxfordHealth.com > Providers (or Facilities) > Tools & Resources > Administrative Tools & Information. UnitedHealthcareOnline.com is a care provider gateway to many other tools, training, and resources.

Voice Portal: 800-666-1353

In most cases, to use the Voice Portal, you are required to enter your physician’s or facility’s Oxford Provider ID number. A Voice Portal Quick Reference guide is located at OxfordHealth.com > Providers or Facilities > Tools & Resources > Administrative Tools & Information > Voice Portal Quick Reference.

Other Contact Information and Resources

<table>
<thead>
<tr>
<th>Commercial Products</th>
<th>WHERE TO GO</th>
</tr>
</thead>
</table>
| **Appeals, Administrative (Claims)** | Mail: UnitedHealthcare Grievance Review Board  
P.O. Box 29134  
Hot Springs, AR 71903 |
| **Appeals, Clinical & Medical Necessity** | Fax: 877-220-7537  
Mail: Oxford Clinical Appeals Department  
P.O. Box 29139  
Hot Springs, AR 71903 |
| **Appeals (Members) Second Level Member Appeals** | OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Forms  
• Claim(s) Review Request Form  
• Member Authorization for a Designated Representative  
Mail: UnitedHealthcare Grievance Review Board  
P.O. Box 29134  
Hot Springs, AR 71903 |
| **Internal appeals- Claims payment disputes** | Forms: OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Forms  
• Claim(s) Review Request (1-19 claims)  
• Claims Research Project (20 or more claims)  
• New Jersey Provider Claim Appeal Form |
| **Appeals: Pharmacy (urgent)** | Fax: 801-994-1058 |
| **Behavioral Health Department** | Phone: 800-201-6991 |
| **Cardiology** Utilization Review/Medical Necessity Review Cardiac Catheterization Prior Authorization Echocardiogram and Stress Echocardiogram | Phone: 877-PREAUTH / 877-773-2884 (Mon - Fri, 7 a.m. to 7 p.m. ET)  
Online: evicore.com 24 hours a day seven days a week  
Medical policy: OxfordHealth.com > Provider > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index. |
| **Chemotherapy Prior Authorization Injectable Outpatient Chemotherapy** | Phone: 877-773-2884 (Mon - Fri, 7 a.m. to 7 p.m., ET)  
Online: UnitedHealthcareOnline.com > Clinician Resources > Oncology |
| **Centers for Disease Control (CDC) National AIDS hotline** | Phone: 800-232-4636 |
| **Chiropractic Services — OptumHealth** | Provider Services/Claims  
Phone: 800-985-3293  
Online: myoptumhealthphysicalhealth.com |
## Commercial Products

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WHERE TO GO</th>
</tr>
</thead>
</table>
| **Claim Submission**            | **EDI:** Commercial Claims Payer ID: 06111  
Online (EDI): [OxfordHealth.com](#) > Providers or Facilities > **Transactions** > Electronic Payments & Statements  
Learn more on [OxfordHealth.com](#) > Providers or Facilities > Tools & Resources > Administrative Tools & Information > **Electronic Data Interchange (EDI)**  
You can also visit [PNTdata.com](#) > Customers > Providers, to learn about a free submission tool that doesn’t require practice management software.  
**Mail (paper claims):**  
UnitedHealthcare  
Attrn: Claims Department  
P.O. Box 29130  
Hot Springs, AR 71903 |
| **Claim Corrections & Reconsiderations** | **EDI:** Submit facility claim corrections electronically.  
**Online:** Use the claim application on Link  
[UnitedHealthcareOnline.com](#) > Quick Links > **Link:** Learn More  
**Paper:**  
[OxfordHealth.com](#) > Providers or Facilities > Tools & Resources > Network Information > **Forms**  
- Claim Review Request (1-19 claims)  
- Claim Research Project (20 or more claims)  
- New Jersey Provider Claim Appeal Form |
| **Claim Status**                | **Online:** [OxfordHealth.com](#) > Providers or Facilities > **Transactions** > Check > Claims.  
**EDI:** Use your vendor or clearinghouse.  
**Phone:** 800-666-1353 and say “Claims” when prompted. You can speak with a representative (Mon – Fri., 8 a.m. to 6 p.m. ET) |
| **Clinical, Administrative and Reimbursement Policies** | **Online:**  
[OxfordHealth.com](#) > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** |
| **Clinical Services Department** | **Phone:** 800-666-1353 (Mon – Fri., 8 a.m. – 6 p.m. ET) |
| **Credentialing and Recredentialing** (Member of the Council for Affordable Quality Healthcare (CAQH)) | **Phone:** United Voice Portal at 877-842-3210  
**Online:** [UnitedHealthcareOnline.com](#) > Tools & Resources > **Policies, Protocols and Guides** > Credentialing & Recredentialing Plan.  
**New Jersey only**  
**Online:** [State of New Jersey Department of Health](#) or [CAQH (Council for Affordable Quality Healthcare)](#)  
**Phone:** Provider Services at 800-666-1353 or CAQH Support at 888-599-1771 |
| **Crisis Intervention Hotline – Connecticut** | **Phone:** 800-203-1234 |
| **Crisis Intervention Hotline – New Jersey** | **Phone:** (within New Jersey) 800-624-2377 |
| **Crisis Intervention Hotline – New York** | **State of New York and New York City information:** 800-541-2437  
**Spanish/bilingual information:** 800-233-7432  
**TTY/TDD (for the hearing-impaired):** 800-369-2437  
**Department of Health Testing Hotline:** 800-825-5448 |
| **Electronic Payments & Statements (EPS)** | **Information and Enrollment:**  
**Online:**  
- [OxfordHealth.com](#) > Provider or Facilities > Tools & Resources > Administrative Tools & Information > **Electronic Payments & Statements (EPS)**, or  
- [WelcometoEPS.com](#), or  
- [Optumhealthfinancial.com](#) > Health Care Professional > Log in  
**Helpdesk:** 877-620-6194 |
### Commercial Products

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WHERE TO GO</th>
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</thead>
<tbody>
<tr>
<td>EDI (Electronic Data Interchange) Check status of referrals, precertifications, and claims</td>
<td>Payer ID: 06111 EDI Support: &lt;br&gt;Phone: 800-599-4334, Mon - Fri, 8:30 a.m. – 5 p.m. ET or &lt;br&gt;Online Information: UnitedHealthcareOnline.com &gt; Contact Us &gt; Electronic Data Interchange (EDI) Claims &gt; EDI Transaction Support Form. OxfordHealth.com &gt; Providers or Facilities &gt; Tools &amp; Resources &gt; Administrative Tools &amp; Information &gt; Electronic Data Interchange UnitedHealthcareOnline.com &gt; Tools &amp; Resources &gt; EDI Education for Electronic Transactions.</td>
</tr>
<tr>
<td>Eligibility and Benefits</td>
<td>Online: OxfordHealth.com &gt; Providers or Facilities &gt; Transactions &gt; Check &gt; Eligibility and Benefits. EDI: Use your vendor or clearinghouse. Voice Portal and Provider Services: 800-666-1353 (Say “Benefits and Eligibility” when prompted.) You can speak with a representative (Mon - Fri., 8 a.m. to 6 p.m. ET.)</td>
</tr>
<tr>
<td>Forms</td>
<td>Online: OxfordHealth.com &gt; Provider (or Facilities) &gt; Tools &amp; Resources &gt; Network Information &gt; Forms</td>
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<tr>
<td>Fraud Hotline</td>
<td>Phone: 866-242-7727</td>
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<tr>
<td>HIPAA compliance and security</td>
<td>Online: UnitedHealthcareOnline.com &gt; Tools &amp; Resources &gt; Health Information and Technology &gt; HIPAA For additional information on granting remote access to your EMR system: <a href="mailto:emrcdsa@uhc.com">emrcdsa@uhc.com</a>.</td>
</tr>
<tr>
<td>Infertility Services – Optum</td>
<td>Phone: 877-512-9340 Fax: 855-536-0491</td>
</tr>
<tr>
<td>Inpatient admission</td>
<td>Online: OxfordHealth.com &gt; Providers or Facilities &gt; Transactions &gt; Submit &gt; Precert Requests EDI: use your clearinghouse Phone: 800-666-1353 Fax: 800-303-9902</td>
</tr>
<tr>
<td>Inpatient and Outpatient- Clinical Services</td>
<td>Phone: 800-666-1353</td>
</tr>
<tr>
<td>Oxford On-Call® (Urgent and non- urgent care)</td>
<td>Phone: 800-201-4911 • Available 24 hours a day, 365 days a year • Staffed by registered nurses • Assistance for urgent and non-urgent medical problems recommend an appropriate site of care</td>
</tr>
<tr>
<td>Pharmacy customer service</td>
<td>Phone: 800-788-4863 TTY/TDD: 800-498-5428 Available 24 hours per day, seven days per week including holidays</td>
</tr>
<tr>
<td>Pharmacy Prior Authorization</td>
<td>Phone: 800-711-4555 Available 24 hours per day, seven days per week including holidays</td>
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### Commercial Products

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WHERE TO GO</th>
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<tbody>
<tr>
<td><strong>Physical and occupational therapy</strong>&lt;br&gt;Claims Submission and Inquiry</td>
<td>Provider services: 877-369-7564&lt;br&gt;<strong>Online:</strong> <a href="http://myoptumhealthphysicalhealth.com">myoptumhealthphysicalhealth.com</a>&lt;br&gt;For claims submitted electronically: Payer ID 06111&lt;br&gt;<strong>Phone:</strong> 800-666-1353&lt;br&gt;<strong>Mail (paper claims):</strong> UnitedHealthcare Attn: Claims Department P.O. Box 29130 Hot Springs, AR 71903</td>
</tr>
<tr>
<td><strong>Prescription Mail Order</strong></td>
<td>OptumRx P.O. Box 2975 Mission, KS 66201</td>
</tr>
<tr>
<td><strong>Prior Authorization Submission</strong></td>
<td><strong>Phone:</strong> Provider Services 800-666-1353 (Mon - Fri., 8 a.m.- 6 p.m. ET)&lt;br&gt;<strong>Online:</strong> <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers or Facilities &gt; <strong>Transactions</strong> &gt; Submit &gt; Precert Requests&lt;br&gt;<strong>Fax:</strong> Submit our form to:&lt;br&gt;Hospitals: 800-699-4712&lt;br&gt;Providers: 800-309-9902&lt;br&gt;The form can be found on <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers or Facilities &gt; Tools &amp; Resources &gt; Network Information &gt; <strong>Forms</strong>&lt;br&gt;<strong>EDI:</strong> Use your vendor or clearinghouse</td>
</tr>
<tr>
<td><strong>Prior Authorization Verification</strong></td>
<td><strong>Phone:</strong> Voice Portal: 800-666-1353 (Representatives are available Mon - Fri., 8 a.m.- 6 p.m. ET) Say “Precertification” when prompted.&lt;br&gt;<strong>Online:</strong> <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers or Facilities &gt; <strong>Transactions</strong> &gt; Check &gt; Precert Status.&lt;br&gt;<strong>EDI:</strong> Use your vendor or clearinghouse</td>
</tr>
<tr>
<td><strong>Radiology and Radiation Therapy</strong>&lt;br&gt;Prior Authorization Utilization Review, Medical Necessity Review</td>
<td><strong>Phone:</strong> 877-PREAUTH/( 877-773-2884) (Mon - Fri., 7 a.m. to 7 p.m. ET)&lt;br&gt;<strong>Online:</strong> <a href="http://evicore.com">evicore.com</a> 24 hours a day seven days a week&lt;br&gt;Medical policy: <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers or Facilities &gt; <strong>Tools &amp; Resources</strong> &gt; Medical Information &gt; Radiology &amp; Radiation Therapy Information.</td>
</tr>
<tr>
<td><strong>Referral Submission or Verification</strong></td>
<td><strong>Online:</strong> <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers &gt; <strong>Transactions</strong> &gt; Submit &gt; Referrals or Transactions &gt; Check &gt; Referrals&lt;br&gt;<strong>Phone:</strong> Voice Portal: 800-666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET) Say “referral” when prompted.&lt;br&gt;<strong>EDI:</strong> Use your clearinghouse or vendor</td>
</tr>
<tr>
<td><strong>Search for Participating Physicians, Other Health Care Professionals and Facilities</strong></td>
<td><strong>Phone:</strong> 800-666-1353&lt;br&gt;<strong>Online:</strong> <a href="http://OxfordHealth.com">OxfordHealth.com</a> &gt; Providers or Facilities &gt; <strong>Search</strong> &gt; (select the provider type)</td>
</tr>
<tr>
<td><strong>Termination Requests</strong></td>
<td><strong>Phone:</strong> 800-666-1353&lt;br&gt;<strong>Mail:</strong> Physicians and other Healthcare professionals send Certified mail, return receipt requested to:&lt;br&gt;UnitedHealthcare Network Contract Support Mail Route: TX023-1000 1311 W President George Bush Highway, Suite 100 Richardson, TX 75080-9870&lt;br&gt;<strong>Behavioral health providers only</strong>&lt;br&gt;<strong>Phone:</strong> 877-614-0484</td>
</tr>
</tbody>
</table>
Provider Responsibilities and Standards

Confirming Eligibility and Benefits
Checking the member’s eligibility and benefits prior to rendering services helps ensure that you submit the claim to the correct payer, allow you to collect copayments, determine if a referral is required and reduce denials for non-coverage. To check eligibility and benefits, use any of the following methods:

• Online: [OxfordHealth.com](#) > Providers or Facilities > Transactions > Check > Eligibility and Benefits.
• Phone: 800-666-1353, and say “benefits and eligibility” when prompted. (Mon. - Fri., 8 a.m. - 6 p.m. ET).
• EDI: Use your vendor or clearinghouse.

For additional assistance with Web, Oxford Voice Portal and EDI solutions, please refer to [OxfordHealth.com](#) > Providers or Facilities > Tools & Resources > Administrative Tools & Information. There are quick reference guides and instructions to assist you.

Member Health Care Identification (ID) Cards
Each member is given a health care ID card that is for identification only and does not establish eligibility for coverage. The member should present their card when requesting any type of covered health care service. We suggest that each time you check a member’s health care ID card you also request photo identification to minimize any risk of an unauthorized use of the member’s card. Possession of a health care ID card is not proof of eligibility. It is important you verify eligibility and benefits before or at the point of service for each office visit.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the [Commercial Health Care ID Card Legend](#) in Chapter 2: Provider Responsibilities and Standards.

Compliance with Quality Assurance and Utilization Review
Physicians and other health care professionals agree to fully comply with and abide by the rules, policies and procedures that we have, or will establish with written notice of any changes provided 30 days in advance, including, but not limited to, the following:

• Quality assurance, including, but not limited to, on-site case management of patients, intensivist programs and notification compliance measures
• Utilization management, including, but not limited to, prior authorization procedures, referral processes or protocols and reporting of clinical accounting data
• Member, physician, and other health care professional grievances
• Timely provision of medical records upon request by us or our contracted business associates
• Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans
• Physician and other health care professional credentialing
• Any similar programs developed by us.

Advising Members of their Rights
Our members have the right to obtain complete, current information concerning diagnosis, treatment and prognosis in terms the member can understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member’s behalf.

Our members also have the right to receive information as necessary to give informed consent prior to the start of any procedure or treatment.

Office and Access Standards
Your office must adhere to policies regarding the following:

• Confidentiality of member medical records and related patient information
• Patient-centered education
• Informed consent; including, advising a member prior to initiating services when a particular service is not covered and disclosing to them the amount they are required to pay for the service.
• Maintenance of advance directives
• Handling of medical emergencies
• Compliance with all federal, state and local requirements
• Minimum standards for appointment and after-hours accessibility
• Safety of the office environment
• Use of physician extenders, such as physician assistants (PA), nurse practitioners (NP) and other allied health professionals, together with the relevant collaborative agreements.

As a participating care provider, you agree to certain access standards, and to arrange coverage for medical services, 24 hours a day, seven days a week, including:

1. Telephone coverage after hours: You must have either a constantly operating answering service or a telephone recording that directs members to call a special telephone number to reach a covering medical professional. Your message must tell the caller to go to the emergency room or call 911 in the event of an emergency. The message should be in English and any other relevant languages if your panel consists of patients with special language needs.
2. **Covering physicians and other health care professionals:** You must provide coverage of your practice 24 hours a day, seven days a week. Your covering physician or health care professional must be a participating physician or health care professional unless there isn’t one in your area. UnitedHealthcare must certify any non-participating health care professionals you use to provide coverage for your practice.

**Americans with Disabilities Act (ADA) Guidelines**
Participating physicians and other health care professionals must have practice policies that demonstrate they accept for treatment any member in need of the health care they provide. The organization and its physicians and other health care professionals must make public declarations (i.e., through posters or mission statements) of their commitment to nondiscriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and nonclinical, in their dealings with each member.

In this regard, new construction and renovations, as well as barrier reductions required to achieve program accessibility, must be undertaken in accordance with the established accessibility standards of the ADA guidelines. For complete details go to [ADA.gov](http://www.ADA.gov) > Featured Topics > (scroll to) A Guide to Disability Rights Laws.

**We May Request From a Physician’s Office**
Any of the following ADA-related information may be requested from you:
- A description of accessibility to your office or facility
- A description of the methods that you or your staff uses to communicate with members who have visual or hearing impairments
- A description of the training your staff receives to learn and implement these guidelines

**Suggested Accessibility Standards**
Resources and technical assistance are available:
- **New York State:** through the New York State Office of Advocate for Persons with Disabilities - 800-624-4143 V/TTY, and the Mayor’s Office for People with Disabilities - 212-788-2830;
- **Connecticut:** through the Connecticut Office of Protection and Advocacy - 800-842-7303 (toll-free), 860-297-4300, 860-297-4380 (TTY);
- **New Jersey:** through the New Jersey Office on Disabilities - 888-285-3036 (toll-free), 609-292-7800 (TTY).

**Care for Members Who Are Hearing-Impaired**
It is important for everyone to be able to communicate with their physicians and other health care professionals. Refusing to provide either care or the assistance of an interpreter while caring for a person with a qualifying disability is a violation of the ADA. Members who are hearing-impaired have the right to use sign-language interpreters to assist them at their doctor visits.

We will bear the reasonable cost of providing an interpreter. The member must not be billed for interpreter fees (28 CFR * Sect. 36.301(c)*). Interpreters are reimbursed by the physician/facility for their services. The physician/facility should bill us for these services by submitting a claim form with Current Procedural Terminology (CPT) code 99199 with a description of the interpreter service.

**Participating Hospitals, Ancillary Providers and Physicians Agree to:**
- Verify a patient’s status. No payments are made for services rendered to persons who are not our members.
- Obtain prior authorization/authorization from us or a delegated vendor for all hospital services that require prior authorization to be obtained prior to rendering services. Generally, all hospital services require our prior authorization.
- Notify us of all emergency/urgent admissions of members upon admission or on the day of admission. If the facility is unable to determine on the day of admission that the patient is our member, the facility must notify us as soon as possible after discovering that the patient has coverage with us.
- Notify of an ambulatory surgery that occurs as a result of an emergency room or urgent care visit within 24-48 hours.
- Admit and treat members on the same basis as all other facility patients (i.e., according to the severity of the medical need and the availability of covered services).
- Render services to members in a timely manner. The services provided must be consistent with the treatment protocols and practices utilized for any other facility patient.
- Work with the responsible PCP to help ensure continuity of care for our members.
- Maintain appropriate standards for your facility.
- Cooperate with our utilization review program and audit activities.
- Receive compensation only from us and adhere to our balance billing policies.
- Complete appeals process in a timely manner, prior to proceeding to arbitration.

*28 CFR Sect. 36...303(c)*
**28 CFR Sect. 36...303(b)(1)**
Standards of Practice
All services performed for members must be consistent with the proper practice of medicine and be performed in accordance with the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which physicians and other health care professionals seek advice and guidance or to which they are subject to licensing and control.

PCP Selection
All HMO products require members to select a PCP to provide primary care services and coordinate their overall care. In addition, female members may also select an obstetrician/gynecologist (OB/GYN) which they may see without a referral from their PCP. Members can only select a PCP within their network (e.g., a Liberty Plan member must select a Liberty Network participating PCP).

Role of the PCP
As a PCP, it is your responsibility to deliver medically necessary primary care services. You are the coordinator of your patients' total health care needs. Your role is to provide all routine and preventive medical services and coordinate all other covered services, specialist care, and care at our participating facilities or at any other participating medical facility where your patients might seek care (e.g., emergency care). You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. You may not discriminate on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, place of residence, health status, or source of payment. Some PCPs are also qualified to perform services ordinarily handled by a specialist. Such a PCP must also be listed as a participating specialist in the particular specialty in order for us to pay claims submitted for specialist services.

HIV Confidentiality
In accordance with New York regulations, all physicians should develop and implement policies and procedures to maintain the confidentiality of HIV-related information. The following procedures should be in place to comply with regulations specific to the confidentiality, maintenance and appropriate disclosure of HIV patient information.

Office staff shall:
- Receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure
- Maintain a list containing job titles and specified functions for which employees are authorized to access such information
- Maintain and secure records, including records which are stored electronically, and make sure records are used for the purpose intended
- Maintain procedures for handling requests by other parties for confidential HIV-related information
- Maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection
- Perform an annual review of the following policies and procedures:
  › HIV testing must be performed on all newborns.
  › Prenatal care physicians should counsel expectant mothers regarding the required testing of newborns and the importance of the mother getting tested.
  › Expectant mothers should also be advised of the counseling and services offered when results are positive.

Only employees, contractors and medical nursing or health-related students who have received such education on HIV confidentiality shall have access to confidential HIV-related information while performing the authorized functions.

Specialists
As a participating specialist, you agree to the following, when applicable:
- Provide referrals for specialty services
- Provide results of medical evaluations, tests and treatments to the member’s PCP
- Pre-certify inpatient admission
- Receive compensation only from us and adhere to our balance billing policies
- Provide access to your records relating to services rendered to our members. If you believe consent is required from the specific member, you must obtain their consent.
- Follow our authorization guidelines for those services requiring prior authorization

You are only reimbursed for services if:
- We have a referral on file or the member has a non-gatekeeper benefit plan and the service is covered and medically necessary.
- A referral is not on file and the member has an out-of-network benefit (i.e., a POS benefit plan), and if the service is covered and medically necessary, you are entitled to the contracted rate, but the member is required to pay any deductible and/or coinsurance based on their out-of-network benefits.
- If the member is enrolled in a benefit plan without an out-of-network benefit (i.e., an HMO benefit plan), we are not responsible for payment (except in cases of emergency), nor can the member be balance billed.
Specialists as PCPs
A member who has a life-threatening condition or a degenerative and disabling condition (i.e., complex medical condition) or disease, either of which requires specialized medical care over a prolonged period of time, is eligible to elect a network specialist as their PCP. A standing referral is granted and the specialist PCP becomes responsible for providing and coordinating all of the member’s primary care and specialty care. The PCP, specialist, and health benefit plan must all be in agreement with the established treatment plan.

A standing referral (See Standing Referrals and Specialty Care Centers) may be authorized when the physician or other health care professional is requesting more than 30 visits within a six month period or covered services beyond a six month period but within 12 months. Under a standing referral, a member may seek treatment with a designated specialist or facility without a separate PCP referral for each service.

If such an election appears to be appropriate, our Clinical Services department faxes the specialist a form to complete and return.

Only after the form is completed and accepted by us are such services covered without a referral. Otherwise, a referral is required for members with a gatekeeper benefit plan.

Transitional Care
Continuity and coordination of care helps ensure ongoing communication, monitoring and overview by the PCP across each member’s entire health care continuum. Documentation of services provided by specialists such as podiatrists, ophthalmologists and mental health practitioners, as well as ancillary care physicians including home care and rehabilitation facilities, help the PCP maintain a medical record that supports whole person care.

Elements of the chart indicating continuity and coordination of care among practitioners are required by NCQA and state departments of health in the tri-state area (New York, New Jersey and Connecticut). We monitor the continuity and coordination of care that members receive through the following mechanisms:

- Medical record reviews
- Adverse outcomes that may develop as the result of disruptions in continuity or coordination of care
- Physician and other health care professional termination

Newly Enrolled Members Who Need Transitional Care or Continuity of Care
When a new member enrolls with us, they may qualify for coverage of transitional care services rendered by their non-participating physicians or other health care professionals. If the member has a life-threatening disease or condition, or a degenerative and disabling disease or condition, the transitional care period is 60 days.

If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. Treatment by the non-participating physician or other health care professional must be determined to be medically necessary by our Medical Director. Transitional care is available only if the physician or other health care professional agrees to:

- Accept as payment our negotiated fees for such services applicable prior to transitional care
- Adhere to all of our Quality Management procedures and provide medical information related to the enrollee’s care
- Adhere to our policies and procedures regarding the delivery of covered services, including referrals and pre-authorization policies, and a treatment plan approved by us

For more information about transitional care, members may call UnitedHealthcare at 800-444-6222.

Reassignment of Members Who are in an Ongoing Course of Care or Who are Being Treated for Pregnancy
We adhere to the following guidelines when notifying members affected by the termination of a physician or other health care professional:

- All members who are patients of any terminated PCP’s panel - internal medicine, family practice, pediatrics, OB/GYN - are notified of our policy and what steps to follow, should the member require transitional care. The same notification procedures hold true for patients being seen regularly by a specialist who is terminated.

- Members of a terminated PCP’s panel are instructed to call the Member Service department if they choose to select a new PCP, or to request transitional care from their current practitioner. They are also encouraged to request our Roster of Participating Physicians and Other Health Care Professionals to make their new selection.

- Members of a terminated specialist are instructed to call the Member Service department if they need to request transitional care from their current specialist. They are also directed to call their current PCP for an alternate specialist referral.

Transitional Care When a Care Provider Leaves Our Network
We use following rules when notifying members affected by the termination of a doctor or other health care professional:

- UnitedHealthcare members in New York qualify for transitional services on a network basis for up to 120 days from the date a care provider ceases to be in the UnitedHealthcare Network.

- All members who are patients of any terminated PCP such as internal medicine, family practice, pediatrics and OB/GYN are told about our policy and what steps
to follow should they need transitional care. The same notice holds true for patients being seen regularly by a specialist who is terminated.

- Patients of such PCPs are instructed to call the Member Service department whether they choose to select a new PCP, or to ask for transitional care from their current practitioner. They are also encouraged to visit OxfordHealth.com to make their new selection.

- Patients of a terminated specialist are also told to call the Member Service department if they need to request transitional care from their current specialist. Additionally, they are told to call their current PCP to ask for a referral to a different network specialist.

**Referrals**

### Submitting and Verifying Referrals

A PCP or OB/GYN can issue a referral to participating physicians, specialists and other health care professionals:

- **Online:** [OxfordHealth.com](https://www.oxfordhealth.com) > Providers (or Facilities) > Transactions > Submit or Check Referrals (non-par providers should call the number below).

- **Phone:** 800-666-1353 (representatives are available Mon - Fri., 8 a.m.- 6 p.m. ET). Participating health care providers may use the prompts to submit or check the status of a referral 24 hours a day, seven days a week.

- **EDI** transaction 278 through your vendor or clearinghouse.

Once the referral is entered, the referring physician or other health care professional may receive a reference number by fax. Provide the reference number of the referral to the member. The member can bring this reference number to the can directly confirm a referral is on file through [oxfordhealth.com](https://www.oxfordhealth.com) or by phone (above). For a complete list of submission and verification methods, please refer to the How to Contact Oxford Commercial list in the beginning of this supplement.

Additional details regarding our referral policy can be found at [oxfordhealth.com](https://www.oxfordhealth.com) > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Referrals

### Referral Policies and Guidelines

Our physician contracts require referrals be issued to participating physicians, hospitals, ancillaries and other health care professionals within the applicable network of care providers available to our members enrolled in gated health benefit plans. The only exceptions to this are:

1. Cases of emergency or

2. When there are no participating physicians or other health care professionals who can treat the member’s condition.

If you would like to direct a member to non-participating physicians and other health care professionals, you must request a network exception from our Clinical Services department and receive approval before the service is rendered. If the member requests to see a specialist and is unable to reach their PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after services have been received.

Precertification guidelines still apply to those covered services that require precertification.

All referrals must be reviewed and approved by us. A referral does not guarantee that we will cover the services provided by the participating specialist. Covered services are subject to:

- Medical necessity, as determined by Oxford’s medical policies

- Member eligibility on the date(s) of service

- Member’s benefits as defined in the conditions, terms and limitations of their Summary of Benefits/Certificates/Contract

Participating specialists can only issue referrals within the applicable network of care providers available to the members enrolled in gated health benefit plans for certain types of covered services as outlined in the Referral Policy referenced above. You may not refer a member to a non-participating specialist. For more information refer to the section on [Using Non-Participating Health Care Providers or Facilities](https://www.oxfordhealth.com).

### Automated Fax Notification

Upon submission of a referral, we send a fax to the referred-to-physician or other health care professional, usually within 24 hours of the submission. This fax serves as a confirmation notice of the referral.

Physicians and other health care professionals have the option to update their referral fax number or decline the auto-fax notification feature on our website in the My Account section.

### Member Self-Referrals

We have created a number of programs designed to improve outcomes for members and to allow us to better manage the use of medical services. Practitioners may refer members to these programs, or members may self-refer, to network specialists for the following services:

1. OB-GYN care, to include prenatal care, two routine visits per year and any follow-up care, or for care related to an acute gynecological condition

2. One mental health visit and one substance use visit with a participating care provider per year for evaluation
3. Vision services from a participating care provider
4. Diagnosis and treatment of Tuberculosis by public health agency facilities
5. Family planning and reproductive health from participating or Medicaid care providers

Outpatient Radiology Self-Referral Procedures
The outpatient imaging self-referral policy is designed to promote appropriate use of diagnostic imaging by network PCPs, specialty physicians and other health care professionals in the office and outpatient setting.

The outpatient imaging self-referral policy does not apply to radiology services performed during an inpatient stay, ambulatory surgery, urgent care, emergency room visit, or pre-operative/pre-admission testing. See the How to Contact Oxford Commercial section for contact information.

The outpatient imaging self-referral list is applicable to commercial benefit plans (excluding Oxford USA Plans). More detailed information can be found on Oxfordhealth.com > Providers (or Facilities) > Tools and Resources > Medical Information > Radiology & Radiation Therapy Information > Oxford’s Outpatient Imaging Self-Referral Policy.

Standing Referrals and Specialty Care Centers
Standing referrals to a participating specialist, ancillary provider, or specialty care center may be requested if a member requires ongoing specialist treatment, has a life-threatening condition or disease, or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period of time. Further, the participating specialist or ancillary provider must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the medically necessary care required for the treatment of the condition or disease. The services to be provided are covered only to the extent they are otherwise covered by the Member’s Certificate of Coverage.

Utilization Management

Prior Authorization (Precertification)
The term “prior authorization” referenced in this supplement is also referred to as “precertification”. You will notice both terms used throughout this supplement.

Prior Authorization (Precertification) requests may be submitted by the following methods:
1. **Phone**: Provider Services 800-666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET)
2. **Online**: OxfordHealth.com > Providers or Facilities > Transactions > Submit > Precert Requests > (log in)
3. **Fax**: Submit our form, which can be found on OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Forms. (Hospital fax 800-699-4712, all other participating providers 800-303-9902).
4. **EDI**: Use your vendor or clearinghouse

We recommend that physicians, facilities, ancillaries and other health care professionals perform a prior authorization status check first to determine if there is already a prior authorization on file.

Prior authorization should be submitted as far in advance of the planned service as possible to allow for review. Prior authorization is required at least 14 business days prior to the planned service date (unless otherwise specified within the Prior Authorization List located at OxfordHealth.com > Providers (or Facilities) > Tools & Resources > Medical Information > Medical and Administrative Policies > Services Requiring Prior Authorizaton).

- Obstetrical admissions for normal delivery should be authorized as early as possible in the course of prenatal care, based on the expected date of delivery.
- Participating physicians and other health care professionals and facilities are responsible for contacting us for:
  - All procedures requiring prior authorization. However, an active referral* must also be on file for services to be covered as network benefits, depending on the member’s health benefit plan.
  - Any change of treating physician or other health care professional, location, CPT codes or dates of service for the authorized service.
  - All member emergency admissions upon admission or on the day of admission. If the physician/facility is unable to determine on the day of admission that the patient is our member, the physician/facility must notify us as soon as possible after discovering that the patient has coverage with us.
- Participating physicians and other health care professionals are notified of all determinations involving New York members by phone and in writing. All participating physicians and other health care professionals are responsible for calling the member the same day that the care provider receives notification of our determination.
- Neither prior authorization nor referral is required for members to access a participating women’s health specialist for routine and preventive health care services. Women’s health specialists include, but are not limited to gynecologists and/or certified nurse midwives. Routine and preventive health care services include breast exams, mammograms, and Pap tests.
- Members are responsible for notifying us of emergency facility admissions to a non-participating facility.
• We may require that a member see a physician or other health care professional, selected by us, for a second opinion. We reserve the right to seek a second opinion for any surgical procedure. There is no formal list of procedures requiring second opinions. Members may also seek a second opinion when appropriate.

Status of a Submitted Authorization Request
Verify the status of an authorization request by the following methods:
• Voice Portal; available 24 hours a day, seven days a week
• Online; available 24 hours a day, seven days a week
• Provider Services

Medically Necessary Services
Medically necessary services are services or supplies provided by a hospital, skilled nursing facility, physician or other health care professional which are required to identify or treat a member’s illness or injury, as determined by our Medical Director. These services or supplies must be:
• Consistent with the symptoms or diagnosis and treatment of a member’s condition
• Appropriate regarding standards of good medical practice
• Not solely for the member’s convenience or that of any physician or other health care professional
• The most appropriate supply or level of service which can safely be provided.
• For inpatient services, it further means that the member’s condition cannot safely be diagnosed or treated on an outpatient basis.

Prior Authorization List
1. You can log on to OxfordHealth.com > Provider or Facilities > Transactions to use the Precert Required Inquiry tool on the Transactions tab to check prior authorization requirements for up to 12 CPT codes at one time.

2. The list of services requiring prior authorization is located on OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical &Administrative Policy Index > Services Requiring Prior Authorization.

3. A copy of the most current list can also be obtained by sending a written request to:
Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Changes to the policies appearing on this list are announced at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin (published monthly).

• Certain services may not be covered within a member’s benefit plan, regardless of whether advance notification is required.

• In the event of a conflict or inconsistency between applicable regulations and the notification requirements in this supplement, we follow applicable regulations.

• Prior authorization requirements may differ by individual physicians, health care professionals and ancillary providers and facilities. If additional prior authorization requirements apply, the physician or other health care professional are notified in advance of the prior authorization rules being applied.

eviCore Healthcare Prior Authorizations Online
eviCore Healthcare provides a secure, interactive web-based program where prior authorization requests can be initiated and determined in real time. If medical necessity is demonstrated during this process, an authorization number is issued immediately. If medical necessity is not demonstrated through the online process, physicians may submit additional information at the conclusion of the session and print a procedure request summary page. Requests for an authorization that do not meet medical necessity criteria online are forwarded for clinical review. Additional information may be requested by eviCore Healthcare for medical necessity review with a Medical Director.

In the event that criteria have not been met, the physician’s office and the member is notified in writing of the denial. Log into evicore.com where the automated system guides you through a series of prompts to collect routine demographic and clinical data. This eliminates the need for a call to eviCore Healthcare and allows you to enter multiple clinical certification requests at your convenience.

Prescription Medications Requiring Prior Authorization
Based on the member’s benefit plan design, select high-risk or high-cost medications may require advance notification in order to be eligible for coverage. This process is also known as prior authorization and requires that you submit a formal request and receive advanced approval for coverage of certain prescription medications.

The list of prescription medications (including generic equivalents, if available) that require prior authorization is available for your reference at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Prescription Drug Information > Drugs Requiring Precertification.
Prior Authorization and Referral Guidelines When Coordinating Benefits

When it is determined that we are the secondary or tertiary carrier, normal requirements for prior authorization and referrals are modified as follows:

• Referral and prior authorization guidelines are waived, deferring to the requirements of the primary carrier. Other requirements are not waived (e.g., itemized bills, student verification, consent for exchange of mental health/substance use information, etc.).

• Exception: Referral and prior authorization guidelines apply:
  › If the primary carrier does not cover a service or applies an authorization penalty.
  › When a motor vehicle accident or workers’ compensation is involved.

Using Non-Participating Health Care Providers or Facilities

As a participating physician or other health care professional, you are required to utilize participating physicians, other health care professionals and facilities within the network (i.e., Liberty Network) applicable to the member’s benefit plan. We have implemented a compliance program to identify participating physicians and other health care professionals who regularly use physicians and other health care professionals and facilities that do not participate in our network, and takes the appropriate measures to enforce compliance.

If a member asks you for a recommendation to a non-participating physician or other health care professional, you must tell the member that you may not refer to a non-participating care provider, and the member must contact us to obtain the required prior authorization. The member may obtain all required prior authorizations by calling 800-444-6222.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility for a member who has out-of-network benefits, the procedure is authorized as out-of-network.

This means that the reimbursement to the non-participating facility is subject to the member’s out-of-network deductible and coinsurance obligations. The non-participating facility’s charges are only eligible for coverage up to the reimbursement levels available under the member’s benefit plan, using either a usual, customary and reasonable (UCR) fee schedule, or a Medicare reimbursement system (called the Out-of-Network Reimbursement Amount for our New York members).

Members are responsible for paying their out-of-pocket cost as well as the difference between the UCR fee or other out-of-network reimbursement and the non-participating facility’s billed charges. Please remind the member that their expenses may be significantly higher when using a non-participating care provider.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility on a member who does not have out-of-network benefits (HMO and EPO benefit plan members), the services are denied.

Exceptions may be considered upon request only when our Medical Director determines in advance that:

1. Our network does not have an appropriate participating network physician or other health care professional who can deliver the necessary care.

2. Medically necessary services are not available through our network care providers.

In such cases, the referral must be approved by us, and must include a treatment plan approved by our Medical Director, the PCP, and the non-participating physician.

Using Non-Participating Physicians

1. The member explicitly agrees pre-service (no more than 90 days before the scheduled date of the procedure) to receive services from a non-participating anesthesiologist by signing the Non-Participating Provider Consent Form and understands that the use of this care provider is:
   - Out-of-Network: For members with out-of-network benefits, non-participating anesthesiologist claims are paid at the Out-of-Network benefit level. Out-of-Network cost shares and deductibles apply.
   - Denied: For Members without out-of-network benefits, non-participating anesthesiologist claims are denied as not covered because the member has no coverage for services provided by non-participating care providers. Members are therefore responsible for the entire cost of the service;

or

2. An In-network exception has been approved.

The following procedures and responsibilities apply in non-emergent situations when the services are provided by a participating gastroenterologist in New York (in office and ambulatory surgery center settings):

1. Verbally discuss options and financial impact with the member. The discussion must explain participating and non-participating alternatives, provide the member with an understanding of all the care providers involved in the member’s care (e.g.; anesthesiologist) and include

Coordinating Benefits
a conversation explaining the financial impact of using a non-participating care provider.

2. Obtain a completed Non-Participating Provider Consent Form. The member needs to either agree or disagree to receive out-of-network services, by signing, dating and returning the Non-Participating Provider Consent Form no less than 14 days before the scheduled date of the procedure.

3. Coordinate the member’s care as directed by the member in the Non-Participating Provider Consent Form (including, but not limited to, using a participating anesthesiologist, network exceptions and/or claim appeals).

You are required to keep a signed copy of the Non-Participating Provider Consent Form on file. Oxford may request a copy of the signed Non-Participating Provider Consent Form at any time, including when responding to a member appeal. Care providers are not required to submit this form with their initial claim.

If the participating gastroenterologist cannot provide the signed Non-Participating Provider Consent Form, within 15 days of the request, as proof that they discussed the member’s options for selecting a participating or non-participating anesthesiologist in advance of the service, Oxford will administratively deny the participating gastroenterologist claim. Any payment previously made for the gastroenterology service will be subject to recovery. The participating gastroenterologist cannot balance bill the member for claims denied for administrative reasons.

For additional details and copies of the Non-Participating Provider Consent Form, please refer to the complete policy at OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > Participating Gastroenterologists Using Non-Participating Anesthesiologists: In-Office & Ambulatory Surgery Centers.

Participating Mastectomy Surgeon Using a Non-Participating Breast Reconstruction Surgeon (New York Products)

If a participating mastectomy surgeon is recommending the use of a non-participating breast reconstruction surgeon (including but not limited to plastic surgeons, assistant surgeons, etc.), for a reconstruction that is being performed within the same surgical or different operative session as the mastectomy, prior to making a recommendation or scheduling services the participating mastectomy surgeon is required to:

1. Verbally discuss options and financial impact with the member. The discussion must happen no more than 90 days, and no less than 14 days before the scheduled date of procedure. Participating and non-participating alternatives must be explained, and the member must be provided with an understanding of all the care providers involved in the member’s care (e.g.; plastic surgeon, assistant surgeon, etc.). A conversation explaining the financial impact of using a non-participating care provider must be included.

2. Obtain a completed Non-Participating Provider Consent Form. The member will need to either agree or disagree to receive out-of-network services, by signing, dating and returning the Non-Participating Provider Consent Form no less than 14 days before the scheduled date of the procedure.

3. Coordinate the member’s care as directed by the member in the Non-Participating Provider Consent Form (including, but not limited to, using a Participating Breast reconstruction surgeon, plastic surgeons, assistant surgeons, etc., network exceptions and/or claim appeals).

4. You are required to keep a signed copy of the Non-Participating Provider Consent Form on file in order to provide to us upon request. If you cannot provide the signed Non-Participating Provider Consent Form within 15 days of the request, we will administratively deny your mastectomy surgery claim for failure to comply with this protocol. Any payment previously made for the mastectomy surgery service will be subject to recovery.

For additional details and/or to obtain a copy of the Non-Participating Provider Consent Form, refer to the complete policy at OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy.

Hospital Services, Admissions and Inpatient and Outpatient Procedures

Facilities are responsible for providing admission notification and obtaining prior authorization (where applicable) for the following types of inpatient admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care (admission notification only)
- All Skilled Nursing Facility (SNF) admissions
- All admissions following outpatient surgery and observation
- All newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged
- Prior authorization by the facility is required even if prior authorization was supplied by the physician and a pre-service approval is on file
Physicians, health care professionals and ancillary providers are responsible for obtaining prior authorization for outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

**Inpatient Hospital Copayment**
State regulations for commercial benefit plans determine when a member should be charged for subsequent inpatient hospital copayment(s) when readmitted into an inpatient setting. According to state laws, inpatient hospital copayments must be based on a “per continuous confinement” basis.

**Concurrent Review: Clinical Information**
Upon admission, Clinical Services will accept concurrent review information provided by the admitting physician or other health care professional and/or the hospital’s Utilization Review department. Furthermore, if not already submitted, the hospital must provide us with the discharge plan on the day of admission. If a patient requires an extended length of stay or additional consultations, please call our Clinical Services department at 800-666-1353 to update the prior authorization.

- For mental health/substance use, all calls related to inpatient prior authorization should be directed to 800-201-6991.
- You must cooperate with all requests for information, documents or discussions for purposes of concurrent review and discharge. When available, provide clinical information by access to Electronic Medical Records (EMR).
- You must cooperate with all requests from the interdisciplinary care coordination team and/or medical director to engage our members directly face-to-face or by phone.
- You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if our request is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. the next business day).
- Oxford uses MCG® Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings.

**Inpatient Maternity Stay and Subsequent Home Nursing**
It is crucial that the member, or their physician or other health care professional, notify us of a pregnancy as early as possible to help ensure the proper application of benefits. Oxford abides by state mandates regarding the length of an inpatient maternity stay and the coverage of subsequent home nursing visits. Regulations vary by state as outlined below.

**Inpatient Maternity Length of Stay**
Oxford will cover inpatient maternity stays for both mother and newborn as follows:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean delivery.

**Post-Discharge Home Nursing Visits**

- Connecticut: Oxford will approve two (2) home nursing visits if both mother and newborn are discharged before the mandated length of stay (48 hours following vaginal delivery and 96 hours following Cesarean delivery).
- New Jersey and New York Plans: Oxford will approve one (1) home nursing visit if both mother and newborn are discharged before the mandated length of stay (48 hours following vaginal delivery and 96 hours following Cesarean delivery).

Non-emergency maternity admissions should be authorized. Newborn coverage varies from benefit plan to benefit plan and state to state. For additional details, refer to [OxfordHealth.com > Providers or Facilities > Transactions > Check Eligibility & Benefits](#).

**Neonatal Intensive Care Unit (NICU) Level of Care**
NICU bed levels are based on the intensity of services and identifiable interventions received by the neonate. The NICU bed levels of care are linked to a revenue code that is defined by the National Uniform Billing Committee. We will assign NICU levels for those facilities contracted with more than one level of NICU. Claims reimbursement is based on the pay codes and Bed Types (levels of care per contract).

**Hospital Responsibilities**
The hospital is required to notify us of:

- Newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged.
- Concurrent inpatient stays (notification prior to discharge).
- Any patient that changes level of care. The member must be enrolled and effective with us on the date the service(s) are rendered. However, if CMS or an employer or group retroactively disenrolls the member up to 90 days following the date of service we may deny or reverse the claim.
The hospital must also:

- Provide daily inpatient census log by 10 a.m. The daily inpatient census log will reflect all admits and discharges through midnight the day prior.
- Provide notification of all admissions of our members at the time of, or prior to, admission. The hospital must notify us of all emergencies (upon admission or on the day of admission). The hospital must also notify us of “rollovers” (i.e., any patient who is admitted immediately upon receiving a preauthorized outpatient service).
- Obtain prior authorization for any transfer admissions of members prior to the transfer unless the transfer is due to life-threatening medical emergency.
- Communicate necessary clinical information on a daily basis, or as requested by our Case Manager, at a specified hour that allows for timely generation of our End of Day Report (EDR).
- Verify the accuracy of the admission and discharge dates for our members listed on the EDR.

If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will be given only if clinical information is received within 48 hours (72 hours for New Jersey facilities).

If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to members and their medical records. It is the responsibility of all physicians and other health care professionals to deliver letters of non-coverage to the member before discharge. This includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

Appeals will be considered if the hospital can demonstrate that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.

Retrospective Review of Inpatient Stays
(Notification of Admission After Discharge)

Members - Upon request from us, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will only be given if clinical information is received within 48 hours (72 hours for New Jersey members).

Our Responsibilities for Inpatient Notifications

- We will maintain a system for verifying member eligibility/status and use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital.
- We will request any necessary clinical information. Failure by us to seek such information will result in our liability for that day’s services.
- We also agree to provide concurrent and prospective certification for all services with a daily EDR when the hospital provides timely necessary clinical information.
- We will assign a first day of review (FDOR) for all elective inpatient services, and all days up to and including the FDOR will be certified. Coverage decisions for the next day will be given on the EDR.
- We will notify the hospital and attending physician or other health care professional either verbally or in writing of all denied days.
- We will perform clinical review of days that fall on the weekends and holidays for which we or the facility is closed, and days upon which there are unforeseen interruptions in business on the following business day. Such reviews will be considered concurrent.

We will not deny services retrospectively or reduce the level of payment for services that have been preauthorized or received concurrent review approval unless:

- The member is retroactively disenrolled.
- The certification or concurrent review approval was based on materially erroneous information.
- The services are not provided in accordance with the proposed plan of care.
- Hospital delays in providing an approved service to prolong the length of stay beyond what was approved.

Mental Health, Substance Use and Detoxification Treatment

Inpatient Care
All inpatient mental health/substance use treatment requires prior authorization.

Partial Hospitalization
Partial hospitalization always requires certification through the behavioral health department. If clinical criteria are met, the Case Manager will facilitate certification and management at a contracted facility with a partial hospitalization program. The Case Manager will continue to follow the member’s treatment while he or she is in the program.
Prior Authorization Outpatient Mental Health Services (New York)

Covered services are those received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility issued operating certificate by the commissioner of mental health, a facility operated by the Office of Mental Health, a professional corporation or university faculty practice corporation including:

- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Crisis intervention

Coverage will be provided to the maximum number of visits shown on the member’s Summary of Benefits.

Inpatient Mental Health Services (New York)

Covered services are received on an inpatient or partial hospitalization basis in a facility as defined by subdivision 10 of section 1.03 of the Mental Hygiene Law, as well as by any other network physician or other health care professional we deem appropriate to provide the medically necessary level of care.

If an inpatient stay is required, it is covered on a semi-private room basis. If partial hospitalization is authorized two partial hospitalization visits may be substituted for one inpatient day. Coverage will be provided for active treatment to the maximum number of days shown on the member’s Summary of Benefits.

Visits for biologically based services will count toward this limit. Active treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

Laboratory Policies and Procedures

Ancillary Services

Our network of laboratory service providers consists of an extensive selection of walk-in patient service centers, many regional and local laboratories and a national provider of laboratory services, Laboratory Corporation of America (LabCorp).

Participating vs. Non-participating Laboratory Provider Referrals

It is important that you refer your patients to participating service centers and laboratories to help them avoid unnecessary costs. Referrals are not required (only a physician’s prescription or lab order form is required).

We review laboratory ordering information periodically, if our data shows a pattern of out-of-network utilization for your practice, we will contact you to share this information and engage you to utilize the contracted network.

Participating Provider Laboratory & Pathology Protocol (New York)

Specific guidelines must be followed if you are recommending the use of, making a referral to, or involving a non-participating laboratory or pathologist in a member’s care. This includes the following:

- Specimens collected in your office for processing by a non-participating care provider (on and off-site).
- Providing the member with a requisition form, prescription or other form to obtain laboratory or pathology services outside of your office.

Prior to making the recommendation, involving, or referring a member to a non-participating laboratory or pathologist, you are required to:

1. Verbally discuss options and financial impact with the member. The discussion must explain participating and non-participating alternatives and the reason for any referral to a non-participating laboratory or pathologist. The discussion must also include a conversation explaining the financial impact of using a non-participating care provider.

2. Obtain a completed Laboratory & Pathology Services Consent Form. The member will need to either agree or disagree to the use of an out-of-network laboratory or pathologist by signing and dating the Laboratory & Pathology Services Consent Form.

3. Coordinate the member’s care as directed by the member in the Laboratory & Pathology Services Consent Form.

You are required to keep a signed copy of the Laboratory & Pathology Services Consent Form on file in order to provide to us upon request. If you cannot provide the signed Laboratory & Pathology Services Consent Form within 15 days of the request, the Evaluation & Management (E&M) code from the office visit which generated the non-participating laboratory or pathology referral will be reversed and denied administratively for failure to comply with this protocol. Any payment previously made for the service will be subject to recovery. You are prohibited from balance billing the member for claims denied for administrative reasons.

For additional details and/or to obtain a copy of the Non-Participating Provider Consent Form, refer to the complete policy at OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > New York Participating Provider Laboratory & Pathology Protocol.
In-Office Laboratory Testing and Procedures List
The in-office laboratory testing and procedure list outlines the laboratory procedural/testing codes that will be reimbursed to network physicians when performed in the office setting. For the most up-to-date list, refer to: OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > In-Office Laboratory Testing and Procedures List. Laboratory procedures/tests not appearing on this list must be performed by one of the participating laboratories in our network. See the How to Contact Oxford Commercial section for contact information.

Specimen Handling and Venipuncture
A physician’s prescription or lab order form is required when using participating laboratories to process specimen. If specimen handling and venipuncture codes are billed in conjunction with a lab code on the In-Office Laboratory Testing and Procedures List, only the lab and venipuncture codes will be reimbursed.

If specimen handling and venipuncture codes are billed without a lab code on our In-Office Laboratory Testing and Procedures List or with other non-laboratory services, the specimen handling and venipuncture codes will be paid per our fee schedule.

Radiology Procedures
Oxford has engaged eviCore Healthcare to perform initial reviews of requests for pre-certification. eviCore healthcare has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology evidence-based guidelines and management criteria are available on the eviCore Healthcare web site.

All pre-certification requests are handled by eviCore Healthcare. To pre-certify a radiology procedure, please contact eviCore healthcare by one of the two options listed below:

- Phone: 877-PRE-AUTH (877-773-2884); or
- Online: evicore.com.

Oxford also requires a minimum physician accreditation and certification requirements for MRI, PET, CT nuclear medicine studies. More detailed information can be found on Oxfordhealth.com > Providers (or Facilities) > Tools and Resources > Medical Information > Radiology & Radiation Therapy Information > Radiology Procedures Requiring Precertification for eviCore National Arrangement.

Imaging Requiring Prior Authorization
The referring physician is responsible for contacting eviCore Healthcare to request prior authorization and to provide sufficient history to demonstrate the appropriateness of the requested services. Our policy does not permit prior authorization requests from persons or entities other than referring physicians.

Radiology Prior Authorization Policy for Urgent Cases
It is the imaging facility’s responsibility to confirm that an authorization number has been issued prior to providing a service. In the case of urgent examinations, or in cases in which, in the opinion of the attending physician or other health care professional, a change is required from the authorized examination, and the eviCore Healthcare offices are unavailable, the services may be performed, and you may request a new or modified authorization number. Requests must be made within two business days of the date of service through the Imaging Care Management department for Radiology. If the eviCore Healthcare offices are available, the request should be made immediately. Clinical justification for the request will be reviewed using the same criteria as a routine request. See the How to Contact Oxford Commercial section for additional information.

Cardiology Procedures
Oxford has engaged eviCore Healthcare to perform initial reviews of requests for pre-certification of for echocardiogram, stress echocardiogram, cardiac nuclear medicine studies, cardiac CT, PET and MRI and cardiac catheterizations procedures. eviCore Healthcare has established correct coding and evidence-based criteria to determine the medical necessity and appropriate billing of cardiology services. The cardiology evidence-based criteria and management criteria are available on the eviCore healthcare website at evicore.com. (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals).

All pre-certification requests are handled by eviCore Healthcare. To pre-certify a cardiology procedure, please contact eviCore Healthcare using one of the three options below:

- Phone: 877-PRE-AUTH (877-773-2884), or
- Fax: 888-622-7369, or
- Online: evicore.com.

The utilization review process involves matching the patient clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Utilization review decisions are made by qualified health professionals including board certified radiologists and board certified cardiologists for cardiac based diagnostic procedures. Data collection for clinical certification of imaging services may be assigned to non-medical personnel working under the direction of qualified health professionals. You will receive communication of review determinations for non-urgent care by fax/telephone within two business days of receiving all the necessary information. Communication received for a determination
involving an urgent request is given within 24 hours of the receipt of information necessary to make a medical necessity determination.

For members, requests for retrospective clinical certification review of medically urgent care are accepted up to two business days after the care has been given for radiology and 15 days for cardiac catheterization, if the services are performed outside eviCore Healthcare’s hours of operation and rendered on an urgent basis. Retrospective review decisions are made within 30 business days of receiving all of the necessary information. If your request is not authorized, the review determination will be sent in writing to the member and the requesting physician within five business days of the decision. All authorization reference numbers are issued at the time of approval. eviCore Healthcare uses the reference CPT code as the last five digits of the authorization number. We require the submission of clinical office notes for specific procedures. Clinical notes include the patient’s medical record and/or letters received from specialists.

Radiation Therapy Procedures

Oxford has engaged eviCore Healthcare to perform prior authorization and medical necessity reviews for all outpatient radiation therapy services (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals.) All pre-certification requests are handled by eviCore Healthcare. The following radiation therapy treatments require prior authorization through eviCore Healthcare for Oxford products:

- Ionizing radiation
- Brachytherapy
- Conventional external beam radiation therapy (CRT)
- Three-dimensional conformal radiation therapy (3D CRT)
- Intensity modulated radiation therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Proton beam therapy (PBT)
- Selective Internal Radiation Therapy (SIRT)
- Stereotactic radiosurgery (SRS)
- Other emerging therapies that use ionizing radiation to treat cancer such as hyperthermia and neutron beam therapy

A complete list of radiation therapy treatments that require Prior Authorization through eviCore Healthcare for Oxford products can be found at: OxfordHealth.com > Providers (or Facilities) > Tools and Resources > Medical Information > Medical and Administrative Policies > Medical and Administrative Policy Index > Radiation Therapy Procedures Requiring Precertification for eviCore healthcare Arrangement.

eviCore Healthcare has established correct coding and evidence-based guidelines to determine the medical necessity and appropriate billing of radiation oncology services. These guidelines have been carefully researched and are continually updated in order to be consistent with the most current evidence-based guidelines and recommendations for the provision of radiation therapy from national and international medical societies and evidence-based medicine research centers.

Oxford New Jersey Small, Individual, Municipality, and School Board Members

Radiology and Radiation Therapy Procedures

eviCore Healthcare will perform a medical necessity review prior to rendering the services. To obtain prior authorization for a course of radiation therapy, please contact eviCore Healthcare using one of the options below:

- Phone: 877-PRE-AUTH (877-773-2884), or
- Online: eviCore.com

We require the submission of clinical office notes for specific procedures if a Medical Necessity Review/Utilization Review is not conducted prior to rendering services. Clinical notes include the patient’s medical record and/or letters received from specialists. Supporting clinical information provided by the ordering physician must contain the ordering/referring physician’s name and signature, address, phone and fax numbers, specialty, tax identification number and information such as:

- Reason for the procedure performed;
- Patient’s signs and symptoms;
- Treatment, including type and duration;
- Previous studies for the specific medical issue; and
- Any other pertinent clinical information to determine medical necessity.

Note: eviCore policy does not permit Prior Authorization requests from persons or entities other than the following:

- Radiology services: It is the ordering physician’s responsibility to provide medical documentation to demonstrate clinical necessity for the outpatient radiology procedure that is being requested, for pre- and post-service review.
- Radiation Therapy services: It is the rendering radiation therapist’s office that is required to request Prior Authorization and, guided by the Physician Worksheets, provide sufficient information to determine the medical necessity of the requested services.

**Referrals**

Certain Oxford products require referrals for radiology or radiation therapy from the member’s PCP. If your patient is enrolled in one of these benefit plans, they will be required to obtain a referral before seeing you for an initial visit.

**Claims Processing**

We will continue to process claims from participating physicians and other health care professionals for radiation therapy services. You will receive payment directly from us. 

If a claim is denied because medical necessity was not demonstrated, contract provisions that prohibit balance billing of members will apply. For any service that is not approved for payment, we will offer all appropriate rights of appeal.

**Cardiology, Cardiac Catheterization, Echocardiogram and Stress Echocardiogram**

Oxford has engaged eviCore Healthcare to perform medical necessity review for outpatient cardiac imaging (CT, PET, MRI and Nuclear medicine), cardiac catheterizations, echocardiogram and stress echocardiogram studies. Prior Authorization will not be required for services when rendered in the emergency room, observation unit, urgent care facility, or during an inpatient stay.

eviCore Healthcare will perform a medical necessity review prior to rendering the services. To obtain prior authorization for a course of radiation therapy, please contact eviCore Healthcare using one of the options below:

- **Phone:** 877-PRE-AUTH (877-773-2884), or  
- **Online:** evicore.com

It is the referring physician’s responsibility to provide medical documentation to demonstrate clinical necessity for the procedure that is being requested (for review prior to service). eviCore policy does not permit prior authorization requests from persons or entities other than referring physicians. For post-service reviews (a review after service was provided) the referring physician is still responsible for providing medical documentation to demonstrate clinical necessity for the procedure performed.

We require the submission of clinical office notes for specific procedures if a Medical Necessity Review/Utilization Review is not conducted prior to rendering services. Clinical notes include the patient’s medical record and/or letters received from specialists. Supporting clinical information provided by the ordering physician must contain the ordering/referring physician’s name and signature, address, phone and fax numbers, specialty, tax identification number and information such as:

- Reason for the procedure performed
- Patient’s signs and symptoms
- Treatment, including type and duration
- Previous studies for the specific medical issue
- Any other pertinent clinical information to determine medical necessity

For a list of Codes that will require prior authorization, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > Medical & Administrative Policy Index > Cardiology Procedures Requiring Precertification for eviCore Healthcare Arrangement. Prior authorization requirements can be verified through one of the following options:

1. Care providers can call the number on the back of the member’s health care ID card and check eligibility.
2. To help ensure physicians or physician representatives have the required information available to initiate the prior authorization process, please use the Diagnostic Heart Catheterization worksheets found online at eviCore.com.
3. For more information, including the clinical criteria, please visit eviCore.com > eviCore Solutions > Cardiology > Cardiology Tools and Criteria.

**Infertility Utilization Review Process**

Oxford has delegated Optum, a UnitedHealth Group company, to perform reviews for infertility services under their Managed Infertility Program (MIP) for all Oxford Commercial members with an infertility benefit. Optum’s MIP is intended to promote both quality of care and continuity of service by supporting patients through every aspect of the infertility process. The program is supported by Optum infertility nurse case managers who will assist patients in making informed decisions about their infertility treatment and care through: treatment education, considerations in choosing where to obtain care, and assistance in navigating the health care system.

For Oxford products, the rendering physician is required to request prior authorization and/or notification of services. This is accomplished by using the Managed Infertility Program Treatment form and providing sufficient information to determine the medical necessity of the requested services.

Optum has been diligent in their research to help ensure that the clinical policies and guidelines they are using are consistent with best practices and state mandates.
The Managed Infertility Program (MIP) Prior Authorization template can be found by:
- Logging onto the OptumHealth website at myoptumhealthcomplexmedical.com, or
- Calling OptumHealth at 877-512-9340 or
- Sending an email to: MIP@optum.com.

Physical and Occupational Therapy
Oxford has delegated certain administrative services related to outpatient physical and occupational therapy services to OptumHealth Care Solutions. The outpatient setting for physical therapy and occupational therapy includes hospital outpatient treatment facilities, outpatient facilities at or affiliated with rehabilitation hospitals.

All physical therapy and/or occupational therapy visits require utilization review and an authorization, including the initial evaluation. After registering on myoptumhealthphysicalhealth.com, click on the ‘Forms’ link and locate the Patient Summary Form. A Patient Summary Form must be submitted to OptumHealth by the treating physician or health care professional. Once the required form is complete, it should be submitted through the OptumHealth website myoptumhealthphysicalhealth.com. Forms should be sent within three days of initiating treatment and must be received within 10 days from the initial date of service indicated on the form. Forms received outside of the 10-day submission requirement will reflect an adjustment to the initial payable date.

The submission of the Patient Summary Form must include the initial visit. If OptumHealth Care Solutions does not receive the required form(s) within this time frame, the claim will be denied. Once the forms are received, OptumHealth Care Solutions will review the services requested for medical necessity. If a patient’s care requires additional visits or more time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred.

Note: Prior authorization is not required for certain groups.

Musculoskeletal Services
OrthoNet, a musculoskeletal disease management company, is our network manager for most musculoskeletal services. OrthoNet’s orthopedic division will perform utilization management to review requested services that should meet approved clinical guidelines for medical necessity. Review is conducted by determining medical necessity and medical appropriateness, and to initiate discharge planning, as appropriate. The review will be based on the clinical information and some or all of the following criteria/tools:
- Member benefits
- Oxford medical and reimbursement policies
- MCG® Care Guidelines, 20th edition, 2016 (Inpatient Care)

Services performed by the following specialties (participating and non-participating) regardless of the diagnosis, are subject to utilization review by OrthoNet’s orthopedic division:
- Orthopedic Surgery
- Pediatric Orthopedic Surgery
- Podiatry
- Neurosurgery
- Hand Surgery
- Physical Medicine Rehabilitation

Services rendered by the below facilities (participating and non-participating) when billed in conjunction with certain identified ICD-9/ICD-10 codes are also managed by OrthoNet’s orthopedic division:
- Acute Care Hospital
- Ambulatory Surgery
- DME
- Other Ancillary Facility
- Home Health Care
- Physical Rehabilitation Hospital
- Physical Rehabilitation Facility
- Skilled Nursing Facility

For a comprehensive list of orthopedic diagnosis codes, or for additional information on Oxford’s arrangement with OrthoNet, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > Medical & Administrative Policy Index > Orthopedic Services.

Chiropractic Services
OptumHealth Care Solutions currently manages our chiropractic benefit. To receive the standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. PCPs should perform the customary initial comprehensive differential diagnosis with the necessary and appropriate work-up.

A chiropractic referral can be generated for a maximum of one visit within 180 days (six months). Once the referral is made (if applicable), all participating chiropractors must complete and submit Patient Summary Forms to OptumHealth Care Solutions for services performed.

Patient Summary Forms should be submitted through the OptumHealth Care Solutions website at myoptumhealthphysicalhealth.com, within three business days and no later than 10 business days following the member’s initial visit or recovery milestone. The submission of the Patient Summary Form must include the initial visit. If OptumHealth Care Solutions does not receive the required form(s) within this time frame, the claim will be denied. Once the forms are received, OptumHealth Care Solutions
will review the services requested for medical necessity, and will make any denial determinations.

If a member’s care requires additional visits or more time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred. According to your contract with OptumHealth Care Solutions, the member may not be balance billed for any covered service not reimbursed if you do not submit the Patient Summary Form, or for those services which do not meet medical necessity or coverage criteria. However, you may file an appeal.

**Acupuncture Services**

Acupuncture is only covered for members who have the alternative medicine rider. If a member does not have the alternative medicine rider, all requests to cover acupuncture will be denied, even if a letter of medical necessity has been submitted. Acupuncture is covered on a network basis and must be performed by one of following care provider types:

- Participating licensed acupuncturist (LAC)
- Participating licensed naturopaths
- Participating physician (MD or DO) who has been credentialed as physician acupuncturist

**Pharmacy Management Programs**

The pharmacy benefit plan includes a dynamic medication list, referred to as the Prescription Drug List (PDL), and various clinical drug utilization management programs. These programs are based upon FDA-approved indications and medical literature or guidelines.

The PDL contains medications within three tiers; Tier 1 is the lowest cost option and Tier 3 is the highest cost option. To help make medications more affordable for your patient who is our member, consider whether a Tier 1 or Tier 2 alternative is appropriate if the patient is taking a Tier 3 medication currently. Some of our groups have a 4-tier benefit design. The PDL is reviewed on an ongoing basis and updated at least twice per year. Medications that require notification or prior authorization are noted with an “N”, medications that require step therapy are noted with “ST and supply limits with “SL.”

**PDL Management Committee and the Pharmacy & Therapeutics Committee**

The UnitedHealthcare PDL Management Committee, a group of senior physicians and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoeconomic evidence.

The UnitedHealthcare National Pharmacy and Therapeutics Committee (P&T) is responsible for evaluating and providing clinical evidence to the PDL Management Committee to assist them in assigning medications to tiers on the PDL. The information provided by the P&T Committee includes, but is not limited to, evaluation of a medication’s place in therapy, its relative safety and its relative efficacy.

The P&T Committee also reviews and approves clinical criteria for prior authorization and step therapy programs, and supply limits. In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for medications, which require administration or supervision by a qualified, licensed health care professional.

The P&T Committee is comprised of medical directors, network physicians, consultant physicians, clinical pharmacists and pharmacy directors.

For more information regarding Oxford’s Pharmacy Management Program, go to [oxhp.com](http://oxhp.com).

**Quality Management and Patient Safety Programs**

**Drug Utilization Review (DUR)**

The majority of prescription claims are submitted electronically for payment. Within seconds, the member’s claim is recorded and the past prescription history is reviewed for potential medication-related problems. DUR helps review for potentially harmful medication interactions, inappropriate utilization and other adverse medication events in an effort to maximize therapy effectiveness within the appropriate medication usage parameters. There are two types of DUR programs: concurrent and retrospective.

**Concurrent Drug Utilization Review (C-DUR)**

The C-DUR program performs online, real-time DUR analysis at the point of prescription dispensing. This program screens every prescription prior to dispensing for a broad range of safety and utilization considerations. C-DUR uses a clinical database to compare the current prescription to the member’s inferred diagnosis, demographic data and past prescription history. Criteria are used to identify potential inappropriate medication consumption, medical conflicts or dangerous interactions that may result if the prescription is dispensed.

If a potential problem is identified, the system either notifies the dispensing pharmacist by sending a soft alert (warning message) or a hard alert (a warning message that also requires the pharmacist to enter an override). The dispensing pharmacist uses their professional judgment to determine appropriate interventions, such as contacting the prescribing physician or other health care professional, discussing concerns with the member and dispensing the medication.
Retrospective Drug Utilization Review (R-DUR)
The R-DUR program involves a quarterly review of prescription claims data to identify medication prescribing and/or medication utilization patterns that may indicate inappropriate or unnecessary medication use. The program uses a clinical database to review patient profiles for potential over- or under-dosing as well as duration of therapy, potential drug interactions, drug-age considerations and therapy duplications.

On a quarterly basis, physicians and other prescribers receive a patient-specific report that outlines the opportunities for intervention and asks them to respond to the issues and concerns raised.

Clinical Programs
Prescription Medications Requiring Prior Authorization (Subject to Plan Design)
Based on the member’s benefit plan design, select high-risk or high-cost medications may require advance notification (N) in order to be eligible for coverage. You may be asked to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect all pertinent clinical data for the service requested. If the prior authorization cannot be approved, a pharmacist or medical director, in keeping with state regulations, will make the final coverage determination. You and the member will be notified of the decision.

Step Therapy (Subject to Plan Design)
Certain medications may be subject to step therapy (ST), also referred to as First Start for New Jersey members. The step therapy program requires a trial of a lower-cost, Step 1 medication before a higher-cost, Step 2 medication is eligible for coverage. When a member presents a Step 2 medication at the pharmacy, the claims history may automatically be checked to see if there is a history of a Step 1 medication in the claims history and the medication may automatically process. If not, request a coverage review. If the medication cannot be approved, a pharmacist or medical director, in keeping with state regulations, will make the final coverage determination and you as well as the member will be notified of the decision.

Supply Limits (Subject to Plan Design)
Certain medications may be subject to supply limits (SL). Supply limits are based on FDA-approved dosing guidelines as defined in the product package insert and the medical literature or guidelines and data that support the use of higher or lower dosages than the FDA-recommended dosage. This program focuses on select medications or categories of medications that are high cost and/or are frequently used outside of generally accepted clinical standards.

When a pharmacist submits an online prescription claim, the online claims processing system compares the quantity entered with the allowable limits.

If the prescription exceeds the established quantity limits, the claim is rejected and the pharmacist receives a message to that effect. In addition, the current supply limit for the medication is displayed in the message. A subset of medications has coverage criteria available to obtain quantities beyond the established limit. For these medications, the pharmacist receives a message that includes the toll-free number to call for the coverage review.

Refill and Save Program
The Refill and Save Program (also known as Adherence Incentive) encourages members to adhere to their treatment regimen by rewarding them with a discount on their copayment/coinsurance for refilling their prescription within the defined time period. Medications included in this program are noted in the PDL.

Emergencies and Urgent Care
Urgent Care
Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency and does not otherwise fall under the definition of emergency care as defined below.

Definition of a Medical Emergency
Connecticut: An “emergency condition” is defined as medical or behavioral condition, that manifests itself by symptoms of sufficient severity, including severe pain, and the absence of immediate medical attention to result in (i) placing the health of such person, or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

New Jersey: An “emergency condition” is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use, and the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer of the woman or unborn child to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

New York: “Emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could
reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Emergency Room Visits
We cover emergency room services for medical emergencies. The member is responsible for paying the applicable copayment. Follow-up emergency room visits within our service areas are not covered. However, follow-up care, if appropriate, should be coordinated through the member’s PCP and is subject to the standard referral process.

• Emergency room visits during which a patient is treated and released without admission do not require notice to us.
• If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, you must notify us within 24-48 hours of when the surgery is performed. Any and all follow-up needs related to such emergency services should be coordinated through the member’s PCP and are subject to the standard referral process.
• When a patient is unstable and not capable of providing coverage information, the facility should submit the concurrent authorization as soon as the information is known and communicate the extenuating circumstances.

In-Area Emergency Services
You do not need to provide notification or obtain authorization for in-area emergency room treatment and subsequent release. However, all emergency inpatient admissions and emergency outpatient admissions (i.e., for emergent ambulatory surgery, etc.) do require notification upon admission or on the day of admission (no later than 48 hours from the date of admission, or as soon as reasonably possible).

Out-of-Area Emergency Services
Out-of-area coverage for emergency room (ER) services are limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a member from using ER services within our service area.

Emergency Admission Review
If the member is admitted to a hospital as a result of an emergency (as defined above), we will review the hospital admission for medical necessity and determine the appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission.

We must be notified of all emergency inpatient admissions (no later than 48 hours from the date of admission, or as soon as reasonably possible). If the member is admitted to a contracted hospital, we will use reasonable efforts to transmit a decision about the admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the decision.

Non-Emergency Hospitalization
Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires prior authorization and is subject to medical necessity review.

Coverage Outside of the United States
Oxford will provide limited coverage for members outside of the United States, Mexico, Canada, or the U.S. Territories.

New York (NY) and Connecticut (CT) Products
Out of Country Providers

• Claims received for services performed outside of the United States do not require an authorization if the services are emergent in nature.
• Members who reside in the United States will not be covered for elective procedures outside of the United States, Mexico, Canada, or the U.S. Territories unless an authorization exists that specifically states to pay the procedure. This includes prenatal care and delivery.
• All claims from out of country care providers must be translated and the amount billed calculated in American dollars using the conversion rate as of the processing date.

New Jersey (NJ) Products
Out-of-Country Providers

• Claims received for services performed outside of the United States do not require an authorization if the services are emergent or urgent in nature.
• Members who reside in the United States will not be covered for elective procedures outside of the United States, Mexico, Canada, or the U.S. Territories unless an authorization exists that specifically states to pay the procedure. This includes prenatal care and delivery.
• All claims from out-of-country care providers must be translated and the amount billed calculated in American dollars using the conversion rate as of the processing date.
Out-of-Country Resident Members
NJ Individual (all benefit plans except HMO)
Services provided outside of the United States are excluded, other than in the case of emergency and except as provided below with respect to full-time student status.

Subject to pre-approval, eligibility for full-time student status, provided the covered Member is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States grants academic credit. Charges in connection with full-time student status in a foreign country, which are not pre-approved, will be denied as non-covered charges.

NJ Small Group/PPO FP and Liberty
Services provided outside of the United States are excluded unless the covered Member is outside of the United States for one of the following reasons:

• Travel, provided the travel is for a reason other than securing healthcare diagnosis and/or treatment, and the travel is for a period of six months or less; or
• Business assignment, provided the covered Member is temporarily outside of the United States for a period of six months or less; or
• Eligibility for full-time student status (subject to pre-approval), provided the covered Member is either enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States grants academic credit.

Note: Charges in connection with full-time student status in a foreign country, which are not pre-approved, will be denied as non-covered charges.

Utilization Reviews
Our UM represents a combination of different disciplines, including: utilization review with benefit and eligibility requirements, effective and appropriate delivery of medically necessary services, quality of care across the continuum, discharge planning, and case management. The goals of UM are to:

• Promote the delivery of appropriate care for all members
• Promote necessary care in the appropriate setting, at the appropriate time and using appropriate resources
• Assess and offer appropriate alternative services

Our Clinical Services department monitors services provided to members to identify potential areas of over and underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Criteria and Clinical Guidelines
We have adopted the MCG® Care Guidelines and criteria for inpatient and ambulatory care where no specific Oxford policy exists. In addition to these guidelines, we develop specific policies related to covered services. Each policy describes the service and its appropriate utilization.

We employ several means to review the consistency and quality of clinical decision making, as directed through policies and adopted guidelines. In addition to those required by regulatory agencies and NCQA are the following processes:

• Inter-rater reliability tests developed in conjunction with an external consultant
• Monthly Medical Director consistency meetings and case discussions
• Monthly blind reviews done by all Medical Directors on a common set of clinical factors

We employ a process for adopting and updating clinical practice guidelines for use by network physicians and other health care professionals. Clinical practice guidelines help practitioners and members make decisions about health care in specific clinical situations. Guidelines are developed for preventive screening, acute and chronic care, and appropriate drug usage, based on:

• Availability of accepted national guidelines
• Ability to monitor compliance
• Projected ability to make a significant impact upon important aspects of care

Clinical practice guidelines are available on our website at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Clinical and Preventive Guidelines.

Clinical Review
Oxford may perform clinical reviews for various reasons, including but not limited to, medical necessity determinations, member eligibility, and to validate the accuracy of coding for services or procedures requested or rendered by participating or non-participating care providers and other qualified health care professionals. Medically necessary services will be considered for reimbursement when rendered to eligible members, as reflected in the clinical information, provided the services are not fraudulent or abusive.

Clinical information may be reviewed on an entire population of, or a subset of physicians, procedures or members, at Oxford’s discretion. Such clinical information may be reviewed on a prospective, concurrent and/or retrospective basis. Clinical Information is defined as the member’s clinical condition, which may include any
relevant medical information presented to us or treatment, service or procedure may be reversed on days of receipt of necessary information. A preauthorized UR decisions will be made within 30 business day of receipt of necessary information. Notice will be provided to the member or their designee. Member appeals may be initiated in writing, or verbally by calling our Member Service department at the number on the member’s health care ID card or at 800-444-6222. However, we strongly recommend that the appeal be filed in writing. Determinations concerning services that symptoms, treatments, dosage and duration of drugs, and dates for other therapies. Dates of prior imaging studies performed and any other information the ordering care provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports should be provided. Clinical information that is reviewed prospectively may be reviewed again concurrently or retrospectively to confirm the accuracy of the information available at the time of previous review. Oxford will retrospectively deny an approval only in circumstances indicated in the approval or in circumstances involving fraud, abuse or material misrepresentation. The procedure and information required for review will depend on the circumstances of interest, as determined by Oxford, in its discretion. The process of selecting services for review, requests for clinical information concerning such services, review of clinical information, and action based on clinical information will comply with all applicable federal and state regulations, laws, and provisions in a specific care provider’s contract with Oxford. Any applicable appeal rights will be made available for adverse determinations as required by applicable law and regulation. Utilization Review of Services Provided to New York Members All adverse utilization review (UR) determinations (whether initial or on appeal) will be made by a clinical peer reviewer, while appeals of adverse UR determinations will be reviewed by a different clinical peer reviewer than the clinical peer reviewer who rendered the initial adverse determination. Initial Utilization Review Determination Time Periods UR decisions will be made by the following methods and in the following time frames: Prior Authorization - UR decisions will be made and notice will be provided to you and the member, by phone and in writing, within three business days of receipt of necessary information. Concurrent review - UR decisions will be made and notice will be provided to the member or their designee by phone and writing within one business day of receipt of necessary information. This requirement may be satisfied by giving notice to you, the physician or other health care professional, by telephone and in writing, within one business day of receipt of necessary information. Retrospective - UR decisions will be made within 30 days of receipt of necessary information. A preauthorized treatment, service or procedure may be reversed on retrospective review under the following circumstances: 1. Relevant medical information presented to us or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and 2. The information existed at the time of the preauthorization review but was withheld or not made available; and 3. UnitedHealthcare or the UR agent was not aware of the existence of the information at the time of the preauthorization review; and 4. Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized. In the event that an initial adverse UR determination is rendered without attempting to discuss such matter with the member’s physician or other health care professional who specifically recommended the health care service, procedure or treatment under review, such physicians and other health care professionals shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the request, and shall be conducted by the member’s physician or other health care professional, as the clinical peer reviewer making the determination. Failure to make an initial UR determination within the time periods described above is deemed to be an adverse determination eligible for appeal. Components of an Initial Adverse Determination If the review results in an adverse determination, the initial adverse determination letter will include the following: 1. The reasons for the determination including the clinical rationale, as applicable; 2. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals, and 3. Information that we will provide (upon request from the member or the member’s designee) the clinical review criteria relied upon to make our decision. 4. The notice will also specify what, if any, additional necessary information must be provided to, or obtained by us, in order to render a decision on an appeal of our determination. Appeal Requirements for Initial Adverse Utilization Review Determinations Member appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. Standard (non-expedited) UR appeals may be filed by telephone or in writing by the member or their designee. Member appeals may be initiated in writing, or verbally by calling our Member Service department at the number on the member’s health care ID card or at 800-444-6222. However, we strongly recommend that the appeal be filed in writing. Determinations concerning services that
have already been provided are not eligible to be appealed on an expedited basis.

**Expedited UR Appeals**

An expedited UR appeal may be filed for denials of:

- Continued or extended health care services, procedures, or treatment
- Additional services for member undergoing a course of continued treatment
- Health care services for which the physician or other health care professional believes an immediate appeal is warranted

Expedited UR appeals will be determined within two business days of receipt of the necessary information to conduct such appeal. If we require additional information to conduct an expedited appeal, we will immediately notify the member and their health care provider by telephone or facsimile to identify and request the necessary information, and follow up with a written notification. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed using the standard appeal process or through the external appeal process.

Failure to make a determination within the applicable time periods shall be deemed to be a reversal of an initial adverse UR determination.

The law allows the member and UnitedHealthcare to jointly agree to waive the internal UR appeal process. Typically, we will not agree to waive the internal UR appeal process. In those rare situations where we are willing to waive the internal UR appeal, we will inform the appeal requester and/or member verbally and/or in writing. If the member agrees to waive the internal UR appeal process, we will provide a letter within 24 hours of the agreement to waive the internal appeal process with information on filing an external appeal to them.

**Internal Utilization Management Appeals Process**

**Retrospective Review Appeals**

A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the services have been rendered. This process does not apply to services where precertification or concurrent review is required. You may request an external appeal on your own behalf, by phone or in writing, when we have made a retrospective final adverse determination on the basis that the service or treatment is not medically necessary, or is considered experimental or investigational (or is an approved clinical trial) to treat the member’s life-threatening or disabling condition (as defined by the New York State Social Security Law).

All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial retrospective medical necessity or experimental/investigational determination. If we require additional information to conduct a standard internal appeal, we will notify the member and their health care provider, in writing, within 15 days of receipt of the appeal, to identify and request the necessary information.

Once a decision is made regarding the retrospective review appeal, we will notify the member and their care provider in writing within two business days from the date the decision is made.

**Medical Necessity Determinations Mandatory Internal Appeals Process for Providers**

If you would like to dispute our payment determination that a service requested for a member is not medically necessary, mail a written request, with relevant supporting clinical documentation that shows why the denial of services should be reversed, to:

Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

The Clinical Appeals department will make a reasonable effort to render a decision within 60 calendar days of receiving the appeal and supporting documentation.

**Note:** There is a separate appeal process for member appeals.

**Final Adverse Determination Notice (FAD)**

The contents of a final adverse determination vary based on the state in which the member’s certificate of coverage was issued. Each notice of final adverse determination will be in writing, dated and include the following:

**Connecticut:**

1. Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount, if known;

2. The specific reason(s) for the adverse determination, including, upon request, a listing of the relevant clinical review criteria including professional criteria and medical or scientific evidence used to reach the denial and a description of Oxford’s standard, internal rule, guideline, protocol or other criterion, if applicable, that were used in reaching the denial;

3. Reference to the specific health benefit plan provisions on which the determination is based;

4. A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

5. A description of Oxford’s internal appeals process, which includes:
   i. Oxford’s expedited review procedures,
   ii. Limits applicable to such process or procedures
iii. Contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and

iv. A statement that the member or, if applicable, their authorized representative is entitled, pursuant to the requirements of the Oxford’s internal grievance process, to receive from Oxford, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the their request.

If the adverse determination is based on:
1. An internal rule, guideline, protocol or other similar criteria:
   i. The specific rule, guideline, protocol or other similar criteria; or
   ii. A statement that:
      • A specific rule, guideline, protocol or other similar criteria was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criteria will be provided to the covered person free of charge upon request;
      • Provides instructions for requesting a copy; and
      • The links to such rule, guideline, protocol or other similar criteria on Oxford’s Internet web site.
2. Medical necessity or an experimental/investigational treatment:
   i. a. A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the benefit plan to the member’s medical circumstance;
   ii. b. Notification of the member’s right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review;
3. A statement explaining the right of the member to contact the Office of the Healthcare Advocate at any time for assistance or, upon completion of the Oxford’s internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include:
   i. The contact information for said offices; and
   ii. A statement that if the member or their authorized representative choses to file a grievance that:
      • Appeals are sometimes successful;
      • The member may benefit from free assistance from the Office of the Healthcare Advocate, which can assist them with the filing of a grievance pursuant to 42 USC 300gg–93, as amended from time to time;
      • The member is entitled and encouraged to submit supporting documentation for Oxford’s consideration during the review of an adverse determination, including narratives from the member or from their authorized representative and letters and treatment notes from the member’s health care professional, and
      • The member has the right to ask their health care professional for such letters or treatment notes.
4. A health carrier may offer a member’s health care professional the opportunity to confer with a clinical peer, as long as a grievance has not already been filed prior to the conference. This conference between the physician and the health care professional peer will not be considered a grievance of the initial adverse determination.

New Jersey:
1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal;
2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by Oxford in the denial;
3. Any new or additional rationale, which was relied upon, considered or utilized, or generated by Oxford, in connection with the adverse benefit determination; and
4. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).

New York:
1. The specific reason for denial, reduction or termination of services.
2. The specific health service that was denied, including the name of the facility/care provider and developer/manufacturer of service, as available.
3. A statement that the member may be eligible for an appeal, and a description of the appeal procedures including a description on the urgent appeal process if the claim involves urgent care.
4. A clear statement, in bold, that the member has 45 days from the FAD to request an external appeal, and that
5. **A description of the external appeals process.**

If Oxford fails to adhere to the requirements for rendering decisions (above) the following rules apply to members enrolled on CT and NJ Products.

**Connecticut:** The member is deemed to have exhausted Oxford's internal appeals process and may file an external review, regardless of whether Oxford could assert substantial compliance or minor (de minimis) error.

**New Jersey:** Members are relieved of their obligation to complete the internal review process and may proceed directly to the External Review Process under the following circumstances:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waive our rights to an internal review of any appeal; or
- The member and/or their care provider have applied for expedited external review at the same time as applying for an expedited internal review.

In such a case where Oxford asserts good cause for not meeting the deadlines of the appeals process, members or their Designee and/or their care provider may request a written explanation of the violation. Oxford must provide the explanation within 10 days of the request and must include a specific description of the bases for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Oxford and rejects the request for immediate review, the member will have the opportunity to resubmit their appeal.

**Member’s Rights to External Appeal**

The member has a right to an external appeal of a final adverse determination (FAD).

A FAD is a first-level appeal denial of an otherwise covered service where the basis for the decision is either a lack of medical necessity, appropriateness, healthcare setting, level of care or effectiveness or the experimental/investigational exclusion. Determinations concerning clinical trials and experimental or investigational procedures may be appealed through the external appeal process only if the member’s physician is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s condition or disease, and has certified that:

- Condition or disease is one for which standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard health service or procedure covered by the health care benefit plan; or
- There exists a clinical trial; and
- The member’s attending physician must have recommended either:
  - A health service or procedure including a pharmaceutical product within the meaning of PHL 4900(5) (b) (B) that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
  - A rare disease treatment for which the member’s attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to the member than the requested service, the requested service is likely to benefit the member in the treatment of the member’s rare disease and such benefit outweighs the risk of the service. In addition, the attending physician must certify that the member’s condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year; or
  - A clinical trial for which the member is eligible; and
  - The specific health service or procedure recommended by the attending physician. An external appeal must be submitted within four months upon receipt of the FAD, regardless of whether or not a second level appeal is requested.

Furthermore, the physician’s certification must include a statement of the evidence relied upon by the physician in certifying their recommendation, and an external appeal must be submitted within 4 months upon receipt of the FAD, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.
**Claims Process**

**Time frame for Claims Submission**
In order to be considered timely, physicians, other health care professionals and facilities are required to submit claims within the specified period from the date of service:

- Connecticut - 90 days from date of service.
- New Jersey - 90 days from date of service OR 180 days from date of service if submitted by a New Jersey participating physician for a New Jersey Line of Business member.
- New York - 120 days from date of service.

The claims filing deadline is based on the date of service on the claim. It is not based on the date the claim was sent or received. Claims submitted after the applicable filing deadline will not be reimbursed; the stated reason will be “filing deadline has passed” or “services submitted past the filing date” unless one of the following exceptions applies.

**Exceptions:**
- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, the agreement will govern.
- If coordination of benefits has caused a delay, you will have 90 days from the date of the primary carrier Explanation of Benefits to submit the claim to us.
- If the member has a health benefit plan with a specific time frame regarding the submission of claims, the time frame in the member’s Certificate of Coverage will govern. If a claim is submitted past the filing deadline due to an unusual occurrence (e.g., provider illness, provider’s computer breakdown, fire, or flood) and the care provider has a historical pattern of timely submissions of claims, the care provider may request reconsideration of the claim.

**Clean and Unclean Claims, Required Information for all Claim Submissions**
For complete details and required fields for claims processing, please go to [OxfordHealth.com > Providers or Facilities > Tools and Resources > Administrative Tools & Information > Claims > Claims Submission Information](#). Appropriate state and federal guidelines are applied to determine whether the claim is complete and can be processed.

**Time Frame for Processing Claims**
The state-mandated time frames for processing claims for our fully insured members are listed below. The time frames are applied based upon the site state of the member’s product.

- Connecticut - 45 days (paper and electronic)
- New Jersey - 40 days (paper), 30 days (electronic)
- New York - 45 days (paper), 30 days (electronic)

We strive to process all complete claims within 30 days of receipt. If you have not received an explanation of benefits (EOB)/remittance advice within 45 days, and have not received a notice from us about your claim, please verify that we have received your claim.

**Hospitals and Ancillary Facilities**
A member must be enrolled and effective with us on the date the hospital and ancillary service(s) are rendered. Once the facility verifies a member’s eligibility with us (we will maintain a system for verifying member status), that determination will be final and binding on us, except to the extent the member or group made a material misrepresentation to us or otherwise committed fraud in connection with the eligibility or enrollment.

If an employer or group retroactively dis-enrolls the member up to 90 days following the date of service, we may deny or reverse the claim. If there is a retroactive disenrollment for these reasons, the facility may bill and collect payment for those services from the member or another payer. Furthermore, a member must be referred by a participating physician to a participating facility within their applicable network. Network services require an electronic referral or prior authorization, in accordance with the member’s benefits.

**Requirements for Claim Submission with Coordination of Benefits (COB)**
Under COB, the primary benefit plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary benefit plan pays the difference between the allowable expense and the amount paid by the primary plan, provided this difference does not exceed the normal plan benefits which would have been payable had no other coverage existed.

If Oxford is secondary to a commercial payer, you should bill the primary insurance company first and when you receive the primary carrier’s explanation of benefits (EOB)/remittance advice, submit it to us along with the claim information. These claims must be submitted using paper claim with primary remittance advice attached. Oxford secondary claims cannot be sent electronically.

We participate in Medicare Crossover for all of our members who have Medicare primary. This means Medicare will automatically pass the remittance advice to us electronically after the claim has been processed. We can process the claim as secondary without a claim form or remittance advice from your office.

**Note:** If Medicare is the secondary payer, you must continue to submit the claim to Medicare. We cannot crossover in reverse.
Determining the Primary Payer Among Commercial Plans
When a member has more than one commercial health insurance policy, primary coverage is determined based upon model regulations established by the National Association of Insurance Commissioners (NAIC).

1. **COB provision rule**: The benefit plan without a COB provision is primary.

2. **Dependent/non-dependent rule**: The benefit plan that covers the individual as an employee, member or subscriber or retiree is primary over the benefit plan that covers the individual as a dependent.

3. **Birthday rule**: The “birthday rule” applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s).

4. **Custody/divorce decree rule**: If the parents are divorced or separated, the terms of a court decree will determine which benefit plan is primary.

5. **Active or inactive coverage rule**: The benefit plan that covers an individual as an employee (not laid off or retired) or as that employee’s dependent is primary over the benefit plan covering that same individual as a laid off or retired employee or as that employee’s dependent.

6. **Longer/shorter length of coverage rule**: If the preceding rules do not determine the order of benefits, the benefit plan that has covered the person for the longer period of time is primary.

Coordinating with Medicare Benefit Plans
We will coordinate benefits for members who are Medicare beneficiaries according to federal Medicare program guidelines.

We have primary responsibility if any of the following apply to the member:

- 65 or older, actively working and their coverage is sponsored by an employer with 20 or more employees
- Disabled, actively working and their coverage is sponsored by an employer with 100 or more employees
- Eligible for Medicare due to end stage renal disease (ESRD) and services are within 33 months of the first date of dialysis.

Reimbursement Claim Components

**Modifiers**: Modified procedures are subject to review for appropriateness in accordance with the guidelines outlined in our policies. For complete details regarding the reimbursement of recognized modifiers, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > Modifier Reference Policy.

**Global surgical package (GSP)**: A global period for surgical procedures GSP may be found in the following for complete details on OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > Global Days Policy.

**Fee schedules**: Although our entire fee schedule is proprietary and cannot be distributed, we will, upon request, provide our current fees for the top codes you bill. Provider Services is available to provide this information and to answer questions regarding claims payment.

**Release of information**: Under the terms of HIPAA, we have the right to release to, or obtain information from, another organization in order to perform certain transaction sets.

**Requests for additional information**: There are times when we will request additional information to process a claim. The requested information must be submitted promptly as outlined in the request. If it is not submitted within 45 days an appeal must be submitted with the information.

**Reimbursement Address, phone or TIN changes**: An accurate billing address is necessary for all claims logging and payment as well as mailings that may go out. It is critical that you notify us of any changes. For instructions and forms on how to do so, refer to Oxfordhealth.com > Providers or Facilities > Tools & Resources > Forms > Provider Demographic Change Form.

**PCP/Specialist reimbursement**: All PCPs and specialists agree to accept our fee schedule and the payment and processing policies associated with the administration of these fee schedules.

**Hospital reimbursement**: We will reimburse hospitals for services provided to members at the rates established in the attachment of the hospital contract.

**Ancillary facility reimbursement**: We will reimburse ancillary health care professionals for services provided to members at the rates established in the fee schedule or in attachment or schedule of the ancillary contract.

**Additional Copies of EOBs/remittance advice**: Should you misplace a remittance advice and need another copy, you can obtain one by performing a claims status inquiry on OxfordHealth.com > Providers or Facilities > Transactions > Check > Claims.
New York Health Care Reform Act of 1996 (HCRA)
The enactment of the HCRA, in part, created an indigent care (bad debt and charity care) pool to support uncompensated care for individuals with no insurance or who lack the ability to pay. As a result of this act, the New York Bad Debt and Charity (NYBDC) surcharge is applied on a claim-by-claim basis. The NYBDC surcharge applies to most services of general facilities and most services of diagnostic and treatment centers in New York. The physician’s or other health care professional’s obligation is to:

• Understand their eligibility as it relates to HCRA
• Know what services are surchargeable services, and bill such services accordingly

For additional information on HCRA, physicians and other health care professionals should reference the New York Department of Health’s website: health.ny.gov > Laws and Regulations (on the right under Site Contents) > Health Care Reform Act.

Member Billing

Balance Billing Policy
Facilities, physicians and other health care professionals in our network are contracted with Oxford to provide specific services to members. Care providers who are participating with Oxford are subject to all Oxford referral, precertification and privileging policies and procedures and may not bill members for unpaid charges related to covered services except for applicable copays, co-insurance, or permitted deductibles. This includes balance billing a member for a covered service that was denied by Oxford because there was no referral or authorization on file with Oxford when one was required.

Exceptions: The instances in which you are authorized to balance bill a member are listed below. (You are still required to follow Oxford’s privileging, referral and/or precertification requirements.) In these instances, you may balance bill the member billed charges. To the extent that the terms and conditions of your contract conflict with these guidelines the terms and conditions of your contract shall prevail. You may balance bill a member when:

• A service or item is not a covered benefit (i.e., the service is excluded in the “Exclusions and Limitations” section of the member’s Certificate of Coverage); or
• The benefit limit, if any limit is applicable, is exceeded/exhausted; or
• Oxford denied a request for precertification, prior to the service being rendered, and the member proceeded to receive the service anyway; or
• Oxford denied a concurrent certification request (i.e., the member is currently receiving the service) and you obtained the member’s signature to a clear, written statement that the service is not covered, and acknowledging s/he would be responsible for the cost of the service, prior to the service being rendered; or
• If you do not participate in a member’s network, and a member self refers to you (i.e., Liberty member self refers to you and you do not participate in Oxford Liberty Network). In this instance, if you participate in our W500 network, you may only bill up to your contracted rate for emergent services.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact us and obtain coverage determination before seeking payment from a member. You are prohibited from balance billing the member for covered services when claims are denied for administrative reasons (lack of referral or authorization when one was required, etc.). In the event that a member has been inappropriately balance billed by a care provider, the member has the right to file a complaint or grievance, verbally or in writing, regarding the balance billing. Participating care providers who repeatedly violate these restrictions on billing Oxford members will be subject to discipline up to and including termination of their provider participation agreement. Ultimately, if a care provider inappropriately balance-bills a member, Oxford will hold the member harmless and pursue the matter directly with the care provider.

Member Out-of-Pocket Costs
Out-of-pocket amounts for outpatient and inpatient care vary by group, type of physician or other health care professional and type of benefit plan. Please check the member’s health care ID for the out-of-pocket cost specific to their benefit plan.

Claims Recovery, Appeals, Disputes and Grievances
See Claim Reconsideration, Appeals Process and Resolving Disputes found in Chapter 8: Our Claims Process for general appeal requirements.

Claims Recovery
The following information applies to physicians, but does not apply to facilities or ancillaries.

Oxford periodically requests that care providers return overpayments as a result of either:

• Administrative reasons: Duplicate payments, payments relating to fee schedules or billing/bundling issues, payments made where Oxford was not the primary insurer; or
• Behavioral issues: Upcoding, misrepresentation of service provided, services not rendered at all, frequent waiver of Member financial responsibility.

Oxford may pursue such claim overpayments as permitted by law and following the applicable statute of limitations (usually six years). We use random sampling, examination
by external experts, and reliable statistical methods to
determine claim overpayments in situations involving large
volumes of potentially overpaid claims.

**Note:** Once a care provider is given notice, we will initiate
discussions and take actions during the following one year
period.

We will not pursue collection of overpayments from
individual participating care providers when overpayments
are identified as isolated mistakes or where the care
provider is not at fault, if the overpayments were more than
one year prior to the date of notice of the overpayment or
use extrapolation. Examples include overpayments related
to duplicate claims, fee schedule issues, isolated situations
of incorrect billing/unbundling, and claims paid when
Oxford was not the primary insurer.

Exception: Oxford will pursue collection of overpayments
beyond one year and utilize statistical methods and
extrapolation in situations where:

1. Oxford has a reasonable suspicion of fraud or a
   sustained or high level of billing errors related to:
   - Extensive or systemic upcoding
   - Unbundling
   - Misrepresentation of services or diagnosis
   - Services not rendered
   - Frequent waiver of member financial responsibility
   - Misrepresentation of care provider rendering the
services or licensure of such care provider, and
   similar issues
2. A care provider affirmatively requests additional
   payment on claims or issues older than one year
3. The Centers for Medicare and Medicaid Services makes
   a retroactive change to enrollment or to primary versus
   secondary coverage of a Medicare benefit plan enrollee

**Participating Provider Claims Reconsiderations and Appeals**

Our administrative procedures for members with an Oxford
product require facilities, physicians or other health care
professionals participating in our network to file a claim
reconsideration and/or appeal before proceeding to
arbitration under their contract.

**Claim Reconsideration**

See **Claim Reconsideration, Appeals Process and
Resolving Disputes** found in **Chapter 8: Our Claims Process**
for general reconsideration requirements and submission
steps. Continue below for Oxford specific requirements.

1. **Pre-Appeal Claim Review**
   Before requesting an appeal determination contact us,
verbally or in writing, and request a review of the claims
payment. We make every effort to clarify or explain
our actions. If we determine that additional payment
is justified, we will reprocess the claim and remit the
additional payment.

2. **Who Can Submit a Reconsideration or Appeal**
   A. Participating care providers appealing a decision
      on their own behalf, according to the terms of their
      agreement with us.
   B. Any care provider or practitioner when appealing
      on behalf of the member, with signed member
      consent. You must follow the process for
      member administrative claims appeals. Refer to
      OxfordHealth.com > Providers or Facilities > Tools &
      Resources > Medical and Administrative Policies
      > Medical & Administrative Policy Index > **Member
      Administrative Grievance and Appeal (Non
      Utilization Management) Process and Timeframes**.

3. **Timeframe for Submitting a Reconsideration or Appeal**
   A. **Claim Reconsideration and Appeal Process**
      If you disagree with the way a claim was processed,
      or need to submit corrected information, you must
      file your reconsideration and/or appeal request
      of an administrative claim determination within 12
      months (or as required by law or your participation
      agreement) from the date of the original Explanation
      of Benefits (EOB) or Provider Remittance Advice
      (PRA). You must include all relevant clinical
      documentation, along with a **Participating Provider
      Review Request Form**.

      The two step process described in the Claim
      Reconsideration and Appeal Process allows for a
total of 12 months for timely filing – not 12 months
      for step one and 12 months for step two. If an appeal
      is submitted after the time frame has expired, Oxford
      will uphold the denial.

      Exceptions: There are separate processes for New
      Jersey (NJ) Participating Providers and Unilateral Coding
      Adjustments for New York Hospitals. Refer to the **New
      Jersey Participating Provider Appeal Process** and Unilateral
      Coding Adjustments for New York Hospitals sections below
      for additional information.

      1. **Step One – Reconsideration Level:** The request
         must include the **Claim Reconsideration Form**
         (located on line at: UnitedHealthcareOnline.com
         > Tools & Resources > Forms) and all supporting
         documentation. If the reconsideration does not
         result in an overturned decision, the EOB or
         response letter will include next level rights and
         where to submit a request for further review.

      2. **Step Two – Appeal Level:** Participating care
         provider and practitioner appeals must be
         submitted in writing within the same 12 month
         time frame, as stated above. The appeal must
         include all relevant documentation including a
         letter requesting a formal appeal and a
         **Participating Provider Review Request Form**. If the
appeal does not result in an overturned decision, the care provider must review their contract for further dispute resolution steps.

B. New Jersey Participating Provider Appeal Process

New Jersey (NJ) participating care providers are subject to the NJ state-regulated appeal process. If a NJ participating care provider has a dispute relating to payment of a claim involving a NJ commercial member, the dispute is eligible for an individual two step process.

1. First Level: The first level appeal is made through Oxford’s internal appeal process. A written request for appeal must be submitted by the
Health Care Provider Application to Appeal a Claims Determination Form created by the NJ Department of Banking and Insurance. This appeal must be submitted within 90 days of the date on Oxford’s initial determination notice to:

UnitedHealthcare
Attn: Provider Appeals
P.O. Box 29136
Hot Springs, AR 71903

The review will be conducted and results communicated to the care provider in a written decision within 30 calendar days of receipt of all the material necessary for such appeal.

2. Second Level: The second level appeal must be made through the external dispute resolution process. If a NJ participating care provider has completed the internal appeal process and is not satisfied with the results of that internal appeal, the care provider has the right under their contract to arbitrate the dispute with Oxford. Care providers should submit their request to:

MAXIMUS, Inc.
Attn: New Jersey PICPA
50 Square Drive, Suite 210
Victor, NY 14564

Requests may be submitted by fax to 585-425-5296 (MAXIMUS, Inc. requests that faxes be limited to 25 pages).

Consult your contract to determine the appropriate arbitration authority. Most such contracts provide for arbitration before the American Arbitration Association (AAA). The costs of arbitration are borne equally by the participating care provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration is binding on the participating care provider and Oxford, pursuant to the terms of the care provider agreement. To commence arbitration, the care provider must file a statement of claim with the AAA at the address listed above.

C. Unilateral Coding Adjustments for New York Hospitals

If a New York hospital receives a remittance advice/payment indicating that Oxford has adjusted payment based on a particular coding (i.e.; assignment of diagnosis and or CPT/HCPCS or other procedure code), the hospital has the right to resubmit the claim, along with the related medical record supporting the initial coding of the claim, within 30 days of receipt/ notification of payment. Oxford must review the medical records within the normal review timeframes (45 days). If Oxford’s initial determination:

• Remains unchanged, the insurer’s decision must be accompanied by a statement providing the specific reasons why the initial adjustment was appropriate.

• Changes and the payment is increased based on the information submitted by the hospital, Oxford must provide the additional reimbursement within the 45 day review timeframe.

If Oxford fails to provide the additional reimbursement within the 45 day review timeframe, Oxford must pay to the hospital interest on the amount of the increase. The interest must be computed from the end of the 45 day period after resubmission of the additional medical record information.

Note: Neither the initial or subsequent processing of the claim by Oxford may be considered an adverse determination if it is based solely on a coding determination.

IV. Method for Submitting a Reconsideration or Appeal

Written Appeals - Utilize Oxford’s Participating Provider Claim(s) Review Request Form to determine the appropriate mailing address.

There are separate processes for the following appeal types:

• Internal and external claims payment appeals for NJ participating care providers who treat NJ commercial members (above).

• The appeal of unilateral coding adjustments made to New York Hospital claims (above)

V. Appeal Decision and Resolution

Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file (paper or electronic). Written notification to the care provider will be issued by means of a letter or updated Remittance Advice (RA) statement at the time of determination of the appeal. This decision will constitute Oxford’s final internal decision. If the care provider is not satisfied with Oxford’s decision, they may arbitrate the issue as set forth in their contract with Oxford. Refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies >
Medical & Administrative Policy Index > Timeframe Standards for Benefit Administrative Initial Decisions.

VI. Arbitration
If the physician wants to file for arbitration after the first level appeal has been completed, the physician must file a statement of claim with the AAA at the following address:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue 4th Floor
East Providence, RI 02914
Phone: 800-293-4053

Care providers located outside of NY, NJ and CT should refer to the AAA web site (adr.org) for submission guidelines.

- Participating physicians who are appealing an adverse determination are entitled under their care provider contract to bring the issue before the American Arbitration Association (AAA). They have this right only under the following circumstances:
  1. The first level internal grievance process has been completed.
  2. The appeal is on their own behalf (not on behalf of the member).
- Participating hospitals and ancillary facilities also have arbitration rights but those rights vary depending on contracts. If a hospital or ancillary facility calls to inquire about arbitration rights, they should be referred to their contract for the specific arbitration entity. Hospitals and ancillary facilities still must utilize the first level internal appeal process.

How to Request a Claim Correction or Reconsideration
See the How to Contact Oxford Commercial section at the beginning of this supplement for contact information related to Claims – Corrections & Reconsiderations.

New York State-Regulated Process for External Review
For participating physicians and other health care professionals treating New York members, this external appeals process applies only to services provided to commercial members who have coverage by virtue of a HMO or insurance benefit plan licensed in New York State. This appeals process does not apply to the self-funded line of business. Care providers cannot use this process unless there is written consent from the member or it is a case involving retrospective review. If the care provider’s agreement includes arbitration language or alternate dispute language, the care provider must follow that process and the external review process is no longer an option for dispute resolution.

External Appeal Process
If the Clinical Appeals department upholds all or part of such an adverse determination, the member or their designee has the right to request an external appeal. An external appeal may be filed when:

1. The member has had coverage of a health care service denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary, but otherwise would have been a covered benefit, and
2. We have made a final adverse determination regarding the requested service, or
3. UnitedHealthcare and the member have both agreed to waive any internal appeal.

All external appeal requests may be sent to the following:
New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209
Phone: 800-400-8882
Fax: 800-332-2729

Medical Necessity Appeals
Standard Medical Necessity Appeals Process
If members or their designees would like to file an appeal, they must hand-deliver or mail a written request within 12 months of receiving the initial denial determination notice to:
Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

Expedited Medical Necessity Appeals Process for Members:
- Members have the right to request an expedited appeal.
- In order to request an expedited appeal, the member or physician or other health care professional must state specifically that the request is for an expedited appeal.
- The Clinical Appeals department will determine whether or not to grant an expedited request.
- If the Clinical Appeals department determines that the request does not meet expedited criteria set by the Clinical Appeals department the member will be notified.

Benefit Appeals
Appeals of benefit denials issued by the Clinical Services and Disease Management departments are handled by the Clinical Appeals department.

Administrative Appeals (Grievances)
Administrative appeals without the Clinical Services department’s involvement are handled by the member appeals unit. If a member would like to file an appeal on a claim determination, they must mail all administrative appeals UnitedHealthcare Grievance Review Board. See How to Contact Oxford Commercial section for address information.
Second-level Member Appeals

Members have the right to take a second-level appeal* to our Grievance Review Board (GRB). If they remain dissatisfied with the first-level appeal determination, they may request a second-level appeal. Members with a CT line of business do not have the option of submitting a second-level appeal request for a benefit or administrative issue. The request for appeal and any additional information must be submitted to the UnitedHealthcare Grievance Review Board. See How to Contact Oxford Commercial section for address information.

External Appeal Process for Members

New York, New Jersey and Connecticut members have the right to appeal a medical necessity determination to an external review agent. They can file a consumer complaint with one of the following applicable regulatory bodies. The applicable regulatory body is determined by the state in which the member’s certificate of coverage was issued, not where the member resides.

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<td>Hartford, CT 06142-0816</td>
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<td>New Jersey</td>
<td>Division of Insurance Enforcement and Consumer Protection</td>
<td>20 West State Street</td>
<td>609-292-5316</td>
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<td>P.O. Box 329</td>
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<td>609-292-5865</td>
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<td>Consumer Protection Services Dept. of Banking and Insurance</td>
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<td>Trenton, NJ 08625-0329</td>
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<td>New York</td>
<td>Consumer Services Bureau</td>
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<td>25 Beaver Street</td>
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<td>212-480-6400</td>
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<td>Office of Managed Care Certification and Surveillance New York Department of Health</td>
<td>Corning Tower, Room 1911 Empire State Plaza Albany, NY 12237</td>
<td>518-474-2121</td>
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*In New York, a second-level appeal is not required by us in order to be eligible for an external appeal.

New York Notice of Care Provider Contract Termination and Appeal Rights

UnitedHealthcare will immediately remove any health care provider from the network who is unable to provide health care services due to a final disciplinary action.

A health care provider cannot be prohibited from, nor may the UnitedHealthcare terminate or refuse to renew a contract solely for the following:

- Advocating on behalf of a member,
- Filing a complaint against UnitedHealthcare,
- Appealing a decision made by UnitedHealthcare,
- Providing information or filed a report pursuant to PHL4406- c regarding prohibitions, or
- Requesting a hearing or review.

We grant physicians and certain health care professionals the right to appeal certain disciplinary actions imposed by us.

The appeals process is structured so that most appeals for terminations, not including non-renewal of the physician’s contract with us, can be heard prior to disciplinary action being implemented.

A physician or health care professional may request an appeal (fair hearing or review) after UnitedHealthcare takes adverse action to restrict, suspend or terminate a physician or health care professional’s ability to provide health care services to UnitedHealthcare members for reasons relating to the professional competence or conduct that adversely affects or could adversely affect the health or welfare of a member.

A notice will be provided within 30 calendar days after the adverse action is taken that will include the following:

1. UnitedHealthcare has determined an adverse action is necessary and the final action will be reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and appropriate state licensing board.

2. A description of and reason for the action.

3. Right to request an appeal in writing within 30 calendar days after receipt of the notice. Failure to file such request shall constitute a waiver of all right to the appeal process, unless such a right is provided under applicable state law.

4. A summary of the physician’s or health care professional’s appeal rights provided.

After receipt of a request for an appeal, the physician or health care professional will be notified of the fair hearing or review date within 30 calendar days of the receipt of request for appeal, or within the timeframe required by applicable state law. The fair hearing or review will take place within 30 calendar days of the receipt of the appeal.
place within 60 calendar days of the date UnitedHealthcare receives the request for appeal, or within the timeframe required by applicable state law.

The hearing panel will be comprised of at least three persons appointed by the UnitedHealthcare. At least one person on the panel will have the same discipline or same specialty as the care provider under review. The panel may consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total panel membership.

The hearing panel will render a decision in a timely manner. Decisions will be provided in writing and include one of the following:
1. Reinstatement; or
2. Provisional reinstatement with conditions set forth by us, or
3. Termination.

Quality Assurance

Medical Records Requirements
As a participating physician or other health care professional, you are required to provide us with copies of medical records for our members within a reasonable time period following our request for the records. We may request such records for various reasons, including an audit of your practice. Such an audit can be performed at our discretion and for several different purposes, as we deem appropriate for our business needs.

Standards for Medical Records
A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. Our recommended medical record standards are published each November for commercial benefit plans in the Network Bulletin found here: OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Network Bulletin. Our requirements include, but are not limited to:
• Separate medical record for each member
• The record verifies that the PCP coordinates and manages care
• Medical record retention period of six years after date of service rendered and for a minor, three years after majority or six years after the date of the service, whichever is later.
• (Prenatal care only): A centralized medical record for the provision of prenatal care and all other services

Transferring Member medical Records
If you receive a request from a member to transfer their medical records, please do so within seven days to help ensure continuity of care. In order to safeguard the privacy of the member’s records, please mark them as “Confidential” and be sure that no part of the record is visible during the transmission.

Electronic Medical Records (EMR)
EMR is any type of electronic concurrent medical information management system. This process improves efficiency and quality of patient care through integrated decision support which allows for better information storage, retrieval and data sharing capabilities. EMR systems allow physicians, nurses and other health care staff to be able to access and share information smoothly and quickly, to enable them to work more efficiently and make better quality decisions.

UnitedHealthcare’s Credentialing and Re-credentialing Notifications
We complete our credentialing process and give notification of the results within 90 days of receiving a completed application. The notification will tell you whether you are credentialed, if additional time is needed, or that UnitedHealthcare is not in need of additional providers at this time. If additional information is needed we will notify the applicant ASAP, but no more than 90 days from the receipt of the application.

Healthcare Provider Performance Evaluations
UnitedHealthcare is required to provide health care professionals with any information and profiling data used to evaluate your performance. On a periodic basis and upon your request we will make available the information, profiling data and analysis used to evaluate your performance. You will be given the opportunity to discuss the unique nature of your patient population which may have bearing on your profile and we will work with you to improve your performance as needed.

Case Management and Disease Management Programs
We have created a number of programs designed to improve outcomes for our members and to allow us to better manage the use of medical services. Practitioners may refer members to these programs, or members may self-refer.

For more information, go to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Managing Disease or by calling our Member Service Department.

Case Management and Disease Management Programs Referrals
You may refer members, or members may self-refer to several Case Management and Disease Management programs. These programs are designed to improve outcomes for members and to allow us to better manage the use of medical services.
The following are comprehensive Case Management/Disease Management programs supported by registered nurses.

For more information please refer to

**Cancer Support Program™ (CSP)**

As of Jan. 1, 2017, the CSP is a clinical nurse case management program which is available to all fully insured and Administrative Services Only (ASO) Oxford members regardless of age, who are diagnosed with cancer or end-stage management and are not in hospice. This program is managed by Optum.

**Transplant Program**

Optum is contracted to manage all aspects of every transplant including prior authorization and coordination of services.

**Managed Infertility Program**

Optum is contracted to manage infertility services for Oxford customers including prior authorization, coordination of services, and recommendations to Optum Infertility Centers of Excellence.

**Healthcare Effectiveness Data and Information Set (HEDIS) measures**

The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). NCQA is an independent group established to provide objective measurements of the performance of managed health care benefit plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates, as well as each benefit plan's financial status.

HEDIS measures have become key criteria that employers, consultants, the CMS (Center for Medicare and Medicaid Services), state regulators (commercial), and prospective members use to evaluate the demonstrated value and quality of different health plans.

Each year we collect data from a randomly selected sample of our members' medical records for HEDIS. HEDIS is mandated by the New York Department of Health, New Jersey Department of Health and Senior Services, Connecticut Department of Health, and the CMS. The HEDIS medical record study measures our participating physicians' adherence to nationally accepted clinical practice guidelines.

**Clinical Process Definitions**

Some services may be subject to prior authorization and/or ongoing medical necessity reviews.

**Acute Hospital Day**

An acute hospital day (AHD) is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high and care cannot reasonably be provided safely in another setting.

**Alternative Level of Care (ALC)**

We will determine that an inpatient ALC applies in any of the following scenarios:

- An acute clinical situation has stabilized.
- The intensity of services required can be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the member’s physician or other health care professional.
- Inpatient ALC must meet the following criteria: *

  › The skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required; and
  › Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

**New Technology**

New technology refers to a service, product, device, or drug that is new to our service area or region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

**Potentially Avoidable Days**

A potentially avoidable day (PAD) arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. PADs must be followed by a medically necessary service.

There are several types of PADs:

- **Approved potentially avoidable day (AOPAD):** We caused delay in service; the day will be payable.
- **Approved physician or other health care professional potentially avoidable day (APPAD):** The physician or other health care professional caused delay in service; the day will be payable.

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*ALC only applies if the facility has a contracted rate.

* *Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.
• Approved mixed potentially avoidable day (AMPAD):
  A delay due to mixed causes not solely attributable to
us, the physician, other health care professional, or the
hospital; the day will be payable.
• Denied hospital potentially avoidable day (DH PAD):
  The hospital caused the delay in service; DH PAD is a
non-certification code, and the day is not payable.

We will not reverse any certified day unless the decision to
certify was based on erroneous information supplied by the
physician or other health care professional, or a potentially
avoidable day was identified.

Re-Admissions
When a member is readmitted to the hospital for the same
clinical condition or diagnosis within 30 days of discharge,
the second hospital admission will not be reimbursed when
any of the following conditions apply:
• The member was admitted for surgery, but surgery was
canceled due to an operating room scheduling problem.
• A particular surgical team was not available during the
first admission.
• There was a delay in obtaining a specific piece of
equipment.
• A pregnant woman was readmitted within 24 hours
and delivered.
• The member was admitted for elective treatment for a
particular condition, but the treatment for that condition
was not provided during the admission because another
condition that could have been detected and corrected
on an outpatient basis prior to the admission made the
treatment medically inappropriate.

In any of the situations noted above, the hospital cannot
bill the member for any portion of the covered services not
paid for by us.

Diagnosis-Related Group (DRG) Hospitals
DRG is a statistical system of classifying an inpatient stay
into groups of specific procedures or treatments. When
a hospital contracts for a full DRG, we will reimburse the
hospital a specific amount (determined by the contract)
based on the billed DRG rather than paying a per diem
or daily rate (DRG facility). A DRG is determined after the
member has been discharged from the hospital.

When admission information is received through our
website, we will consider this to be notification only; first
day approval will not be granted to hospitals with a DRG
contract. When we receive notification of an admission to a
hospital with a DRG contract, our Case Manager will review
the admission for appropriateness. If the Case Manager
cannot make a determination based on the admitting
diagnosis, the Case Manager will request an initial review to
determine whether the admission is medically necessary.
The hospital is required to provide admission notification
and a daily inpatient census of all our members.

Prepayment DRG Validation Program
We may request a DRG hospital to send the inpatient
medical record prior to claim payment so we may validate
the submitted codes. After review of all available medical
information, the claim will be paid based on the codes that
have been substantiated following review of the medical
record. See the Claims Recovery, Appeals, Disputes and
Grievances section of this supplement for Appeal Rights.

Hospital records may be requested to validate ICD-10-CM
or its successor codes and/or revenue codes billed by
participating facilities for inpatient hospital claims. If the
billed ICD-10-CM codes (or successor codes) or revenue
codes are not substantiated, the claim will be paid only with
the validated codes.

Disposition Determination
A disposition determination is a technical term describing
a process of care determination that results in payment
as agreed at specific contracted rates, and is designed to
eliminate certain areas of contention among participating
parties and allow processing of claims. Specific instances
where a disposition determination may apply:
• Delay in hospital stay
• APPAD/AMPAD when so contracted
• ALC determinations when so contracted, unless there is
  a separate ALC rate
• Discharge delays that prolong the hospital stay under a
case rate

Late and No Notification
Late notification is defined as notification of a hospital
admission after the contracted 48-hour notification period
and prior to discharge. No notification is defined as failure
to notify us of a member’s admission to a hospital after
discharge, up to and including at the time of submitting
the claim.

Mental Health and Substance Use Services
The behavioral health department specializes in the
administration of mental health and substance use
benefits. The department consists of a Medical Director
who is licensed in psychiatry, facility care advocates
(licensed RNs and licensed/certified social workers) and
intake staff who collectively handle certification, referrals
and case management for our members.

We encourage coordination of care between our
participating behavioral health clinicians and primary
care physicians as the best way to achieve effective and
appropriate treatment. For this purpose, we developed
a Release of Information (ROI) Form that is designed to
facilitate member consent and to share information with
the PCP in the presence of their behavioral health clinician.
See the How to Contact Oxford Commercial section for
telephone numbers.
Clinical Definitions and Guidelines
The behavioral health department uses the Optum Level of Care Guidelines when determining the medical necessity of inpatient psychiatric, partial hospitalization substance abuse treatment and rehabilitation, and outpatient mental health treatment. For a complete list of programs and detailed information on the level of care guidelines visit the Optum network website at providerexpress.com.

Inpatient Mental Health
Inpatient (or acute) care for a mental health condition is indicated when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention.

Partial Hospitalization - Mental Health
Partial hospitalization for mental health treatment involves day treatment of a mental health condition at a hospital or ancillary facility with the following criteria:
• The primary diagnosis is psychiatric.
• The facility is licensed and accredited to provide such services.
• The duration of each treatment is four or more hours per day.

Residential Treatment
Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for members who do not require acute inpatient care but who do require 24-hour structure.

Outpatient Mental Health
Psychotherapeutic approaches to treatment of mental health conditions, including methods from different theoretical orientations (e.g., behavioral, cognitive, and interpersonal) may be administered to an individual, family or group on an outpatient basis.

Inpatient Detoxification
Inpatient detoxification is defined as the treatment of substance dependence to treat a life-threatening withdrawal syndrome, provided on an inpatient basis.

Outpatient Substance Use Rehabilitation
Outpatient substance use rehabilitation is defined as the treatment of a substance use disorder including dependence at an accredited, licensed substance use treatment facility.

Member Rights and Responsibilities
For the entire list of Member Rights and Responsibilities, go to UHC.com > Individuals & Families > Member Resources > Legal > Annual Member Notices, select any code.

Medical and Administrative Policy Updates
The contents of this supplement are subject to change and will be amended annually to reflect changes in policies or as required by regulation. A complete library of Oxford’s Clinical, Administrative and Reimbursement Policies is available for your reference at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index. You can also request a paper copy of a Clinical, Administrative or Reimbursement Policy by writing to:
Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Policy Update Bulletin
Oxford publishes monthly editions of the Policy Update Bulletin, a user-friendly online resource that provides notice to our network physicians and facilities of any changes to our Clinical, Administrative and Reimbursement Policies. The Policy Update Bulletin is posted on the first calendar day of every month and is accessible online at OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin. As a supplemental reminder to the detailed policy update summaries announced in the Policy Update Bulletin, a list of recently approved, revised and/or retired Clinical, Administrative and Reimbursement Policies is also included in the monthly Network Bulletin available at UnitedHealthcareOnline.com > Tools & Resources > News & Network Bulletin.
Eligibility

Check the back of the member health care ID card for steps on eligibility verification.

To help streamline processes for care providers, River Valley health benefit plans that are subject to this supplement are being administered on our core UnitedHealthcare claims processing system on their renewal date beginning on or after April 1, 2016.

All member River Valley benefit plans will have transitioned to the core UnitedHealthcare systems by March 31, 2017.

Member ID Cards

For members whose River Valley benefit plan has transitioned:

Members will have a new ID card with a new member ID number. The phone number, website and claims address for our core UnitedHealthcare systems are listed on the back. Use the new member ID number for claims with dates of service on or after the member transition date.

For members whose River Valley benefit plan has not transitioned:

The member health care ID card has a member ID number that begins with “JD”. On the back it lists the UnitedHealthcare of the River Valley website, phone number and claims address. Check eligibility online each time a member visits your office in case a member who has transitioned presents their old health care ID card.

The information in this supplement applies to River Valley benefit plans that are subject to this supplement, regardless of whether the benefit plan has transitioned to the core UnitedHealthcare system, unless otherwise indicated in this supplement. If you are unable to confirm whether a member’s River Valley benefit plan has transitioned to UnitedHealthcare system, call 877-842-3210 to check member eligibility.

Information Regarding the Use of this Supplement

This River Valley Entities (River Valley) Supplement applies to covered services rendered to River Valley Entities members other than Medicare Advantage, Medicaid and CHIP members.

This River Valley Supplement applies to physicians, health care professionals, facilities and ancillary providers in both of the following categories:

• Their UnitedHealthcare participation agreement includes a reference to the River Valley or John Deere Health protocols or Guides, or they have directly contracted with one or more of the River Valley Entities to participate in networks maintained for River Valley Entities members; and

• They are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Whiteside, Lee, Mercer, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford and McLean.

Benefit plans for River Valley members are sponsored, issued or administered by one of the following River Valley Entities:

• UnitedHealthcare Services Company of the River Valley, Inc.
• UnitedHealthcare Plan of the River Valley, Inc.
• UnitedHealthcare Insurance Company of the River Valley, Inc.

Our River Valley members can be identified by a reference to one of the legal entities listed above on the front of their health care ID card (bottom left).

Physicians, health care professionals, facilities and ancillary providers whose participation agreements do not subject them to this supplement (including, but not limited to, providers in Louisiana, North Carolina, Ohio and South Carolina) can disregard this information and work with us when providing services to River Valley members in the same way as you do when providing services to other UnitedHealthcare members. Information regarding a River Valley member, such as eligibility information and claims status information can be obtained by calling the telephone number on the back of the member’s health care ID card.

For protocols, policies and procedures not specified in this supplement refer to appropriate chapter in the preceding guide.

Refer to the UnitedHealthcare Community Plan administrative guides available at uhccommunityplan.com

> For Health Care Professionals for policies and procedures relating to the TennCare®, Iowa Medicaid/hawk-i®, and Secure Plus Complete Medicaid Plans®.
# How to Contact River Valley

Physicians, health care professionals, facilities and ancillary providers that practice in Illinois, Iowa and Wisconsin should refer to the “Midwest” references in the following grid. Physicians, health care professionals, facilities and ancillary providers that practice in Arkansas, Georgia, Tennessee and Virginia should refer to the “Southeast” references in the following grid.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
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| Provider Web sites:               | For members that have not transitioned (per ID card info): uyhrivervalley.com > Providers  
                                    | For members that have transitioned (per ID card info): UnitedHealthcareOnline.com and Link                                              |
| Claims Submission (Electronic)    | Medical claims payer ID: 87726  
                                    | Dental claims payer ID: 95378  
                                    | 866-509-1593 or RVITEDISolutions@uhc.com                                 |
| Claims Submission on paper        | For members who have not transitioned: UnitedHealthcare of the River Valley Commercial  
                                    | P.O. Box 5230  
                                    | Kingston, NY 12402-5230  
                                    | For members who have transitioned: UnitedHealthcare  
                                    | P.O.Box 740800  
                                    | Atlanta, GA 30374-0800 |
| Tax ID Numbers (TIN)/ Provider ID Numbers | 866-509-1593 or RVITEDISolutions@uhc.com                                      |
| Claim Reconsideration and Appeals | Refer to the Claim Reconsideration, Appeals Process and Resolving Disputes section in Chapter 8: Our Claims Process for online options, or mail to:  
                                    | For members who have not transitioned: UnitedHealthcare of the River Valley  
                                    | Attn: Appeals  
                                    | P.O. Box 5230  
                                    | Kingston, NY 12401-5230  
                                    | For members who have transitioned: UnitedHealthcare Appeals  
                                    | P.O. Box 30432  
                                    | Salt Lake City, UT 84130-0432  
                                    | Fax: 801-938-2100 |
| Electronic Payments and Statements (EPS)  | By enrolling in EPS, you can receive claims payments by direct deposit or virtual card payment and access your explanations of benefits (EOBs/remittance advice) online or through 835 ERA files. There’s no change to your posting method and no special software is required. To enroll in EPS, go to myservices.optumhealthpaymentservices.com/HowToEnroll.do and follow the instructions.  
                                    |  
                                    | The current EFT processes for UnitedHealthcare of the River Valley began to change April 1, 2016. If you are signed up for EFT for UnitedHealthcare of the River Valley but are not yet enrolled in EPS, you will begin receiving paper payments and remittance advices for these members once they are transitioned. To continue receiving your payments electronically, you will need to enroll in EPS.  
                                    |  
                                    |  
                                    | United Voice Portal:  
                                    | For members who have not transitioned: Illinois/Iowa/Wisconsin: 800-747-1446  
                                    | Tennessee/Virginia/Arkansas/Georgia: 800-224-6602  
<pre><code>                                | For members who have transitioned: 877-842-3210 |
</code></pre>
<table>
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<tr>
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<th>Where to go</th>
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| **Preauthorizations:** for procedures and services, except for those otherwise referenced below, including preauthorization for certain DME | For members who have not transitioned:  
Fax: 888-242-9058  
Phone: 800-747-1446 Ext: 65212  
Mail: UnitedHealthcare  
Attn: Clinical Coverage Review  
1300 River Drive, Suite 200  
Moline, IL 61265  
For members who have transitioned:  
Please submit your request [Online: UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Notifications/Prior Authorizations > Notification/Prior Authorization Submission.  
Phone: (Inpatient requests only) 877-842-3210, option 3, or the number on the back of the member’s ID card.  
Fax: 866-756-9733 (be sure to include place of service and CPT codes).  
Fax: 801-994-1083 |
| **Appeals (Urgent)** |  
Illinois/Iowa/Wisconsin: 800-747-1446  
Tennessee/Virginia/Arkansas/Georgia: 800-224-6602  
**Skilled/extended Care**  
Phone: Midwest: 800-747-1446  
Southeast: 800-224-6602  
Fax: Midwest: 888-534-3258  
Southeast: 800-880-5403  
**Pharmacy services/prescription drugs requiring preauthorization**  
Phone: 800-711-4555  
[uhcrivervalley.com](http://uhcrivervalley.com) > Pharmacy  
**Preauthorization for end-of-life care and home health care including infusion services**  
Phone: 800-747-1446 Ext: 65212  
Fax: 800-340-2184  
Mail: UnitedHealthcare  
Attn: Clinical Coverage Review  
1300 River Drive  
Moline, IL 61265  
**Out-of-network referrals**  
Phone: 800-747-1446 Ext: 65287  
Fax: 800-299-3779  
Mail: UnitedHealthcare  
Attn: Clinical Coverage Review  
1300 River Drive  
Moline, IL 61265  
**Notification of inpatient admissions**  
Phone: Midwest: 800-747-1446  
Southeast: 800-224-6602  
Fax: Midwest: 888-534-3258  
Southeast: 800-880-5403  
**Case Management/Utilization Management**  
For members who have not transitioned:  
Continue using the current process to initiate case management and utilization management.  
For members who have transitioned:  
If the member has a new health care ID card or is listed on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), they have transitioned to the core UnitedHealthcare systems. Please follow the new process to initiate case management and utilization management  
Congenital Heart Disease: 800-747-1446  
Kidney Resource Services: 800-747-1446  
Transplant Resource Services fax: 855-250-8157  
Ventricular Assist Devices: fax: 855-282-8929  
Congenital Heart Disease: 877-842-3210  
Kidney Resource Services: 888-936-7246  
Transplant Resource Services: 877-842-3210 or fax 855-250-8157  
Ventricular Assist Devices: 877-842-3210 or fax 855-282-8929  
**Disease Management**  
Phone: 800-369-2704, Option # 4 (Mon - Fri., 8a.m - 4:30p.m., CT)  
Fax: 866-950-7759, Attn: CMT Coordinator  
Email: [MailWebCDM@uhc.com](mailto:MailWebCDM@uhc.com)  
Online: [uhcrivervalley.com](http://uhcrivervalley.com) > Providers > Health Programs |
## Cardiology:
- Diagnostic Catheterization,
- Electrophysiology Implants
- Echocardiogram and Stress Echocardiogram

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<tr>
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<td>For members who have not transitioned:</td>
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<tr>
<td>Online: <a href="http://evicore.com">evicore.com</a></td>
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<tr>
<td>Phone: 866-889-8054</td>
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<tr>
<td>For members who have transitioned:</td>
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<tr>
<td>Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline</a> &gt; Clinician Resources &gt; Cardiology</td>
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<tr>
<td>Phone: 866-889-8054</td>
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For members who have transitioned, use [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) and Link to perform secure transactions for your patients, including checking member eligibility and benefits, managing claims and prior authorization requests. To learn more, visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Help.

## Provider e-Services for Members Who have not Transitioned
Our provider e-Services can be accessed at [uhcrivervalley.com](http://uhcrivervalley.com). You will find the following tools* that will allow you to quickly and efficiently obtain important and up-to-date information you need when providing services to our members.

### Claim Status Review
Locate specific claims using either your provider ID or a specific member’s ID and obtain a claim summary or line-item detail about claims status including whether we have received the claims and whether they have been paid, pended or denied.

### Benefits and Eligibility
Verify the eligibility of your patients before you see them and obtain information about their benefits including required copayments and any deductibles, out-of-pockets maximums or co-insurance for which your patients are responsible.

### PCP Roster
You may find a list of all members who have designated you as their Primary Care Provider.

### Registration for Provider e-Services (for Members Who have not Transitioned)
For additional information on the registration process, go to [uhcrivervalley.com](http://uhcrivervalley.com) > e-Services and select “Register Now!” or the link for providers under “Why use e-Services”.

Before you may use Provider e-Services, your office is required to designate a Security Administrator. The Security Administrator will be the primary contact with us and is responsible for maintaining access for all users in your office. An officer of your organization who has authority for the TINs and is seeking access to Provider e-Services should complete the Security Administrator Form identifying the Security Administrator. Submit the form online at: [uhcrivervalley.com](http://uhcrivervalley.com) > Providers > Providers e-Services > Register Now!

The Security Administrator will receive a user ID and password in separate letters by US mail seven to 10 days after submission.

For technical assistance or information, contact our e-Business department from 8 a.m. – 4:30 p.m. CT at 866-509-1593.

## Reimbursement Policies
In accordance with your agreement with us, payment of claims is subject to reimbursement policies, among other things. You may find these policies at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > Policies, Protocols and Guides > Reimbursement Policies – Commercial. Changes to our reimbursement policies are generally announced in the Network Bulletin available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > News & Network Bulletin.

We also apply coding edits procedures, based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS’ Outpatient Code Editor (OCE). You may find the NCCI edits and the OCE at [cms.gov](http://cms.gov) > Medicare > Coding > National Correct Coding Initiative Edits.

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* The tools for preparing, submitting and managing claims found on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), including the Claim Estimator are not available to River Valley members.
Referrals

Network Referrals
A network referral allows a member enrolled in a primary care coordinator (PCC) benefit plan to access care from a participating provider other than a PCP (for instance, a specialist) at the network benefit level. Additional information regarding network referrals for PCC benefit plans is provided in the sections below.

Referrals are required when we are the primary or secondary payer.

A referral does not guarantee payment of a claim.

Network Referral Process for Primary Care Coordinator (PCC) Plans
A network referral allows a member to access care from a participating provider other than a PCP (for instance, a specialist) at the network benefit level. Referral requests must originate from the member’s network PCP. The final decision concerning a referral will be the sole responsibility of the participating PCP. Specialist-to-specialist referrals are not allowed. If the treating specialist feels it is necessary for the member to see another specialist, they must contact the member’s PCP, who will be responsible for making all new referrals.

Standard Exceptions to the Network Referral Process
• Female members are allowed direct access to network OB/GYN providers without a referral.
• Members are allowed direct access to network ophthalmologists or contracted vision providers for an annual diabetic dilated eye exam, without a referral.
• Members with a split copayment (where the member has one copay amount for PCP visits and a higher copay amount for specialty visits) do not require a referral to see a network specialist.

Process to Facilitate Network Referrals for the Member:
• The PCP determines the need for a network referral to a network specialist, communicates this to the member, and sends a letter of referral or phones/faxes a referral to the consulting specialist. The PCP indicates in the referral what services they are requesting that the specialist provide.
• Service requests must be a covered benefit under the member’s benefit plan and must be made to participating care providers.
• To facilitate continuity and coordination of care, the referring PCP should provide timely communication of clinical information to the specialist. Likewise, the specialist should provide written communication to the member’s PCP, providing a description of health services rendered to the member.

Out-of-Network (OON) Referrals
An OON referral means a written authorization provided by a participating care provider and approved by us for services to be received from a non-participating provider. OON referrals must be requested by the member’s PCP.

If an OON referral is obtained, services received from a non-participating care provider are covered at a network level of benefits under the member’s benefit plan. An OON referral is needed when services are not available from a participating care provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance use services. To determine whether an OON referral is necessary under a member’s benefit plan, contact us at the number on the back of the member’s health care ID card. Additional information regarding OON referrals is provided in a section below.

Referrals are required when we are the primary or secondary payer. A referral does not guarantee payment of a claim.

Out-of-Network Referral Approval
When services are not available from a participating care provider, an out-of-network referral to a non-participating care provider must be approved by us prior to services being rendered by the non-participating care provider. We must be advised of all requests for out-of-network referrals (except emergencies). A Medical Director will review requests not meeting approval criteria. In the case of emergencies, we must be notified the first business day following the referral. Prior approval for modified or expired out-of-network referrals must also occur as described herein. Prior approval for referral extensions must also occur as described above. Prior approval of an out-of-network referral is required for each follow up visit unless we indicate otherwise.

Requests for prior approval may be obtained by completing an out-of-network referral request form and faxing it with documentation for consideration. A copy of the out-of-network referral request form can be accessed at uhcrivervalley.com > Providers > Forms > Out-of-Network Referral Form.

• Decisions will be made within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee for Quality Assurance (NCQA) standards.
• A letter confirming our approval or denial of a referral will be sent to the member and your office.
• If a member requests approval after the fact, please advise the member that this is contrary to policy and refer the member to the following numbers if they have questions: Illinois/Iowa/Wisconsin: 800-747-1446; Tennessee/Virginia/Arkansas/Georgia: 800-224-6602.

Participating care providers may not refer their own family members to non-participating physicians/facilities due to the inherent conflict of interest. If the physician denies a referral to the member, the physician must inform the member that they should refer to their benefit document for any appeal rights or call the following numbers:
Illinois/Iowa/Wisconsin: 800-747-1446;
Tennessee/Virginia/Arkansas/Georgia: 800-224-6602

Utilization Management

The term “prior authorization” is referenced in this supplement pertaining to UnitedHealthcareOnline.com, is also referred to as “Preauthorization” when referencing uhcrivervalley.com. You will notice both terms used throughout this supplement, both terms have the same meaning.

Our Utilization Management Program (UM) has several components. These include but are not limited to: (1) preauthorization for various procedures, medical services, treatments, prescription drugs and durable medical equipment; (2) review of the appropriateness of inpatient admissions and ongoing coverage of inpatient care; (3) prior approval for referrals to non-participating providers, if applicable under a member’s benefit plan; and (4) case management. Our goal is to encourage the highest quality of appropriate care, in the most appropriate setting from the most appropriate provider.

Care providers must cooperate with our UM program. You will allow us access, in the form we request, to information on covered services provided to our members and you will allow us to collect data that will facilitate UM reviews and decisions.

Medical Policies, Drug Policies and Coverage Determination Guidelines


Preauthorization

Services that Require Preauthorization
We require preauthorization for certain procedures, items of durable medical equipment (DME), prescription drugs and other services.

The list of services requiring preauthorization is available at:
• UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements > UnitedHealthcare of the River Valley Advance Notification Procedure Codes; or
• uhcrivervalley.com > Providers > Coverage Policy Library > Services Requiring Preauthorization.

Care Provider Responsibility for Submitting Adequate Clinical Documentation
It is your responsibility to request preauthorization when it is required. It is important that you provide complete clinical information and medical documentation to support preauthorization for each procedure, device, drug, or service at the time you submit your request so that we may promptly determine whether the services are covered and medically necessary. You should refer to our Medical Policies, Drug Policies and Coverage Determination Guidelines when determining what documentation and information you should provide. We make these determinations based upon the information available to us at the time we are required to make a decision. We will consider additional information provided within the time period allowed for review, but delayed submissions increase administrative time.

How to Request Preauthorization
Please refer to the How to Contact River Valley section at the beginning of this supplement for information regarding how to submit a request for preauthorization.

If you do not obtain a required preauthorization the claim may be denied. You cannot bill the member for such denied services.

Preauthorization Review Hours of Operation
Our staff is available to review your preauthorization requests Monday through Friday from 8 a.m. until 4:30 p.m. CT with the exception of national holidays and the day after Thanksgiving. Medical Directors are available to discuss clinical policies or decisions by calling the following numbers.

For members who have not transitioned:
Illinois/Iowa/Wisconsin: 800-747-1446
Tennessee/Virginia/Arkansas/Georgia: 800-224-6602
For members who have transitioned: 877-842-32110
Clinical Review of a Preauthorization Request
When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the submitted clinical information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate. Our nursing staff make decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a Medical Director or other appropriate reviewer such as a Board-Certified Physician in the applicable specialty or a Registered Pharmacist, to evaluate circumstances or conditions that the criteria do not address. Only physicians and other appropriate care providers may issue a medical necessity denial for coverage.

River Valley’s staff and our delegates who make these decisions are not rewarded for denying coverage, and we do not offer incentives to physicians to encourage underutilization of care or services.

The treating physician has the ultimate authority for the medical care of the patient. The medical management process does not override this responsibility.

Utilization Management Decisions
We make our utilization management decisions within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee for Quality Assurance (NCQA) standards.

We also provide notice of our decisions to care providers and members in the form and manner required by applicable state and federal law and in accordance with NCQA standards and River Valley policy. Among other things, all denial letters outline a member’s appeal rights, including, where applicable, the right to an expedited and/or external review, as well as the requirements for submitting an appeal and the requirements for our response. A member may designate a health care professional to appeal a decision on the member’s behalf. A copy of the member’s written consent is required and must be submitted with the appeal.

Facility Utilization Review
Notification of Inpatient Admission Required
Facilities are required to notify us of an inpatient admission within 24 hours of the admission or on the next business day following a holiday or weekend admission. The notification should include the member’s name, identification number, admitting diagnosis, and the name of the attending physician.

Failure to Notify
If the facility does not notify us of an inpatient admission as required, claims will be returned to the facility as not allowed. The facility is not allowed to bill the member for the services. The facility must contact our Utilization Management department with case information and a Medical Director will determine the appropriateness of the admission and length of stay. The facility will be responsible for all hospital charges deemed not allowed by our Medical Director. The facility will need to resubmit the claims.

Inpatient Review
Inpatient review is a component of our utilization management activities. The Medical Director and other clinical staff review member hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are medically appropriate and consistent with evidence-based guidelines.

Where appropriate, River Valley also uses MCG® Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions, on a case by case basis, in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. Criteria other than MCG® Care Guidelines may be used in special situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.

Inpatient review also gives us the opportunity to contribute to decisions about discharge planning and case management. In addition, we may identify opportunities for quality improvement and cases appropriate for referral to one of our disease management programs.

We usually begin our review on the first business day following admission. If a nurse reviewer believes that an admission or continued stay does not meet criteria you will be asked for more information concerning the treatment and case management plan. The nurse will then refer the case to our Medical Director. If our Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.

If you wish to speak with our Medical Director, you will be allowed that opportunity within one business day of the request. When complex decisions require expertise outside the scope of the usual physician advisor, we will have a board-certified physician of the relevant specialty (or similar specialty) review the case. External independent review will be obtained when we determine it is appropriate or by member request according to applicable law.

Admission to Rehabilitation Units
All rehabilitation confinements require authorization for admission and are reviewed concurrently for continued services at this level of care. Please refer to the Skilled/Extended Care row in the How to Contact River Valley section at the beginning of this supplement for information on how to submit a request for preauthorization.
Admission to Skilled Nursing Units
A member may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

• Preauthorization is required for all admissions to a Skilled Nursing Facility (or skilled level of care within an acute facility). Please refer to the How to Contact River Valley section at the beginning of this supplement for information regarding how to submit a request for preauthorization.

• The facility must submit the documented plan of care including treatment goals, summary of services to be provided, expected length of stay (LOS), and initial discharge plan.

• Initial certification for admissions will be authorized consistent with the level of care required based upon the anticipated treatment plan.

Concurrent Review is Conducted at Least Weekly, or More Often if Indicated.
• The skilled facility provider is responsible for providing appropriate/adequate documentation, including changes in the level of care.

• Approval for additional days of authorized coverage must be obtained prior to the expiration of the authorization.

• Determinations regarding levels of care must consider not only the level of service but also the medical stability of the member.

• Disagreements regarding the level of care required will be addressed by our Medical Director in consultation with you (as the physician managing the member in the skilled facility, not the transferring attending physician). The appeal procedure can be initiated as desired by the member and/or authorized representative when coverage is not authorized.

• We determine whether the admission and subsequent stay and care are covered and medically necessary based upon the following clinical guidelines among others:

  • Services must be ordered by a physician and be reasonable and necessary for the treatment of the member’s illness or injury, i.e., be consistent with the nature and severity of the individual’s illness or injury, particular medical needs, and accepted standards of medical practice.

  • The member must be clinically stable with clinical and lab findings improving/unchanged for the last 24 hours and diagnosis and initial treatment plan established prior to admission to the skilled nursing facility.

  • The services must also be reasonable in terms of duration and quantity. The member must require skilled services on a daily basis (i.e., available on a 24-hour basis, 7 days/week). If skilled rehabilitation services are not available on a seven-day-a-week basis, a member whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services at least five days a week. Skilled services, however, are required and provided at least three times per day. The frequency with which a service must be performed does not, by itself, make it a skilled service.

  • The nature and complexity of a service and the skills required for safe and effective delivery of that service are considered in determining whether a service is skilled. Skilled care requires frequent patient assessment and review of the clinical course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care is goal-oriented to progress the member toward functional independence, and requires the continuing attention of trained medical personnel.

Admission for Observation
We may review observation services concurrently or post-discharge to determine whether the use of hospital services was appropriate and medically necessary. Inappropriate use of observation services may result in physician education, sanction, or payment denial or any other action permitted under your participation agreement.

Observation services are a means to evaluate and determine a member’s need for hospital admission. Observation may be appropriate when determining response to treatment, or monitoring/diagnosing a medical condition when such diagnostic testing or treatment exceeds usual outpatient care. Observation is generally used when 48 hours or less is needed for evaluation of a member’s condition. In rare and exceptional cases, observation services may span more than 48 hours.

Transition to inpatient admission status from observation is generally indicated when:

• A condition is diagnosed requiring a long-term (usually greater than 48 hours) stay (e.g., acute MI).

• Long-term (usually greater than 48 hours) treatment or monitoring is needed for a condition (e.g., persistent severe asthma).

Notice of Termination of Inpatient Benefits
We may determine that an admission and/or a continued stay in a Hospital, Rehabilitation Unit or Skilled Nursing Facility (SNF) are not covered benefits for a number of reasons including, but not limited to the following:

• A Medical Director determines that an admission or continued stay, which was not preapproved at an out-of-network facility, is not medically necessary at the level of care the facility provides.

• Preauthorization was not obtained for a procedure or service subject to that requirement and/or the procedure or service is not a covered benefit under the member’s benefit plan.
• A Medical Director determines that the member’s condition is custodial, and is a non-covered benefit.
• A Medical Director and the attending physician determine that continued acute inpatient/Acute Inpatient Rehabilitation/SNF level of care is no longer medically necessary but the patient refuses discharge.
• The member has exhausted all existing inpatient or skilled care benefits under their benefit plan. If a non-coverage determination is made, written notification will be provided to the physician, the member and facility on the day the determination is made.

Services Obtained Outside the River Valley Service Area
• We process service requests for treatment authorizations as directed by you and the out-of-area (OOA) attending physician.
• In conjunction with you and the OOA attending physician, we coordinate a member’s transfer back to the Service Area when medically feasible and appropriate.
• We provide coverage for OOA services for urgent or emergent stabilization services in accordance with the member’s benefit plan. This will include the time they are stabilized in the emergency room, prior to admission as an inpatient or discharged from the facility.
• We also provide coverage for post-stabilization care services. Post-stabilization care services are those services provided after a member is stabilized in order to maintain the stabilized condition.
• Coverage from OOA inpatient services continues only as long as the member’s condition prevents transfer to a participating hospital. Transfers should occur within 48 hours of the determination that a transfer is medically feasible and appropriate. Payment for preventive or non-emergent/urgent services performed outside of the network varies according to the benefit plan. Determinations on benefit coverage may include, but are not limited to: non-covered; covered at a reduced level of benefit; or covered at the network level of benefit with a referral. Please contact our member service department for specific questions.

Special Requirements for Certain Requests
Durable Medical Equipment (DME)
• Preauthorization is required for some DME. Please refer to the How to Contact River Valley section at the beginning of this supplement for information on how to submit a request for preauthorization.
• Subject to the exceptions noted below, all DME, orthotics, prosthetics and supply items must be obtained from a contracted vendor. If an item is not available from a contracted vendor, whether or not preauthorization is required, you must obtain an out-of-network referral or payment for the item will be denied unless the member has an out-of-network benefit for DME.

Note: Even when medically necessary, certain items, (for example orthotic devices), may not be covered under a member’s benefit plan. Others, (for example prosthetic devices), may be subject to benefits limits.

Contact a Member Service Representative for information about a member’s benefit plan and about any additional requirements that may require preauthorization (for example DME, procedures, prescription drugs or other services).

Prescription Drugs
• Preauthorization is required for some prescription drugs. Please refer to the How to Contact River Valley section at the beginning of this supplement for information on how to submit a request for preauthorization.
• Some drugs have special rules and require special management services. These include drugs with therapy prerequisites, quantity limitations and/or a multiple copay requirement. A list of some of the drugs that require preauthorization or have special rules may be found at uhcrivervalley.com > Providers > Preauthorization > Drugs. There are links for the list of drugs with special rules.
• If you order and/or administer any medication that requires preauthorization or special clinical management services, you may be required to acquire those medications from a participating specialty pharmacy, unless we authorize a non-specialty pharmacy in a particular situation.
• Certain drugs are available in quantities up to 90 or 100 day supplies, depending on plan benefit design. A list of many of the drugs on the three-month supply list is available at uhcrivervalley.com > Pharmacy > 90 and 100 Day Supply Lists. This list is subject to change at any time without notice.
• River Valley’s Prescription Drug Lists (PDLs), which identify those drugs that currently have special rules are located at uhcrivervalley.com > Pharmacy, and can be found by clicking on the links for: “4-Tier PDL”, “Traditional PDL”, and “Advantage PDL”.

Not all drugs on a PDL are covered under a member’s pharmacy benefit. On uhcrivervalley.com > Providers > Pharmacy, you may determine whether a medication is covered by viewing the Online Pharmacy.

Sleep Studies to Diagnose Sleep Apnea and Other Sleep Disorders
• Preauthorization is required for laboratory assisted and polysomnography treatment and for the site of service (sleep lab v. portable home monitoring).

Home Health Care (Including Home Infusion Services)
• Preauthorization is required for Home Health Care including but not limited to Home Infusion Services.
• You must complete a specific Home Health Authorization Form which you can be found at: uhcrivervalley.com > Providers > Forms. Please refer to the How to Contact


Preauthorization is required for all follow-up care.

Post-Transplant Care

- Transplants require preauthorization. Please contact the Optum transplant case manager at 888-936-7246. The transplant case manager will request medical records necessary to review the member’s individual appropriateness for a potential transplant. All information is sent to a physician expert in that particular field of transplantation for review prior to authorization.

- If authorized, the case manager coordinates all referrals, assists in selecting a transplant center based upon the member’s needs, and provides information about the value of our transplant management program.

- If a transplant candidate is in need of home care or is actively involved with a participating center, services will be arranged by the transplant case manager.

- Any post-transplant lab or pathology that cannot be performed or interpreted by a network physician can be sent to the transplant center for interpretation. Please notify the transplant case manager if assistance is needed in making arrangements. Most of these services are covered under the transplant contract. It is cost effective to use the transplant center when appropriate. It is important that the transplant center be involved in the continuing care of the transplant patient.

Post-Transplant Care

- Preauthorization is required for all follow-up care. Requests should be made using the standard River Valley preauthorization process.

- One year post transplant, members will be transferred back to their respective local physician for any additional care management services required.

End of Life Care

Some members have end of life care benefits which may include hospice services. Preauthorization is required for these services. Approved care is coordinated by our care managers. Requests for end of life care may be faxed to the Home Health Department at 800-340-2184.

Claims Process

Electronic Data Interchange (EDI)

We prefer you use EDI to submit claims and conduct other business with us electronically. To enroll, call EDI customer service at 866-509-1593 or send an email to RVITEDISolutions@uhc.com.

Claims Transmission

You should inform your office software vendor that you want to begin electronic transmission of claims to the River Valley Payer ID 87726 for medical claims and 95378 for dental.

All claims are received through our clearinghouse, OptumInsight. The clearinghouse sets up all claims as commercial. Your EDI software vendor is responsible for establishing your connectivity to the clearinghouse. Your software vendor can advise you of the specific requirements that apply to claims transmissions to us.

EDI Acknowledgment & Status Reports

Your software vendor will provide you with a report that shows only that an electronic claim left your office. It does not confirm that claims have been received or accepted at the clearinghouse or by us.

Clearinghouse acknowledgment reports do show the status of your claims. They are returned after each transmission so you are able to confirm immediately whether a claim reached us for payment or was rejected because of an error, because additional information is needed or for any other reason. This allows you to correct any errors and retransmit a claim the same day so there will be no delay in processing.

You will also receive various status reports from us that provide additional information on the status of claims including copies of EOBs/remittance advice and denial letters that may request additional information.

It is very important that you carefully review all vendor reports, clearinghouse acknowledgment reports and the River Valley status reports as soon as you receive them. You will know the status of each claim you have submitted and you will be able to correct any errors promptly.

Paper and Electronic Claims Format

All claims for medical or hospital services must be submitted using, as applicable, the Form 1500 or UB-04, their successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims. The use of black ink is recommended when completing a Form 1500 claim. Black ink on a red Form
1500 claim will allow for optimal scanning into our claims processing system.

**Electronic Claims Submission and Billing**
You should submit your claims electronically. Specific exceptions to this requirement are set forth below.

For electronic claims submission requirements, please see our HIPAA Transaction Standard Companion Guide located at [uhcrivervalley.com > Providers > HIPAA Information > Companion Documents](http://uhcrivervalley.com).

This document should be shared with your software vendor. We update the Companion Guide from time to time and you should routinely review the Companion Guide to help ensure you have the most current information about our requirements.

To obtain more information regarding electronic claims, please refer to the EDI section of this supplement or [uhcrivervalley.com](http://uhcrivervalley.com).

**Exceptions to Electronic Claims Submission Guidelines**
The following claims require attachments and, therefore, must be submitted on paper:

- Claims submitted for dental pre-treatments for crown lengthening, periodontics, implants and veneers.
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field.

Except as provided above, please do not send claims on paper or with claim attachments unless we request it.

- Modifier 59 is used to identify procedures/services commonly bundled together but are appropriate to report separately under some circumstances. No special rules apply to electronic claims that are joined using Modifier 59 or for claims for dental pre-treatment; however, as noted above certain pre-treatment claims must be submitted on paper.

**Special Rules for Electronic Submission**
- **Corrected Claims** must include the words “corrected claims” in the notes field. Your software vendor can instruct you on correct placement of all notes.
- **Unlisted Procedure Code Claims** must include a sufficient description in the notes field. If you are not able to do so you must submit a paper claim.
- **Claims That Require Dates of Service by Line Item:** Claims for occupational therapy, speech therapy, physical therapy, dialysis, and mental health or substance use services require the date of service by line item. We do not accept span dates for these types of claims.

- **Secondary Coordination Of Benefits (COB) Claims** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount.
  - **Professional:** Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (Amount that the payer paid to the member not the care provider).
  - **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount (contractual discount amount of other payer), Patient Paid Amount (Amount that the payer paid to the member not the care provider).
  - **Span Dates:** Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS-1500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

**Requirements for Claims (Paper or Electronic) Reporting Revenue Codes**
- All claims reporting revenue codes require the exact dates of service if they are span dates.
- If revenue code 270 is submitted by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.
- If you report revenue code 274, you are required to provide a description of the services or a valid CPT or HCPCS code.
- Claims reported with revenue codes 250-259 require an itemized statement if the charges exceed $1,000.
- All claims reporting the revenue codes on the list below require that you report the appropriate CPT and HCPCS codes.
### Revenue Codes Requiring CPT® and HCPCS Codes

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>260</td>
<td>IV Therapy (General Classification)</td>
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<tr>
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<td>Infusion Pump</td>
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<td>262</td>
<td>IV therapy/pharmacy services</td>
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<tr>
<td>263</td>
<td>IV therapy/drug/supply delivery</td>
</tr>
<tr>
<td>264</td>
<td>IV Therapy/Supplies</td>
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<tr>
<td>269</td>
<td>Other IV therapy</td>
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<tr>
<td>290</td>
<td>Durable Medical Equipment (other than renal)</td>
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<tr>
<td>291</td>
<td>Durable Medical Equipment/Rental</td>
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<tr>
<td>292</td>
<td>Purchase of new DME</td>
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<tr>
<td>293</td>
<td>Purchase of used DME</td>
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<tr>
<td>300</td>
<td>Laboratory (General Classification)</td>
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<td>Chemistry</td>
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<td>Immunology</td>
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<td>Renal Patient (Home)</td>
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<td>Non-Routine Dialysis</td>
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<td>305</td>
<td>Hematology</td>
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<td>306</td>
<td>Bacteriology &amp; Microbiology</td>
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<td>307</td>
<td>Urology</td>
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<td>309</td>
<td>Other Laboratory</td>
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<td>Laboratory -Pathology (General Classification)</td>
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<td>Cytology</td>
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<td>Histology</td>
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<td>319</td>
<td>Other Laboratory Pathological</td>
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<td>Radiology – diagnostic (General Classification)</td>
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<td>Angiocardiology</td>
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<td>Arthrocardiography</td>
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<td>Arteriography</td>
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<td>Chest X-Ray</td>
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<td>329</td>
<td>Other Radiology-Diagnostic</td>
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<td>330</td>
<td>Radiology – Therapeutic and/or Chemotherapy</td>
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<td>331</td>
<td>Administration (General Classification)</td>
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<td>332</td>
<td>Chemotherapy Administration- Injected</td>
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<td>Chemotherapy Administration-Oral</td>
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<td>334</td>
<td>Radiation Therapy</td>
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<td>Chemotherapy Administration-IV</td>
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<td>339</td>
<td>Other Radiology-Therapeutic</td>
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<td>Nuclear Medicine (General Classification)</td>
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<td>341</td>
<td>Diagnostic Procedures</td>
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<td>342</td>
<td>Therapeutic Procedures</td>
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<td>CT Scan (General Classification)</td>
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<td>CT-Head Scan</td>
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<td>352</td>
<td>CT-Body Scan</td>
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<td>359</td>
<td>CT-Other</td>
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<td>Operating Room Services (General Classification)</td>
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<td>Minor Surgery</td>
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<td>Organ Transplant- Other Than Kidney</td>
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<td>367</td>
<td>Kidney Transplant</td>
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<td>Other Operating Room Services</td>
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<td>Other Imaging Services (General Classification)</td>
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<td>Diagnostic Mammography</td>
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<td>Screening Mammography</td>
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<td>Other Imaging Services</td>
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<td>Respiratory Services (General)</td>
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<td>Inhalation Services</td>
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<td>Other Respiratory Services</td>
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<td>460</td>
<td>Pulmonary Function (General Classification)</td>
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<td>469</td>
<td>Other-Pulmonary Function</td>
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<td>Audiology (General Classification)</td>
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<td>Audiology/Diagnostic</td>
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<td>Audiology/Treatment</td>
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<td>Cardiology (General Classification)</td>
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<td>Cardiac Cath Lab</td>
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<td>Echocardiology</td>
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<td>489</td>
<td>Other Cardiology</td>
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<tr>
<td>490</td>
<td>Ambulatory Surgical Care (General Classification)</td>
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### Revenue Codes Requiring CPT® and HCPCS Codes

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<th>Code</th>
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<td>Other Ambulatory Surgical Care</td>
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<td>Magnetic Resonance Technology (General Classification)</td>
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<td>MRI – Brain/Brain Stem</td>
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<td>618</td>
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<td>Erythropoietin (EPO) &lt; 10,000 units</td>
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<td>Erythropoietin (EPO) &gt; 10,000 units</td>
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<td>Gastro-Intestinal (GI) Services (General Classification)</td>
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<td>Other Therapeutic Services (General Classification)</td>
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<td>Recreational Therapy</td>
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<td>Education/Training (Diabetic Education)</td>
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<td>949</td>
<td>Other Therapeutic Services (HRSA approved weight loss providers)</td>
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</tbody>
</table>

### Claim Reconsideration and Appeals Process and Resolving Disputes

Please refer to *Claim Reconsideration, Appeals Process and Resolving Disputes* section in *Chapter 8: Our Claims Process* and in the *How to Contact River Valley* section of this supplement.

If you have a question about a pre-service appeal, please see the section on *Pre-Service Appeals* in Chapter 6: Medical Management.
Applicability of This Supplement

This supplement is intended for use by non-capitated physicians, health care professionals, facilities, ancillary providers and their respective staff. Unless otherwise specified, any references to UnitedHealthcare West in this supplement are intended to apply to any or all of the entities and benefit plans listed below. This information is subject to change.

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, you are paid a set amount for each member assigned to you, whether or not that person seeks care. If you have a UnitedHealthcare West capitation agreement with us, this supplement does not apply to you. Please click [here](UHCWest.com) to access the UnitedHealthcare West Capitated Provider Guide, or go to UHCWest.com > Library tab and click the Provider Administrative Guides link in the left navigation pane.

Care providers who participate in the benefit plans listed below are subject to both the preceding guide and this supplement. This supplement controls if it conflicts with information in the preceding guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the preceding guide.

Benefit Plans Referenced in this Supplement

We offer a wide range of products and services for employer groups, families and individual members. Benefit plan availability may vary. Contact us for more information about benefit plan availability and service areas where each of these products and supplemental benefits are available.

<table>
<thead>
<tr>
<th>State</th>
<th>Legal Entities</th>
<th>Products Offered</th>
<th>Benefits Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>PacifiCare of Colorado, Inc.</td>
<td>Medicare Advantage</td>
<td>▪ AARP® MedicareComplete®&lt;br&gt;▪ UnitedHealthcare® Group Medicare Advantage</td>
</tr>
<tr>
<td>Colorado</td>
<td>PacifiCare of Colorado, Inc.</td>
<td>Medicare Advantage</td>
<td>▪ AARP® MedicareComplete® SecureHorizons®&lt;br&gt;▪ UnitedHealthcare® Group Medicare Advantage</td>
</tr>
<tr>
<td>Nevada</td>
<td>PacifiCare of Colorado, Inc.</td>
<td>Medicare Advantage</td>
<td>▪ AARP® MedicareComplete®&lt;br&gt;▪ UnitedHealthcare® Group Medicare Advantage</td>
</tr>
<tr>
<td>California</td>
<td>UnitedHealthcare of California</td>
<td>Commercial and Medicare Advantage</td>
<td><strong>Commercial:</strong>&lt;br&gt;UnitedHealthcare SignatureValue® family of products including, but not limited to:&lt;br&gt;▪ UnitedHealthcare SignatureValue&lt;br&gt;▪ UnitedHealthcare SignatureValue Advantage&lt;br&gt;▪ UnitedHealthcare SignatureValue VEBA&lt;br&gt;▪ UnitedHealthcare SignatureValue Alliance&lt;br&gt;▪ UnitedHealthcare SignatureValue Flex&lt;br&gt;▪ UnitedHealthcare SignatureValue Focus&lt;br&gt;<strong>Medicare:</strong>&lt;br&gt;▪ AARP® MedicareComplete® SecureHorizons®&lt;br&gt;▪ Sharp® SecureHorizons® Plan by UnitedHealthcare®&lt;br&gt;▪ UnitedHealthcare® Group Medicare Advantage</td>
</tr>
</tbody>
</table>
| California| UnitedHealthcare Benefits Plan of California | Commercial | ▪ UnitedHealthcare CoreSM® and Core EssentialSM  
*This UHC West Capitated Supplement does not apply to this benefit plan. Please refer to Physician, Health Care Professional, Facility and Ancillary Provider 2016 Administrative guide For Commercial and Medicare Advantage Products for regulations, processes, and contact information |
<p>| Oklahoma  | UnitedHealthcare of Oklahoma, Inc. | Commercial and Medicare Advantage | <strong>Commercial:</strong>&lt;br&gt;▪ UnitedHealthcare SignatureValue®&lt;br&gt;<strong>Medicare:</strong>&lt;br&gt;▪ AARP® MedicareComplete® SecureHorizons®&lt;br&gt;▪ UnitedHealthcare® Group Medicare Advantage |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Legal Entities</th>
<th>Products Offered</th>
<th>Benefits Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>UnitedHealthcare of Oregon, Inc.</td>
<td>Commercial and Medicare Advantage</td>
<td>Commercial:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare SignatureValue®</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicare:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• AARP® MedicareComplete®</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare® Group Medicare Advantage</td>
</tr>
<tr>
<td>Texas</td>
<td>UnitedHealthcare Benefits of Texas, Inc.</td>
<td>Commercial and Medicare Advantage</td>
<td>Commercial:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare SignatureValue®</td>
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<td>Medicare:</td>
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<td></td>
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<td></td>
<td>• AARP® MedicareComplete® SecureHorizons®</td>
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<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare® Chronic Complete</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>• UnitedHealthcare Dual Complete®</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare® Group Medicare Advantage</td>
</tr>
<tr>
<td>Washington</td>
<td>UnitedHealthcare of Washington, Inc.</td>
<td>Commercial Medicare Advantage</td>
<td>Commercial:</td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare of Oregon, Inc.</td>
<td></td>
<td>• UnitedHealthcare® SignatureValue®</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicare:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• AARP® MedicareComplete®</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• UnitedHealthcare® Group Medicare Advantage</td>
</tr>
</tbody>
</table>

**Commercial products**

Commercial benefit plans consist of a Health Maintenance Organizations (HMOs) or Managed Care Organizations (MCOs). Health services are accessed through network primary care physicians (PCPs) who manage the member’s medical history and individual needs. HMOs/MCOs offer minimal paperwork and low, predictable out-of-pocket costs. Members pay a predetermined copayment or a percentage copayment each time they receive health care services.

**Medicare Advantage products**

Please reference *Chapter 4: Medicare Advantage Products* for a description of Medicare Advantage Products offered.

Administrative services are provided by the following affiliated companies: UnitedHealthCare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California or United Behavioral Health operating under the brand Optum.
# How to Contact UnitedHealthcare West Non-Capitated Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Helpful Health Plan Service</strong>&lt;br&gt;Phone Numbers</td>
<td><a href="http://Uhcwest.com">Uhcwest.com</a> &gt; Contact Us &gt; Select the appropriate state &gt; Phone numbers will display.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare West Provider Website</strong>&lt;br&gt;Preauthorization (Non-delegated)</td>
<td><a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>, Link and <a href="http://Uhcwest.com">Uhcwest.com</a></td>
</tr>
<tr>
<td><strong>Radiology-Advanced Outpatient Imaging Procedures (Non-delegated):</strong>&lt;br&gt;CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology.</td>
<td>Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Clinical Resources &gt; Radiology&lt;br&gt;Phone: 866-889-8054&lt;br&gt;Request prior authorization of radiology services as described in Outpatient Radiology Notification/Prior Authorization Protocol in Chapter 6: Medical Management.</td>
</tr>
<tr>
<td><strong>Cardiology (Non-delgated):</strong>&lt;br&gt;Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram</td>
<td>Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Clinical Resources &gt; Cardiology&lt;br&gt;Phone: 866-889-8054&lt;br&gt;Request prior authorization of cardiology services as described in Cardiology Notification/Prior Authorization Protocol in Chapter 6: Medical Management.</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Notification,</strong>&lt;br&gt;(Non-delegated) Inpatient includes: Acute Inpatient, Skilled Nursing Admission, Long Term Acute Care, Inpatient Rehabilitation Places of Service.</td>
<td>Phone: 800-799-5252  Fax: 800-274-0569&lt;br&gt;Mental health Medicare Advantage: 800-508-0088&lt;br&gt;Transplant: 866-300-7736  Fax: 888-361-0502</td>
</tr>
<tr>
<td><strong>EDI Support</strong>&lt;br&gt;Encounter Collection, Submission &amp; Controls</td>
<td>Password and User ID are not required to review and access EDI information on <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>.&lt;br&gt;Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Contact Us &gt; EDI Claims &gt; EDI Transaction Support, or <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> &gt; Tools &amp; Resources &gt; EDI Education for Electronic Transactions.&lt;br&gt;Phone: 800-842-1109  Email: <a href="mailto:supportedi@uhc.com">supportedi@uhc.com</a></td>
</tr>
<tr>
<td><strong>United Voice Portal</strong>&lt;br&gt;(follow prompts to access information)</td>
<td>Commercial &amp; Medicare Advantage HMO/ MCO:&lt;br&gt;• California: 800-542-8789&lt;br&gt;• Arizona/Colorado/Nevada: 888-866-8297&lt;br&gt;• Oklahoma/Texas: 877-847-2862&lt;br&gt;• Oregon: 800-920-9202&lt;br&gt;• Washington MCO: 800-213-7356</td>
</tr>
<tr>
<td>Resource</td>
<td>Where to go</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Standard Commercial Member Appeals</strong>&lt;br&gt;(applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
<td>California, Oklahoma, Oregon, Texas, Washington&lt;br&gt;<strong>Mail:</strong>&lt;br&gt;Mailstop CA124-0160&lt;br&gt;P.O. Box 6107&lt;br&gt;Cypress, CA 90630&lt;br&gt;<strong>Fax:</strong> 866-704-3420&lt;br&gt;<strong>Phone:</strong>&lt;br&gt;CA: 800-624-8822&lt;br&gt;OK/TX: 800-825-9355&lt;br&gt;OR/WA: 800-932-3004</td>
</tr>
<tr>
<td><strong>Medicare Advantage Member Appeals</strong>&lt;br&gt;(applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
<td>Mailstop CA124-0157&lt;br&gt;P.O. Box 6106&lt;br&gt;Cypress, CA 90630&lt;br&gt;<strong>Fax:</strong> 888-517 7113&lt;br&gt;<a href="http://AARPMedicareComplete.com"><strong>AARPMedicareComplete.com</strong></a></td>
</tr>
<tr>
<td><strong>Expedited Commercial Member Appeals</strong>&lt;br&gt;(applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
<td>California Oklahoma, Oregon, Texas, Washington&lt;br&gt;<strong>Phone:</strong> 888-277-4232&lt;br&gt;<strong>Fax:</strong> 800-346-0930</td>
</tr>
<tr>
<td><strong>Urgent Clinical Appeals</strong></td>
<td>Urgent Medical or Pharmacy appeals: Fax: 800-346-0930</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td>Commercial products: <a href="http://UHCWest.com"><strong>UHCWest.com</strong></a>&lt;br&gt;Medicare products: <a href="http://UHCMedicareSolutions.com"><strong>UHCMedicareSolutions.com</strong></a> &gt; Our Plans &gt; Medicare Prescription Drug Plans&lt;br&gt;<strong>Phone:</strong> 800-711-4555&lt;br&gt;<strong>Fax:</strong> 800-527-0531&lt;br&gt;<strong>Fax:</strong> 800-853-3844&lt;br&gt;<strong>Online:</strong> <a href="http://OptumRx.com"><strong>OptumRx.com</strong></a>&lt;br&gt;Medicare Advantage Part D Medication Therapy Management: 866-798-8780, Option 2</td>
</tr>
<tr>
<td><strong>Mental Health/ Substance Use, Vision or Transplant Services</strong></td>
<td>See member’s health care ID card for carrier information and contact numbers. The health care ID card can be viewed when you verify eligibility on UnitedHealthcareOnline.</td>
</tr>
<tr>
<td><strong>California Language Assistance Program</strong>&lt;br&gt;(applies only to commercial products in California)</td>
<td>[<strong>Online:</strong> <a href="http://UHCWest.com"><strong>UHCWest.com</strong></a> &gt; Provider &gt; Library &gt; Publications &gt; California Language Assistance Program Information](<a href="http://UHCWest.com">http://UHCWest.com</a>)&lt;br&gt;<strong>Phone:</strong> 800-752-6096</td>
</tr>
<tr>
<td><strong>Health Management and Disease Management Programs</strong></td>
<td>[<strong>Online:</strong> <a href="http://UnitedHealthcareOnline.com"><strong>UnitedHealthcareOnline.com</strong></a> &gt; Tools &amp; Resources &gt; Health Resources for Patients:&lt;br&gt;<strong>Phone:</strong> 877-840-4085&lt;br&gt;Fax completed referral form to: 877-406-8212](<a href="http://UnitedHealthcareOnline.com">http://UnitedHealthcareOnline.com</a>)</td>
</tr>
</tbody>
</table>
Provider Responsibilities

Monitor Eligibility
You are responsible for checking member eligibility within two business days prior to the date of service. You may be eligible for reimbursement under the Authorization Guarantee program described in this supplement for authorized services as long as you have checked and confirmed the member’s eligibility within two business days prior to the date of service.

Member Eligibility
You must verify the member’s eligibility each time they receive services from you. We provide several ways to verify eligibility:

- **Online:** UHCWest.com, UnitedHealthcareOnlin.com
- **EDI:** Transactions 270/271 through your vendor or clearinghouse
- **Phone:** (See How to Contact UnitedHealthcare West Non-Capitated Resources for specific numbers.)
- **Electronic eligibility lists** (upon request)

Additional details regarding a specific member’s benefit plan, may be contained in the member’s Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, or may be addressed in procedures/protocols communicated by us. Details may include, but are not limited to, the following:

- Selection of a PCP;
- Effective date of coverage;
- Changes in membership status while a member is in a hospital or skilled nursing facility (SNF);
- Member transfer/disenrollment; or
- Removal of member from receiving services by a PCP

Health Care Identification (ID) Cards
Each member receives a health care ID card with information to help you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. It is important to check the member’s health care ID card at each visit and to keep a copy of both sides of the card for your records. Sample healthcare ID cards specific to the member are available when you verify eligibility online.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health Care Identification (ID) Cards section of Chapter 2: Provider Responsibilities and Standards.

Access & Availability: Exception Standards for Certain UnitedHealthcare West States
We monitor members’ access to medical and behavioral healthcare to make sure that we have an adequate provider network to meet the members’ healthcare needs. We use member satisfaction surveys and other feedback to assess performance against standards.

We have established access standards for appointments & after hours care. Exceptions or additions to those standards are shown in the table below.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular or routine</td>
<td>UnitedHealthcare Standard: 14 calendar days</td>
</tr>
<tr>
<td></td>
<td>California Commercial HMO: Members are offered appointments for non-urgent PCP within 10 business days of request, within 15 business days for non-urgent specialist request; Texas: Within three weeks for medical conditions.</td>
</tr>
<tr>
<td>Preventive care</td>
<td>UnitedHealthcare Standard: Four weeks</td>
</tr>
<tr>
<td></td>
<td>California: Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. Texas: Within two months for child, and within three months for adult. Medicare Advantage within 30 days.</td>
</tr>
<tr>
<td>Urgent exam (PCP or Specialist)</td>
<td>UnitedHealthcare Standard: Same day (24 hours)</td>
</tr>
<tr>
<td></td>
<td>California Commercial Members: Within 48 hours when no prior authorization required, within 96 hours when prior authorization required.</td>
</tr>
<tr>
<td>In-office wait time</td>
<td>California Members: In-office wait time is less than 30 minutes.</td>
</tr>
<tr>
<td>Referral process</td>
<td>Notification to the member should be completed in a timely manner, not to exceed five business days of a request for non-urgent care or 72 hours of a request for urgent care.</td>
</tr>
<tr>
<td>Non-urgent ancillary (diagnostic)</td>
<td>15 business days.</td>
</tr>
</tbody>
</table>

1. Members must have access to all physicians and support staff that work for you and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.
2. Members must have access to appointments during all normal office hours and not be limited to appointments on certain days or during certain hours.

3. Members must have access to the same time slots as all other patients who are not our members.

4. You must work cooperatively with our Medical Management department toward:
   - Managing inpatient and outpatient utilization; and
   - Member care and member satisfaction;

5. Use your best efforts to refer members to our network care providers. You must use only our network laboratory and radiology providers, unless specifically authorized by us.

**Timely Access to Non-Emergency Health Care Services (Applies to Commercial in California)**

- The timeliness standards require licensed health care providers to offer members appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

- Triage or screening services by phone must be provided by licensed staff 24 hours per day, seven days per week. Unlicensed staff persons shall not use the answers to those questions in an attempt to assess, evaluate, advise or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

- UnitedHealthcare of California managed care members and covered persons of UnitedHealthcare Insurance Company benefit plans have access to free triage and screening services 24 hours a day, seven days a week through Optum’s Nurse Line at 866-747-4325.

**Electronic Data Interchange (EDI)**

EDI is our preferred choice for conducting business transactions with physicians and health care industry partners. We accept EDI claims submission for all of our product lines. You can find information and help with EDI by going to UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions, and in this guide under Electronic Data Interchange (EDI) section of Chapter 2: Provider Responsibilities.

**Notification of Practice or Demographic Changes**

All demographic changes, open/closed status, product participation or termination should be reported to us.

For complete information please the Proactive Notification of Changes section of Chapter 2: Provider Responsibilities and Standards.

**California** For participating medical/groups, IPAs or independent physicians, in accordance with California Senate Bill 137, effective July 1, 2016, we are required to perform ongoing updates to our provider directories, both online and hardcopy. As a participating medical/group, IPA or independent physician, you are required to update UnitedHealthcare within five business days if there are any changes to your ability to accept new patients. If you are no longer accepting new patients and are contacted by an enrollee or a potential enrollee seeking to become a new patient, you must direct them to both UnitedHealthcare, for additional assistance in finding a care provider, and, as applicable, either the California Department of Managed Health Care or the California Department of Insurance to report inaccuracy with our provider directory. You must cooperate with and provide us with information necessary for us to satisfy the requirements of Senate Bill 137.

We are required to contact all participating care providers including but not limited to, contracted medical groups/IPAs, on an annual basis, and independent physicians every six months. The care provider outreach includes a summary of the information that we have on record and requires you to respond confirming information is accurate, or with applicable changes.

The notice includes information that failure to respond to our request and provide accurate information may result in a delay in either payment or reimbursement to you.

If we do not receive a response from you within 30 business days, we have 15 business days to make attempts to verify your information.

If these subsequent attempts are unsuccessful, we notify you that after 10 business days you will be removed from our provider directory if you continue to be nonresponsive.

If the final 10 business day period lapses with no response from you, we may implement a one-time withhold from the medical groups/IPA’s capitation, delay any fee-for-service payments, and remove you from the directory.

We reimburse you within three business days of receiving the information, or at the end of one-calendar month if the information is not received.

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*As an “authorization representative” of UnitedHealthcare, physicians are responsible to notify the member about the prior authorization determination, unless State regulation requires otherwise.
To ensure UnitedHealthcare West has your most current practice information, medical groups/IPAs or independent physicians can submit applicable changes to:

- For delegated care providers: Email changes to Pacific_DelProv@uhc.com or delprov@uhc.com.
- For non-delegated care providers: Visit UnitedHealthcareOnline.com > Tools & Resources > Forms for the Provider Demographic Change Submission Form.

We retain the right to terminate care provider contracts if there is a pattern or repeated failure to provide the information required for UnitedHealthcare West to comply with this regulatory requirement.

Compliance with the Medical Management Program
Complying with the Medical Management Program includes, but is not limited to:

- Allowing our staff to have on-site access to members and their families while the member is an inpatient;
- Allowing our staff to participate in individual case conferences;
- Facilitating the availability and accessibility of key personnel for case reviews and discussions with the Medical Director or designee representing UnitedHealthcare West, upon request; and
- Providing appropriate services in a timely manner.

Benefit Interpretation Policies & Medical Management Guidelines
A complete library of Benefit Interpretation Policies and Medical Management Guidelines is available at UHCWest.com > Provider Log In > Library > Guidelines & Interpretation Manuals.

For detailed information regarding access to policies and policy updates, please refer to Chapter 15: Provider Communication and Outreach.

Utilization and Medical Management
Medical Emergencies & Emergency Medical Conditions

The member should be directed to call 911, or its local equivalent, or to the nearest emergency room. Prior authorization or advance notification is not required for emergency services. However, notification of the member’s emergency should be provided by calling 800-799-5252 between 8 a.m. and 5 p.m. Monday through Friday.

After-hours and weekend emergency services should be provided as clinically appropriate; the notification should be entered into UHCWest.com or faxed to us at 800-274-0569 on the next business day.

Urgently Needed Services
Please check the member’s Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for the benefit plan definition of urgent care. You must contact the member’s PCP or hospitalist upon a commercial member’s arrival for urgently needed services. These services should be requested by calling 800-799-5252 between 8 a.m. and 5 p.m., Monday through Friday.

Routine Authorizations
All other services are considered routine. To request preauthorization, (see below for services requiring preauthorization), the PCP must enter all the necessary information into UHCWest.com, contact the delegated Medical Group for approval, or complete and submit the appropriate Preauthorization Request Form. Routine requests are responded to within the following time frames, if all required clinical information is received:

<table>
<thead>
<tr>
<th>Product</th>
<th>State</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage Urgent</td>
<td>All</td>
<td>72 Hours</td>
</tr>
<tr>
<td>Medicare Advantage Routine</td>
<td>All</td>
<td>14 Calendar Days</td>
</tr>
<tr>
<td>Commercial Urgent</td>
<td>OR, WA</td>
<td>2 Business Days</td>
</tr>
<tr>
<td></td>
<td>CA, OK</td>
<td>72 Hours</td>
</tr>
<tr>
<td></td>
<td>TX</td>
<td>3 Calendar Days</td>
</tr>
<tr>
<td>Commercial Routine</td>
<td>OR, WA</td>
<td>2 Business Days Exception - a delay of decision (DOD) letter</td>
</tr>
<tr>
<td></td>
<td>CA</td>
<td>5 Business Days Exception - a delay of decision (DOD) letter</td>
</tr>
<tr>
<td></td>
<td>OK</td>
<td>15 Calendar Days</td>
</tr>
<tr>
<td></td>
<td>TX</td>
<td>3 Calendar Days</td>
</tr>
</tbody>
</table>

Authorization Status Determination
Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as applicable and appropriate) may determine whether to delay, modify or deny services to a member for reasons of medical necessity.

Prior Authorization Referral Process
A list of services that require prior authorization is available at UHCWest.com > Quick Links > Notification/Prior Authorization / Commercial - Medicare.

Services rendered without the required prior authorization will be denied as provider liability. The member cannot be billed for such services.
Primary Care Services
Most PCP services do not require prior authorization. However, if prior authorization is required, the following guidelines apply:

1. The PCP/requesting care provider is responsible for verifying eligibility and benefits prior to rendering services.

2. To request prior authorization, the PCP/requesting care provider must enter the request into UHCWest.com, contact the delegated medical group, or complete and submit the appropriate prior authorization request form (unless the services are required urgently or on an emergency basis). The completed form must include the following information:
   - Member’s presenting complaint,
   - Physician’s clinical findings on exam,
   - All diagnostic and lab results relevant to the request,
   - Conservative treatment that has been tried,
   - Applicable CPT and ICD codes.

3. The PCP/servicing care provider may check the status of a treatment request through UHCWest.com.

4. If approved, the treatment request is given a reference number that can be viewed through UHCWest.com or by contacting the delegated medical group, faxed back to the physician office based on the method that the PCP/servicing care provider used to submit the form.

5. The reference number should be noted on the claim when it is submitted for payment.

6. All authorizations expire 90 calendar days from the date of issuance.

   • Participating care providers should refer members to network care providers. Referrals to non-network care providers require prior authorization.
     - If there are no network care providers identified within the member’s service area for a necessary service, the PCP/servicing care provider must submit a completed UnitedHealthcare West Prior Authorization Request Form to us with the name of the proposed non-network care provider for approval, as appropriate. The Prior Authorization Request Form can be found at UHCWest.com > Providers. You must be registered for site access.
     - Once the PCP refers a member to a network specialist, that specialist may see the member as needed for the referring diagnosis. The specialist is not required to direct the member back to the PCP to order tests and/or treatment.
     - If a specialist feels that a member needs other services related to the treatment of the referral diagnosis, the specialist may refer the member, according to the online UHCWest.com Prior Authorization List, to a participating care provider.

UnitedHealthcare West or its agents shall conduct review throughout a member’s course of treatment. Multiple authorizations may be required throughout such course of treatment as authorizations may be limited to specific services or time periods.

Serious or Complex Medical Conditions
The PCP should identify members with serious or complex medical conditions and develop appropriate treatment plans for these members, in conjunction with case management. The treatment plan should include an authorization for referral to a specialist for an adequate number of visits to accommodate the treatment plan.

Specialty Care (Including Gynecology) in an Office-Based Setting
We send the status of the authorization request (approved as requested, approved as modified, delayed, or denied) to the specialist by fax or on UHCWest.com. For those services that do not require prior authorization, the specialist’s office receives a referral request directly from the PCP;

1. All specialist authorizations will expire 90 calendar days from the date of issuance.

2. Plain film radiography rendered by a network care provider, or in the specialist’s office in support of an authorized visit, does not require prior authorization.

3. Routine lab services performed in the specialist’s office, or are provided by a designated participating care provider in support of an authorized visit, do not require prior authorization.

4. Members may self-refer to a gynecologist who is a participating care provider for their annual routine gynecological exams. For women’s routine and preventive health care services, female Medicare Advantage members may self-refer to a women’s health specialist who is a participating care provider.

5. Female Medicare Advantage members over age 40 may self-refer to a participating radiology care provider for a screening mammogram.

Note: Mammograms may require prior authorization in California.

Obstetrics
1. A member may self-refer to an obstetrician who is a participating care provider for routine obstetrical (OB) care. If the member is referred to a non-participating health care specialist, the specialist must notify us through UHCWest.com or by fax at the number designated on the top of the Prior Authorization Form to make sure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and two ultrasounds.

3. Plain film radiography that is performed by a participating care provider or in the obstetrician’s office in support of an authorized visit, do not require prior authorization.

4. Routine labs performed in the obstetrician’s office, or are provided by a participating care provider in support of an authorized visit, do not require prior authorization.

5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician’s office that do not require prior authorization may be performed.

**Second Opinions (California Commercial Plans)**

We authorize and provide a second opinion by a qualified health care professional for members who meet specific criteria. A second opinion consists of one office visit for a consultation or evaluation only. Members must return to their assigned PCPs for all follow-up care. For purposes of this section, a qualified health care professional is defined as a PCP or specialist who is acting within the scope of practice and who possesses a clinical background, including training and expertise related to the member’s particular illness, disease or condition.

The PCP may request a second opinion on behalf of the member in any of the following situations:

1. The member questions the reasonableness or necessity of a recommended surgical procedure.
2. The member questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function or threatens substantial impairment, including, but not limited to, a serious chronic condition.
3. The clinical indications are not clear or are complex and confusing.
4. A diagnosis is in doubt due to conflicting test results.
5. The treating care provider is unable to diagnose the condition.
6. The member’s medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the member is requesting a second opinion regarding the diagnosis or continuance of the treatment.
7. The member has attempted to follow the treatment plan or has consulted with the treating care provider and has serious concerns about the diagnosis or treatment plan.

**Post-Stabilization Care**

Members are covered for post-stabilization services following emergency services. Post-stabilization services are medically necessary, but non-emergent, services needed to stabilize the member from the time the treating hospital requests authorization from Medical Management until one of the following events occur:

1. The member is discharged;
2. A participating care provider assumes responsibility for the member’s care (either at the hospital or through transfer); or
3. The treating physician and UnitedHealthcare West agree to another arrangement. We are responsible for the cost of post-stabilization services:
   a. Pre-approved by us; and
   b. Medically necessary.

Post-stabilization care is considered approved if we do not respond within one hour of the request for post-stabilization care or we cannot be contacted for pre-approval.

**Extension of Prior Authorization Services**
The specialist must request an extension of authorization through [UHCWest.com](http://UHCWest.com), by contacting the delegated Medical Group, or by fax, if they desire to perform services:

- Beyond the approved visits;
- Beyond the allotted time frame of the approval (typically 90 calendar days);
- In addition to the approved procedures, and/or diagnostic or therapeutic testing.

The extension must be authorized before care is rendered to the member. The request for extension of services must include the following information:

- Member’s presenting complaint;
- Physician’s clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- All treatment that has been tried;
- Applicable CPT and ICD codes; and
- Requested services (e.g., additional visits, procedures).

The existing authorization is reviewed by the receiving party, and a response is mailed or faxed back to the physician and/or information made available on [UHCWest.com](http://UHCWest.com). There is no need to contact the member’s PCP.
Hospital Notifications

Independent from prior authorization, notification by the facility is required for inpatient admissions on the day of admission for urgent/emergent, scheduled/elective, medical, surgical, out-of-area, hospice and obstetrical services.

Hospitals, rehabilitation facilities and skilled nursing facilities are required to notify us daily of all admissions, changes in inpatient status and discharge dates.

Admission Notification

Facilities are responsible for admission notification for all inpatient admissions including:

• Planned/elective admissions for acute care
• Unplanned admissions for acute care
• Skilled Nursing Facility (SNF) admissions
• Admissions following outpatient surgery
• Admissions following observation
• Newborns admitted to Neonatal Intensive Care Unit (NICU)
• Newborns who remain hospitalized after the mother is discharged (notice required within 24 hours of the mother’s discharge)

Unless otherwise indicated, we must receive the admission notification within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or holiday). For weekend and holiday admissions, we must receive the notification by 5 p.m. local time on the next business day.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual member’s benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility’s participation agreement with UnitedHealthcare.

Admission notifications must contain the following details regarding the admission:

• Member name, health care ID number, and date of birth
• Facility name and TIN or NPI
• Admitting/attending physician name and TIN or NPI
• Description for admitting diagnosis or ICD-10-CM diagnosis code
• Actual admission date
• Primary Medical Group/IPA

For emergency admissions where a member is unstable and not capable of providing coverage information, the facility should notify us by phone or fax within 24 hours (or the next business day, for weekend or holiday admissions) from the time the information is known and communicate the extenuating circumstances.

The following reports must be faxed daily to our Clinical Information department:

• Census report for all our members;
• Discharge report;
• Face sheets to report outpatient surgeries and SNF admissions; and
• Inpatient Admission Fax Sheet to report “no UnitedHealthcare West admissions” for that day.

The census report or face sheets must include the following information:

• Primary Medical Group/IPA
• Admit date
• Member name (first and last) and date of birth
• Bed type/accommodation status/level of care (LOC)
• Expected length of stay (LOS)
• Admitting physician
• Admitting diagnosis (ICD)
• Procedure/surgery (CPT Code) or reason for admission
• Attending physician
• Facility
• City/State
• Policy number/member health care ID number
• Other insurance
• Authorization number (if available)
• Discharge report, including member demographic information, discharge date and disposition

Coordination of Care

Facilities are required to assist in the coordination of a member’s care by:

• Working with the member’s PCP;
• Notifying the PCP of any admissions; and
• Providing the PCP with discharge summaries.

After Hour Admissions/ SNF Transfers

• For admissions or transfers after-hours or on weekends, the member should be admitted to the appropriate facility at the appropriate level of care. Authorization can be obtained on the next business day.
• Transfers/admissions to SNFs can be admitted directly from the emergency room or home to a SNF.

Out-of-Network Admissions

• A referral/transfer to a non-network facility requires prior authorization. However, in the case of an emergency, a non-participating hospital may be used without prior authorization.
• After initial emergency treatment and stabilization, we may request that a member be transferred to a network hospital, when medically appropriate.

• If a PCP directs a member to a non-network hospital for non-emergent care without prior authorization, the PCP may be held responsible.

Consultation with Providers During Inpatient Stays
Authorization is not required for a consultation with a participating network provider during an inpatient stay. However, consultation with a non-network care provider requires prior authorization.

Concurrent Review
We conduct concurrent review on all admissions from the day of admission through the day of discharge. Concurrent review is performed by phone, as well as on-site at designated facilities, by clinical staff. We have established procedures for on-site concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling on-site reviews in advance; and (c) staff requirements to follow facility rules. If the clinical reviewer determines that the member may be treated at a lower level of care or in an alternative treatment setting, we discuss the case with the hospital case manager and the admitting physician. If a discrepancy occurs, our Medical Director or designee discusses the case with the admitting physician.

Variance Days
Variance days are days we determine inpatient care coordination and provision of diagnostic services are not medically necessary or are not provided in a timely manner contributing to delays in care. We adjust reimbursement accordingly. Our concurrent review staff attempts to minimize variance days by working with the attending physicians and hospital staff. If a variance is noted in the patient’s acute care process, our concurrent review staff discusses the variance with the hospital’s medical management/case management representative. If the variance exists after the discussion, our concurrent review staff documents the variance in our utilization records and submit to a concurrent review manager for approval. If approved, the variance is entered into our database as a denial of reimbursement for the variance time period. We mail a letter to the facility stating the variance type and time period. The facility may appeal the variances in writing. Our Medical Director will review the appeal and render a decision to overturn or uphold the decision.

Medical Observation Status
We authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a member’s medical condition and determine the need for actual admission, or to stabilize a member’s condition and typically lasts less than 48 hours. For Medicare Advantage members, we also follow any applicable CMS guidelines to determine whether observation services are medically appropriate. Typical cases, when observation status is used, include rule-out diagnoses and medical conditions that respond quickly to care. Members under observation status may later convert to an inpatient admission if medically necessary.

Emergency and/or Direct Urgent Admissions (Commercial Plans)
If a hospital does not receive authorization from us within one hour of the initial call requesting authorization, the emergent and/or urgent services prompting the admission are assumed to be authorized and should be documented as such to us until we direct or arrange care for the member. Once we become involved with managing or directing the member’s care, all services provided must be authorized by us.

Skilled Nursing Facilities (SNFs)
Before transfer/admit to a SNF, we must approve the member’s treatment plan. The member’s network physician must perform the initial physical exam and complete a written report within 48 hours of a member’s admission to the SNF. We perform an initial review and subsequent reviews as we deem necessary. Federal and state regulations require that members at SNFs be seen by a physician at least once every 30 calendar days.

Discharge Planning
The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

• Assessment and documentation the member’s needs as compared to those upon admission, including the member’s functional status and anticipated discharge disposition, if other than a discharge to home;

• Development of a discharge plan, including evaluation of the member’s financial and social service needs and potential need for post-hospital services, such as home health, DME, and/or placement in a SNF or custodial care facility;

• Approved authorizations for necessary post-discharge plan, as required by us;

• Organizing, communicating and executing the discharge plan;

• Evaluating the effectiveness of the discharge plan;

• Referrals to population-based disease management and case management programs, as indicated.

For after-hours or weekend discharges requiring home health and/or DME, the care should be arranged and authorization can be obtained on the next business day.
Retrospective Review (Medical Claim Review)

Medical claim review, also known as medical cost review, medical bill review and/or retrospective review, is the examination of the medical documentation and/or billing detail after a service has been provided. Medical claim review is performed to provide a fair and consistent means to retrospectively review medical claims to make sure medical necessity criteria are met, confirm appropriate level of care and length of stay, correct payer source and identify appropriate potential unbundling and/or duplicate billing occurrences.

The review includes an examination of all appropriate claims and/or medical records against accepted billing practices and clinical guidelines as defined by entities such as CMS, AMA, CPT coding and MCG® Care Guidelines depending on the type of claims submitted.

Claims that meet any of the following criteria are reviewed before the claim is paid:

- High dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Claims for implants that are not identified or inconsistent with the UnitedHealthcare West's Implant Guidelines;
- Claim check or modifier edits based on our claim payment software;
- Foreign country claims; and
- Claims with LOS or LOC mismatch.

To help ensure timely review and payment determinations, you must respond to requests for all appropriate medical records within seven calendar days from receipt of the request, unless otherwise indicated in your agreement.

We may review specific claims based on pre-established retrospective criteria to make sure acceptable billing practices are applied.

For hospital providers, we may reduce the payable dollars if line item charges have been incorrectly unbundled from room and board charges.

Minimum Content of Written or Electronic Notification

If we deny, delay delivery, or modify a request for authorization for health care services, our written or electronic notices will, at a minimum, include the following:

- The specific service(s) denied, delayed in delivery, modified, or partially approved, including:
  - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;
  - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
  - Clinical reasons for decisions regarding medical necessity; and
  - Contractual rationale for benefit denials.
- Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the member’s physician can request a peer-to-peer review;
- Alternative treatment options offered, if applicable;
- Description of any additional material or information necessary from the member to complete the request, and why that information is necessary;
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
  - Information regarding the member’s right to appoint a representative to file an appeal on the member’s behalf;
  - The member’s right to submit written comments, documents or other additional relevant information;
  - Information notifying the member and their treating care provider of the right to an expedited appeal for time-sensitive situations (not applicable to retrospective review);
  - Information regarding the member’s right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  - Information that the member may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products);
- For the treating care provider, the name and direct phone number of the health care professional responsible for the decision.
Pharmacy Formulary

Member benefit plans may or may not include pharmacy coverage. Our commercial and Medicare formularies include most generic drugs and a broad selection of brand name drugs. Prescription drugs/medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization in order to be covered.

In some instances, a member’s commercial pharmacy benefit plan may not include coverage for non-formulary prescriptions/medications. In these instances, the costs are the member’s financial responsibility, unless the prescribing physician requests prior authorization review and the member meets our criteria for coverage.

Use the online formulary to search by drug name or therapeutic class. Any restriction or limitation is also noted along with formulary alternatives, when applicable. The commercial formulary is updated twice a year, in January and July. The Medicare formulary is updated up to nine times during a calendar year. Physician requests for formulary review of medications or preauthorization guidelines are welcome. Prior authorization guideline change request forms and formulary change request forms can be obtained by going to OptumRx.com > HealthCare Professionals > Healthcare Provider Tools > Forms and Documents.

Prior Authorization Exception Process

We have a prior authorization process to provide for coverage of select formulary and non-formulary/non-covered medications. We delegate prior authorization services to OptumRx®. OptumRx staff will adhere to benefit plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards in reviewing each case.

Request for Prior Authorization of Non-formulary Medications

Only the physician, or their designee located in the physician’s office or other site where the member is receiving medical services, may make a request for prior authorization of a non-formulary drug. The prior authorization functions may not be delegated to a third-party who is not located at the physician’s office or other site where the member is receiving medical services. However, clinical pharmacists who work in a medical management capacity within a medical group and who are directly employed by or participating with that medical group may also make requests.

You can request an authorization by:

- **Phone:** 800-711-4555
- **Written request:** You can obtain a Commercial Prescription Prior Authorization Form – CA on UnitedHealthcareOnline > Tools & Resources > Forms or through OptumRx.com > Health Care Professionals Portal > Prior Authorizations.
  - **Fax:** 800-527-0531 for oral medications and 800-853-3844 for injectable/specialty medications.
- **Online:** OptumRx.com > HealthCare Professionals > Prior Authorizations. This online service enables physicians and health care professionals to submit a real-time prior authorization request 24 hours per day, seven days per week. After logging on at OptumRx.com with their unique National Provider Identifier (NPI) number and password, a physician or health care professional can submit patient details securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly.

Also, physicians and health care professionals can use this service to check on the status of a prior authorization request, even if it was not submitted online. This online service applies to oral drugs as well as specialty medications.

The prior authorization request must include specific information related to the member’s medical condition and course of treatment, as requested by OptumRx. OptumRx does not process the request until all necessary information has been submitted. OptumRx communicates with the physician or designated employee regarding whether the non-formulary drug is covered. Once all necessary information has been received, OptumRx makes the determination within the applicable time frame as defined by federal and/or state regulations. No decision is made on incomplete requests.

Non-formulary medications and/or other medications that require prior authorization may be authorized in accordance with the member’s benefit plan, provided the member’s benefit plan restrictions (applied to the requested agent(s)/therapeutic class, and the prior authorization process) are not exceeded and when any of the following criteria are met:

- The requested non-formulary medication has limited efficacy and relatively high incidence of side effects, but indication for specific disease management meets criteria outlined in the National Pharmacy & Therapeutics Committee (NPTC) guidelines;
- Documented failure of a therapeutic trial of a formulary agent(s);
- The formulary alternative(s) is/are contraindicated for treatment;
• The member is currently maintained and stabilized on a non-formulary medication previously approved by the benefit plan that is not excluded from coverage;

• The member experienced allergic reaction(s) to the formulary alternative (e.g., rash, urticaria, drug fever, anaphylactic type, or established adverse effects as published in the package insert of respective product relating to the pharmacological properties of the medications, formulations or differences in absorption, distribution, or elimination of the medications);

• The member meets established medical necessity criteria per clinical guidelines and/or standards;

• No other formulary agent is appropriate to meet the member’s condition; or

• The prescriber provides compelling medical evidence supporting the use of the requested non-formulary medication over the formulary agent where the requested therapeutic class is necessary for medical management.

The following information is required to evaluate each case prior to issuance of an authorization:

• Member’s name, health care ID number, date of birth, and gender

• Prescriber’s name, specialty, address, and phone/fax number

• Medication name, dosage strength and directions for use

• Diagnosis

• Date member was started on the non-formulary medication

• Name of specific drugs tried and failed

• Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice.

• Any other compelling medical information that would support the use of the non-formulary medication over a formulary alternative.

A written communication of case resolution is faxed to the care provider for each case serviced. If prior authorization is approved, the medication is covered for the applicable cost sharing. If prior authorization is denied, the member is responsible for paying the cost of the prescription.

Denial determinations require a letter to be sent to both member and prescriber stating the reason why the non-formulary medication is being denied and outlining the process for filing standard and expedited appeals.

Medicare Advantage Part D Members

For Medicare Advantage members, OptumRx prior authorization staff follows the coverage determination timelines as established by CMS. Standard coverage determinations must be completed within 72 hours. Expedited coverage determinations must be completed within 24 hours. Turnaround time varies by case type, and may be extended beyond the initial 24 or 72 hours based on incomplete service level agreements (SLAs) as agreed upon by the specific benefit plan and Centers for Medicare & Medicaid Services (CMS).

OptumRx communicates with the physician, or their designee, and the member for additional information regarding the request, and sends notification of the resulting case decision.

Different types of requests include:

• Prior Authorization (PA)

• Medicare Part B vs Medicare Part D (BvsD)

• Non-Formulary Exception (NF)

• Step Therapy (ST)

• Quantity Limit (QL)

• Tier Cost Sharing Exception (TCSE)*

Tier Cost Sharing Exception rules vary by specific benefit plan and available alternatives. Criteria for copayment reduction (Tier Cost Sharing Exception) are:

• The Requested drug is FDA-approved for the condition being treated; or

• One of the following:
  › Diagnosis is supported as a use in AHFS under the Therapeutic Uses section; or
  › Diagnosis is supported in the Therapeutic Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better; or
  › Diagnosis is listed in the Therapeutic Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation of III or Class Indeterminate; and Efficacy is rated as “Effective” or “Evidence Favors Efficacy”; and
  › History of failure, contraindication, or intolerance to all formulary alternatives in the lower qualifying tiers.

Authorizing and Dispensing Injectable/Infusion Medications

Members may use the OptumRx Specialty Pharmacy or a participating network retail pharmacy to obtain covered self-injectable and injectable/infusion medications. A list of participating retail pharmacies is available at OptumRx.com.

All medications are subject to the member’s benefit plan and delegation of medical/physician groups.

The physician must submit the following information to request a covered injectable and/or self-injectable medication for a member:

• Complete Prior Authorization Form (the requesting physician’s signature is required to allow the vendor to accept the document as a legal prescription)

*For Medicare Advantage Part D members, under certain circumstances and on an individual basis, members or physicians may request a reduction in the copayment or coinsurance amount for a drug on the formulary (Tier Cost Sharing Exception).
• Recent history and physical
• Copies of any pertinent laboratory results
• Copies of any reports by consultant providers

Submit requests to the OptumRx Specialty Pharmacy:

**Online:** [OptumRx.com](http://OptumRx.com)
**Phone:** 800-711-4555
**Fax:** 800-853-3844.

OptumRx verifies the member’s eligibility, notify the physician of the determination, and if appropriate, contacts the physician’s office to coordinate delivery of the medication(s). In the case of approved self-injectables, the vendor contacts the member to coordinate delivery of the medication(s).

For those self-administered drugs that may be covered by Medicare Part D, please refer or download a copy of the formulary online at [UHCWest.com](http://UHCWest.com), [AARPMedicarePlans.com](http://AARPMedicarePlans.com), or [UHCMedicareSolutions.com](http://UHCMedicareSolutions.com).

**California Commercial HMO and PPO products:**
Prescribing providers in California must use the [Prescription Drug Prior Authorization Request Form](http://Prescription Drug Prior Authorization Request Form) when submitting authorization requests to OptumRx.

• Article 1.2 Section 2218.30 to the California Code of Regulations (CCR) Title 10, Chapter 5, Subchapter 2.

Also, the California utilization management delegates may have contractual responsibilities for payment of certain prescription medications. When the delegate requires prior authorization for use of those drugs prescribed by their care providers, the delegate must also require the use of Optum’s [Prescription Drug Prior Authorization Request Form](http://Prescription Drug Prior Authorization Request Form). The delegate must have a policy and process in place and be able to demonstrate compliance.

**Claims Process**

Instructions and quick tips for EDI can be found at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > EDI Education for Electronic Transactions

EDI claims/encounters
EDI claims/encounters
EDI is the preferred method of claim submission for participating physicians and health care providers. Submit all professional and institutional claims and/or encounters electronically for UnitedHealthcare West and Medicare Advantage HMO product lines.

Please refer to our online [Companion Guides](http://Companion Guides) for the data elements required for these transactions found on the EDI Education for Electronic Transactions webpage.

OptumInsight Connectivity Solutions is available to assist you to begin submitting and receiving electronic transactions. For more information call 800-341-6141.

**Submit your claims and encounters as EDI transaction 837:**
• Before submitting your EDI claims to us, refer to the front of the member’s health care ID card to determine the appropriate UnitedHealthcare West product type.
• After verifying the product type, refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > EDI Education for Electronic Transactions for the correct payer ID number.

Previously submitted claims that were either denied or pended for additional information should not be resubmitted by EDI or paper claim. Please use the Claim Management application on Link.

The payer ID is an identification number that instructs the clearinghouse where to send your electronic claims/encounters. In some cases, the payer ID listed on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate payer ID number or refer to your clearinghouse published Payer Lists.

**Claims Adjudication**

We use industry claims adjudication and/or clinical practices, state and federal guidelines, and/or our policies, procedures and data to determine appropriate criteria for payment of claims. To find out more about this information, please contact your Network Account Manager, Physician Advocate or Hospital Advocate or visit our website at [UHCWest.com](http://UHCWest.com).

**Complete Claims Requirements**

We follow the Requirements for Complete Claims and Encounter Data Submission, as found in Chapter 8: Our Claims Process.

**National Provider Identification (NPI)**

We are able to accept the NPI on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN. For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy. We will accept NPIs submitted through any of the following methods:

• **Online:** [UnitedHealthcareOnline](http://UnitedHealthcareOnline) > Practice/Facility Profile (requires log in).
• **Phone:** 877-842-3210 through the United Voice Portal, select the “Health Care Professional Services” prompt. State “Demographic changes” and your call is directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

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Level of Care Documentation and Claims Payment
Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, we pay only the authorized level of care and the member shall not be billed for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, we pay you based on the lower level of care, which was determined by you to be the appropriate level of care for the member.

Member Financial Responsibility
You can verify the eligibility of our members before you see them and obtain information about their benefits including required copayments and any deductibles, out-of-pockets maximums or co-insurance that are the member’s responsibility.

Services Provided to Ineligible Members
In the event that we provide eligibility confirmation indicating that a member is eligible at the time the health care services are provided and it is later determined that the patient was not in fact eligible, we are not responsible for payment of services provided to the member, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the member (to the extent permitted by law) or from any other source of payment.

Authorization Guarantee Program (California Commercial)
The Authorization Guarantee program provides for reimbursement to you as a participating care provider for covered services provided to a member for which (1) an authorization has been provided, (2) who is determined to have been ineligible with UnitedHealthcare West on the date the authorized services were rendered and, (3) where the member’s lack of eligibility is only determined after authorized services have been rendered. The Authorization Guarantee program does not apply to self-insured or Medicare Advantage benefit plans.

Authorization Guarantee and Reimbursement Program
Our systems automatically deny claims for services provided to members who are not eligible regardless of prior authorization. We review all fee-for-service claims denials that are based on lack of eligibility to determine whether services are eligible for reimbursement. We overturn denials payable under the California commercial Authorization Guarantee program without any action by you. We reimburse you the amount that would have been due to you had the same services been provided to an eligible member.

If you receive payment for the same services from another source before we make a payment under the Authorization Guarantee and Reimbursement program, you must refund us the amount we paid within 45 business days.

Otherwise, for the Authorization Guarantee and Reimbursement program you must submit the bulleted items below to our Provider Dispute Resolution Team for Authorization Guarantee reimbursement consideration at:

Provider Disputes
P.O. Box 6098
Cypress, CA 90630

- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within two business days prior to the date of service;
- A copy of the authorization for the services rendered; and
- A record of any payment received from any other responsible payer, and amount due based on your contract with us, less any payment received from any other responsible payer.

Claims Status Follow-up
If you have not received an Explanation of Payment (EOP) within the time frames in accordance with state and federal law, you may follow-up on the status of a claim using one of the following methods:

- Online: UHCWest.com > Provider > Login > Check Eligibility. The website provides real-time data and is the quickest method for retrieving claim status information.
- EDI: (HIPAA 276/277). Please contact your EDI clearing house for additional information.
- Link: sign in to UnitedHealthcareOnline.com with your Optum ID.
- United Voice Portal - See How to Contact UnitedHealthcare West Non-Capitated Resources sections for telephone numbers. This system provides a fax of the claim status detail information that is available.

Claims Submission Requirements
You can mail paper Form 1500s, or UB-04s to the address listed on the member’s health care ID card. Refer to the Prompt Claims Processing section of Chapter 8: Our Claims Process, for more information about electronic claims submission and other EDI transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g., PMG, MSO, Hospital), then bill that entity directly for reimbursement.

Claims Submission Requirements for Reinsurance Claims for Hospital Providers
If covered services fall under the reinsurance provisions set forth in your agreement with us, then follow the terms of the agreement to make sure:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
• Only those inpatient services specifically identified under the terms of the reinsurance provision(s) may be used to calculate the stipulated threshold rate;

• Applicable eligible member copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;

• The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;

• The reinsurance is applied to the specific, authorized acute care confinement; and

• Claims are submitted in accordance with the required time frame, if any, as set forth in the agreement. In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms of the agreement and/or this supplement, you shall:
  › Indicate if a claim meets reinsurance criteria; and
  › Make medical records available upon request for all related services identified under the reinsurance provisions (e.g., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, we process the claim at the appropriate rate in the agreement. An itemized bill is required to compute specific reinsurance calculations and to properly review reinsurance claims for covered services.

**Interim Bills**

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The process outlined below will increase efficiencies for both us and the Hospital/SNF business offices:

• 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).

• 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).

• 114 Interim – Last Claim: Review admits to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

**Reciprocity Agreements**

You shall cooperate with our participating care providers and our affiliates and agree to provide services to members enrolled in benefit plans and programs of UnitedHealthcare West affiliates and to assure reciprocity with providing health care services.

If any member who is enrolled in a benefit plan or program of any UnitedHealthcare West affiliate, receives services or treatment from you and/or your sub-contracted care providers (if applicable), you and/or your sub-contracted care providers (if applicable), agree to bill the UnitedHealthcare West affiliate at billed charges and to accept the compensation provided pursuant to your agreement, less any applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare West affiliate and this agreement for reimbursement of such services or treatment.

**Overpayments**

Please follow the instructions as indicated in the Overpayments section of Chapter 8: Our Claims Process.

**End-Stage Renal Disease (ESRD)**

If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the plan for the first 30 months after becoming eligible for Medicare due to ESRD. After the 30 months elapse, Medicare is the primary payer. However, if the employer group benefit plan coverage were secondary to Medicare when the member developed ESRD, Medicare is the primary payer and there is no 30 month period.

**Medicaid (Applies Only to Medicare Advantage)**

Please follow the instructions as indicated in the Member Financial Responsibility section of Chapter 9: Compensation.

**Time Limits for Filing Claims**

All care providers are required to submit to clean claims for reimbursement no later than 1) 90 days from the date of service, or 2) the time specified in your participation agreement, or 3) the time frame specified in the state guidelines, whichever is greater.

If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) which are denied for untimely filing cannot be billed to a member.

We established internal claims processing procedures to help ensure timely claims payment to care providers. We are committed to paying claims for which we are financially responsible within the time frames required by state and federal law.

The date of receipt is used as the business day when a claim, by physical or electronic means, is first delivered to our claims payment office, post office box, designated claims processor or to the capitated care provider for that claim. The following date stamps may be used to determine date of receipt:

• Our Claims Department date stamp
• Primary payer claim payment/denial date as shown on the EOP
• Delegated provider date stamp
• TPA date stamp
• Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender

Note: Date stamps from other health benefit plans or insurance companies are not valid received dates for timely filing determination.

Provider Claims Appeals

Claims Research and Resolution (Applies to Commercial in Oklahoma & Texas)
The Claims Research & Resolution (CR&R) process applies:
• If you do not agree with the payment decision after the initial processing of the claim; and
• Regardless of whether the payer was UnitedHealthcare West, the delegated Medical Group/IPA or other delegated payer, or the capitated hospital/provider, you are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare West researches the issue to identify who holds financial risk of the services and abides by federal and state legislation on appropriate timelines for resolution. We work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim Reconsideration Requests (Does Not Apply in California)
You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. The most efficient way to submit your requests is through the claim reconsideration application on Link. Learn more on UnitedHealthcareOnline.com > Quick Links > Link: Learn More. You can submit your request to us in writing by using the Claims Rework Request form (available at UHCWest.com > Providers > Login > Select State > Library > Resource Center > Forms).

Please refer to the chart titled UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section for the address to which your request should be sent.

Submission of Bulk Claim Inquiries
The Claims Project Management (CPM) team handles bulk claim inquiries. You should contact the CPM team at the address below to initiate a bulk claim inquiry:

<table>
<thead>
<tr>
<th>Provider’s state</th>
<th>Contact information</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>California</td>
<td>Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 19 or more claims.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Nevada</td>
<td>For Medicare Advantage claims: UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638</td>
<td>The Nevada delegated payer handles bulk claim inquiries received from providers of service. The provider of service should submit the bulk claims with a cover sheet indicating “Appeal” or “Review” to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for 10 or more claims.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 10 or more claims.</td>
</tr>
<tr>
<td>Texas</td>
<td>Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Washington</td>
<td>Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 10 or more claims.</td>
</tr>
</tbody>
</table>

UnitedHealthcare West’s Response
We respond to issues as quickly as possible.

• Reworks/disputes requiring clinical determination: Individuals with clinical training/background who were not previously involved in the initial decision review all clinical
rework/dispute requests. We send a letter to you outlining our determination and the basis for that decision.

• Reworks/disputes requiring claim process determination: Individuals not previously involved in the initial processing of the claim review the rework/dispute request.

• Response details: If claim requires an additional payment, the EOP serves as notification of the outcome on the review. If the original claim status is upheld, you are sent a letter outlining the details of the review.

Applies to California: If a claim requires an additional payment, the EOP does not serve as notification of the outcome of the review. We send you a letter with the determination. In addition, payment must be sent within five calendar days of the date on the determination letter. We respond to you within the applicable time limits set forth by federal and state agencies. After the applicable time limit has passed, call Provider Relations at 877-847-2862 to obtain a status.

Provider Dispute Resolution (CA, OR, and WA Commercial Plans)

A provider dispute is a dispute of a claim for which a determination has previously been issued by us. You must submit a provider dispute, in writing, and with additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement or state law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of provider disputes, in accordance with state and federal regulations. We do not discriminate, retaliate against or charge you for submitting a provider dispute. The PDR process is not a substitution for arbitration and is not deemed as an arbitration.

What to Submit
As the care provider of service, you should submit the dispute with the following information:

• Member’s name and health care ID number
• Claim number
• Specific item in dispute
• Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved
• Your contract information

Disputes are not reviewed if the supporting documentation is not submitted with the request.

For California physicians and health care professionals: A Provider Dispute Resolution form can be obtained online at [UHCWest.com](http://UHCWest.com) > Login > Select “California” > Library > Resource Center > Provider Disputes (California Only). The dispute resolution form is not required; however, the minimum requirements outlined in AB1455 must be met.

Where to Submit
State-specific addresses and other pertinent information regarding the PDR process may be found in the UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section.

Accountability for Review of a Provider Dispute
The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/provider.

Excluded From the PDR Process
The following are examples of issues excluded from the PDR process:

• Instances in which a member has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the member’s appeal takes precedence. You can submit a care provider dispute after the member appeal decision is made. If you are appealing on behalf of the member, the appeal is processed as a member appeal.

• An Independent Medical Review initiated by a member through the member Appeal Process.

• Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply “good cause” for the delay.

• Any delegated claim issue that has not been reviewed through the delegated payer’s claim resolution mechanism.

• Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/ provider and does not involve an issue of medical necessity or medical management.
<table>
<thead>
<tr>
<th>Provider’s state</th>
<th>Contact Information</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078</td>
<td>First Review: Request for reconsideration of a claim is considered a grievance. Physicians and health care professionals are required to notify us of any request for reconsideration within one year from the date the claim was processed. Second Review: Request for reconsideration of a grievance determination is also considered a grievance. Physicians and health care professionals are required to notify us of any second level grievance within one year from the date the first level grievance resolution was communicated to the care provider.</td>
</tr>
<tr>
<td>California</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>UnitedHealthcare of California acknowledges receipt of paper disputes within 15 business days and within two business days for electronic disputes. If additional information is required, the dispute is returned within 45 business days. A written determination is issued within 45 business days.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983</td>
<td>Upon receipt of a dispute, Colorado Resolution Team: • Acknowledges receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conducts a thorough review of the care provider’s dispute and all supporting documentation; • Acknowledges receipt, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Processes payment, if necessary, within five business days of the written determination; • Replies to the care provider of service within 30 calendar days if additional information is required. If additional information is required, we will hold the dispute request for 30 additional calendar days.</td>
</tr>
<tr>
<td>Nevada</td>
<td>For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638</td>
<td>All Nevada Medicare Advantage HMO claims are processed by a delegated payer. Therefore, the care provider appeals are reviewed primarily by the delegated payer.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>UnitedHealthcare of Oregon allows at least 30 calendar days for care providers to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.</td>
</tr>
<tr>
<td>Texas</td>
<td>UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>UnitedHealthcare of Washington allows at least 30 calendar days for care providers to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.</td>
</tr>
</tbody>
</table>
California Language Assistance Program (California Commercial Plans)

UnitedHealthcare of California members who have limited English proficiency, have access to translated written materials and oral interpretation services, free of charge, to assist them in obtaining covered services. For more information, call 800-752-6096.

If the member’s language of choice is not English or has limited English proficiency, please arrange for oral interpretive services prior to the date of service, if feasible.

Member Complaints & Grievances

Member disputes may arise from time-to-time with UnitedHealthcare West or with our participating care providers. UnitedHealthcare West respects the rights of its members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service. Instructions on how to file a complaint or grievance with us can be found in the member’s Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage.
# Applicability of This Supplement

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers individual personal health products including Golden Rule Insurance Company (“GRIC”), UnitedHealthcare Life Insurance Company, (“UHCLIC”), and some individual products offered by Oxford Health Insurance, Inc.

This Supplement applies to services provided to members enrolled in GRIC, UHCLIC and UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.

Care providers are subject to both the preceding guide and this Supplement and the insured’s benefit plan. This supplement and the member’s benefit plan controls if it conflicts with information in the preceding guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this Supplement please refer to appropriate chapter in the preceding guide.

## How to Contact UnitedHealthOne Resources

<table>
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<tr>
<th>Resource</th>
<th>Where to go</th>
<th>Requirements and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GRIC– Group Number 705214</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Notification</strong></td>
<td>Call the number on the back of the member's health care ID card or go to UnitedHealthcareOnline.com.</td>
<td></td>
</tr>
<tr>
<td><strong>Benefits and Eligibility</strong></td>
<td>Call the number on the back of the member’s health care ID card or go to myuhone.com.</td>
<td>To inquire about a member’s plan benefits or eligibility.</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>Go to myuhone.com</td>
<td>To view pending and processed claims.</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td>Prior Authorizations:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Phone: 800-711-4555</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fax for non-specialty meds: 800-527-0531</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fax for specialty meds: 800-853-3844</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Benefit Information:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Call the pharmacy number on the back of the member's health care ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>UHCLIC– Group Number 755870, GRIC – Group Number 902667 and Oxford– Group Number 908410</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td>Online: <a href="http://www.providerexpress.com">providerexpress.com</a></td>
<td>Submit admission notification or prior authorization for behavioral health, including substance abuse and autism.</td>
</tr>
<tr>
<td></td>
<td>Phone: (855) 779-2859</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiology:</strong></td>
<td>Online: UnitedHealthcareOnline.com &gt; Notification/Prior Authorization Phone: 866-889-8054</td>
<td>Request prior authorization for services as described in the Cardiology Notification/Prior Authorization Protocol section of Chapter 6: Medical Management.</td>
</tr>
<tr>
<td>Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic, physical and occupational therapy</strong></td>
<td>Online (clinical submission request): myoptumhealthphysicalhealth.com.</td>
<td>Follow the clinical submission process for chiropractic, physical and occupational therapy as described in Chapter 6: Medical Management.</td>
</tr>
<tr>
<td></td>
<td>Phone: 888- 676-7768.</td>
<td></td>
</tr>
<tr>
<td><strong>Claims Submission</strong></td>
<td>Electronic Claims Submission: Payer ID 37602</td>
<td></td>
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<tr>
<td></td>
<td>Paper Claims Submission: Mail to the address listed on the back of the ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td>Prior Authorizations:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Phone: 800-711-4555</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fax for non-specialty meds: 800-527-0531</td>
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<td></td>
<td>• Fax for specialty meds: 800-853-3844</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Benefit Information:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Call the pharmacy number on the back of the member's health care ID card.</td>
<td></td>
</tr>
</tbody>
</table>
## Health Care ID Card

Members receive health care ID cards containing information to help you submit claims accurately and completely. Information varies in appearance or location on the card. However, cards display the same basic information (e.g., claims address, copayment information, and phone numbers).

Be sure to check the member’s health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use the electronic payer ID on the health care ID card.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health Care Identification (ID) Cards Section of Chapter 2: Provider Responsibilities and Standards.

## Claims Process

We know that you want to be paid promptly for the services you provide. This is what you can do to help promote prompt payment:

1. Notify us, in accordance with the notification requirements set forth in this supplement.
2. For Navigate and Compass referrals, refer to Chapter 5: Referrals.
3. Prepare a complete and accurate claim form. For facility (UB04/8371) claims see number five below.
4. Submit electronic claims using the electronic payer ID on the health care ID card, or submit paper claims to the address listed on the member’s health care ID card. GRIC payer id is 37602 and UHCLIC is 81400.
5. Requirements for claims (paper or electronic) reporting revenue codes:
   - All claims reporting revenue codes require the exact dates of service if they are span dates.
   - If you report revenue code 274, you are required to provide a description of the services or a valid CPT or HCPCS codes.
   - All claims reporting the revenue codes on the list below require that your report the appropriate CPT and HCPCS codes.

## Resource Table

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
<th>Requirements and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorization and Notification</strong></td>
<td>Online: UnitedHealthcareOnline.com &gt; Notifications/Prior Authorizations  Phone: 800-999-3404</td>
<td>Prior authorization and admission notification is required as described in Chapter 6: Medical Management. EDI 278A transactions are not available.</td>
</tr>
<tr>
<td><strong>Radiology/Advanced Outpatient Imaging Procedures:</strong>  CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology</td>
<td>Online: UnitedHealthcareOnline.com &gt; Notifications/ Prior Authorizations  Phone: 866-889-8054</td>
<td>Request prior authorization for services as described in the Outpatient Radiology Notification/Prior Authorization Protocol section of Chapter 6: Medical Management.</td>
</tr>
<tr>
<td><strong>UHCLIC– All Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Notification</strong></td>
<td>Call the number on the back of the member’s health care ID card.</td>
<td>Notification is required for inpatient stays that exceed three days.</td>
</tr>
<tr>
<td><strong>Benefits and Eligibility</strong></td>
<td>Call the number on the back of the member’s health care ID card.</td>
<td>To inquire about the member’s plan benefits or eligibility.</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td>Call the pharmacy number on the back of the member’s health care ID card.</td>
<td>For information on the Prescription Drug List (PDL).</td>
</tr>
</tbody>
</table>
### Revenue codes requiring CPT® and HCPCS codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>IV Therapy (General Classification)</td>
</tr>
<tr>
<td>261</td>
<td>Infusion Pump</td>
</tr>
<tr>
<td>262</td>
<td>IV therapy/pharmacy services</td>
</tr>
<tr>
<td>263</td>
<td>IV therapy/drug/supply delivery</td>
</tr>
<tr>
<td>264</td>
<td>IV Therapy/Supplies</td>
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<td>269</td>
<td>Other IV therapy</td>
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<td>290</td>
<td>Durable Medical Equipment (other than renal)</td>
</tr>
<tr>
<td>291</td>
<td>DME/Rental</td>
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<td>292</td>
<td>Purchase of new DME</td>
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<td>293</td>
<td>Purchase of used DME</td>
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<td>300</td>
<td>Laboratory (General Classification)</td>
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<td>301</td>
<td>Chemistry</td>
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<td>Immunology</td>
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<td>Renal Patient (Home)</td>
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<td>Non-Routine Dialysis</td>
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<td>305</td>
<td>Hematology</td>
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<td>306</td>
<td>Bacteriology &amp; Microbiology</td>
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<td>307</td>
<td>Urology</td>
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<tr>
<td>309</td>
<td>Other laboratory</td>
</tr>
<tr>
<td>310</td>
<td>Laboratory - Pathology (General Classification)</td>
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<tr>
<td>311</td>
<td>Cytology Histology</td>
</tr>
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<td>312</td>
<td>Other Laboratory Pathological</td>
</tr>
<tr>
<td>319</td>
<td>Radiology - diagnostic (General Classification)</td>
</tr>
<tr>
<td>320</td>
<td>Angiocardiology</td>
</tr>
<tr>
<td>321</td>
<td>Arthrography</td>
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<td>Other EKG/ECG</td>
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Revenue codes requiring CPT® and HCPCS codes

- 740 EEG (Electroencephalogram) (General Classification)
- 750 Gastro-Intestinal (GI) Services (General Classification)
- 790 Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
- 921 Peripheral Vascular Lab
- 922 Electromyogram
- 923 Pap Smear
- 924 Allergy Test
- 925 Pregnancy Test
- 929 Additional Diagnostic Services
- 940 Other Therapeutic Services (General Classification)
- 941 Recreational Therapy
- 942 Education/Training (Diabetic Education)
- 949 Other Therapeutic Services (HRSA)

Note: Use the payer ID number on the member’s health care ID card. The electronic claims submission number does vary and is rejected if the correct payer ID is not used.

Claim Adjustments

If you believe your claim was processed incorrectly, please call the number on the back of the member’s health care ID card and request an adjustment as soon as possible, in accordance with applicable statutes and regulations. If you or our staff identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination (see the following Claims Appeals section).

Claims Appeals

If you disagree with a claim payment determination, send a letter of appeal to the following address:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0370
Fax: 317-715-7648
Phone: 800-657-8205

If you feel your situation is urgent, request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Fax: 920-661-9981
Phone: 800-291-2634

Your appeal must be submitted within 180 calendar days from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

Please refer to Claim Reconsideration, Appeals Process and Resolving Disputes section in Chapter 8: Our Claims Process.

If you disagree with the outcome of the claim appeal, you may file an arbitration proceeding as described in your participation agreement.

Member Complaints & Grievances

Member disputes may arise from time-to-time with UnitedHealthOne or with our participating care providers. We respect the rights of our members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service. Instructions on how to file a complaint or grievance with us can be found in the member’s Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage. Please refer to Member Appeals, Grievances or Complaints section in Chapter 8: Our Claims Process for detailed information about your role in the member appeal process.

UnitedHealthcare Oxford Navigate Individual - Internal Utilization Review (UR) Appeals Process

Internal UR appeals must be initiated by the member or their designee 180 calendar days from receipt of the initial adverse UR determination.

To initiate the standard internal UR appeal process, write to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: 317-715-7648

If you feel the situation is urgent, request an expedited (urgent) appeal orally, by fax or in writing to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Fax: 920-661-9981
Phone: 800-291-2634

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. Expedited UR appeals are determined within 72 hours of receipt of the appeal. Standard (non-expedited) UR appeals are determined within 10 calendar days of our receipt of the appeal.

All UR appeals are conducted by clinical peer reviewers other than the clinical peer reviewer who rendered the initial adverse UR determination.

If the member or designee is not satisfied with the results of the appeal process, the member or designee may pursue an external appeal through an independent Utilization Review Organization (“IURO”) for final internal UR determinations. You must complete an internal appeal before you can request a review by an IURO, except when:
1. We fail to meet the deadlines for completion of the internal appeals process:
   a. Without demonstrating good cause, or
   b. Because of matters beyond our control, and
   c. While in the context of an ongoing, good faith exchange of information between parties, and
   d. It is not a pattern or practice of noncompliance;
2. We, for any reason, expressly waive our rights to an internal review of an appeal; or
3. The treating care provider and/or member have applied for expedited external review at the same time as applying for an expedited internal review.

To initiate the external appeal, the member or designee must:
1. File a written request with the New Jersey Department of Banking and Insurance within four months of receiving a final determination on an appeal.
2. Sign a release that allows the IURO to review all of the necessary medical records related to the appeal; and
3. Send a check or money order in the amount of $25 made payable to: New Jersey Department of Banking and Insurance with the request. The form, release and check must be sent to:

   Department of Banking and Insurance
   Consumer Protection Services
   Office of Managed Care
   P.O. Box 329
   Trenton, NJ 08625-1062
   Phone: 888-393-1062

The review is completed within 45 days of the IRUO’s receipt of the appeal application. If the appeal involves care for urgent or emergency care, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person’s ability to regain maximum function, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

If UnitedHealthcare Oxford Navigate Individual has good cause for not meeting the deadlines of the appeals process, members or their designee and/or their care provider may request a written explanation of the delay. UnitedHealthcare Oxford Navigate Individual must provide the explanation within 10 days of the request and must include a specific description of the bases for which it was determined the delay should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with UnitedHealthcare Oxford Navigate Individual and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Notice to Texas Providers
- To verify benefits for GRIC members, call 800-395-0923.
- To verify benefits for UHCLIC members, call 800-657-8205.

Tools have been developed by third parties, such as the MCG® Care Guidelines, (formerly known as Milliman Care Guidelines®), to assist in administering health benefits and to assist clinicians in making informed decisions in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, GRIC, UHCLIC and Oxford Health Insurance, Inc. may also use UnitedHealthcare’s medical policies as guidance. These policies are available online at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides.

Notification does not guarantee coverage or payment (unless mandated by law). The member’s eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the phone number on the back of the member’s health care ID card.

To obtain a verification as required by 28 TAC §19.1719, please call 800-842-1792.

Important Information Regarding Diabetes (Michigan)
Michigan has a law requiring insurers to provide coverage for certain expenses to treat diabetes. The law also requires insurers to establish and provide to members and participating providers a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines published by the ADA.

The program for participating care providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations at care.diabetesjournals.org.

Subscription information for the American Diabetes Journals is available on the website or by calling 800-232-3472, select option one, 8:30 a.m. to 8 p.m. ET, Monday through Friday. View journal articles without a subscription online at the website listed above.
Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the health insurance plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or medically unnecessary services. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Accreditation: A process that a care provider goes through to be recognized for meeting certain standards such as quality.

Acute Inpatient Care: Care provided to persons sufficiently ill or disabled requiring:
1. Constant availability of medical supervision by attending provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the provider

Adjudication: The process of determining the proper payment amount on a claim.

Ambulatory Care: Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term “ambulatory care” usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility: A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services: Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal: An oral or written request by a member or member’s personal representative received by UnitedHealthcare for review of an action.

Authorization: Approval obtained by care providers from UnitedHealthcare for a designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Authorized Care Provider: A care provider who meets UnitedHealthcare’s licensing and certification requirements and has been authorized by UnitedHealthcare to provide services.

Balanced Billing: When a care provider bills a member for the difference between billed charges and the UnitedHealthcare allowable charge after UnitedHealthcare pays a claim.

Benefit: The amount of money UnitedHealthcare pays for care and other services.

Capitation: Per person way of payment for medical services. UnitedHealthcare pays a participating capitated care provider a fixed amount for every member he or she cares for, regardless of the care provided.

Care Provider: This can be a person who provides medical or other health care (doctor, nurse, therapist or social worker) or office support staff. A care provider can be a doctor practicing alone, in a hospital setting, or in a group practice. A care provider could work from a remote location, in a public space, or any combination of locations.

Claim: The documentation of the services that have occurred during the course of a visit to a health care provider.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): United States federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.

Clean Claim: A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services.

Coordination of Benefits (COB): Allows benefit plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

Coinsurance: The member’s share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Members may pay co-insurance plus any deductibles owed.

Commercial: Refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers’ compensation, TRICARE, or other governmental programs (except that “Commercial” also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities).

Contract: The policy is a contract between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay.
Copayment: A fixed amount members may pay for a covered health care service, usually upon receiving the service.

Covered Services: Medically necessary services included in the member’s benefit plan. Covered services change periodically and may be mandated by federal or state legislation.

Credentialing: The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare.

Current Procedural Terminology Codes (CPT): American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Deductible: The amount a member owes for health care services the health insurance or benefit plan covers before the health insurance or benefit plan begins to pay.

Delivery System: The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, health care facilities, care provider offices, and home health care.

Dependent: A child, disabled adult or spouse covered by the health benefit plan.

Disallow Amount: Medical charges for which the network provider is not permitted to receive payment from the health benefit plan and cannot bill the member. Examples are:

1. The difference between billed charges and contracted rates; and
2. Charges for services, bundled or unbundled, as detected by Correct Coding Initiative edits.

Discharge Planning: Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Disease Management: A prospective, disease-specific approach to improving health care outcomes by providing education to members through non-physician.

Disenrollment: The discontinuance of a member’s eligibility to receive covered services from a contractor.

Durable Medical Equipment (DME): Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a physician.

Electronic Data Interchange (EDI): The electronic exchange of information between two or more organizations.

Electronic Medical Record (EMR): The electronic version of a member’s health records.

Emergency Care: The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most voluntarily established pension and health benefit plans in private industry to provide protection for individuals in these benefit plans.

Encounter: An interaction between a patient and health care providers, for the purpose of provider healthcare services or assessing the health status of a patient.

Expedited Appeal: An oral or written request by a member or member’s personal representative received by UnitedHealthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Fee for Service: Health care providers are paid for each service (like an office visit, test, or procedure).

Fraud: Health care fraud is a crime that involves misrepresenting information, concealing information, or deceiving a person or entity in order to receive benefits, or to make a financial profit. (18 U.S.C.§1347).

Grievance: An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Insurance Portability and Accountability Act (HIPAA) Act of 1996: A federal legislation that provides data privacy and security provisions for safeguarding medical information.

Health Plan Employer Data and Information Set (HEDIS): Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers’ needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Home Health Care (Home Health Services): Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.
Managed Care: A system designed to better manage the cost and quality of medical services. Managed care products not only offer less member liability but also less member control. Managed care aims to improve accessibility to health care, reduce cost, and improve quality of service. Many managed care health insurance programs work with Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) boards to promote use of specific health treatment procedures. Managed care health insurance benefit plans also educate and work with consumers to improve overall health by addressing disease prevention. The common types of managed care products are HMO, PPO, and Point of Service (POS) benefit plans.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

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

- Necessary to meet the basic health needs of the client;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
- Consistent with the diagnosis of the condition;
- Required for means other than convenience of the client or their physician;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value; and
- No more intense level of service than can be safely provided.

Member: Refers to an individual who has been determined UnitedHealthcare eligible and enrolled with UnitedHealthcare to receive services pursuant to the Agreement. Other common industry terms: customer, patient, beneficiary, insured, enrollee, subscriber, dependent.

National Provider Identification (NPI): NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

Network Care Provider: A professional or institutional care provider who has an agreement with UnitedHealthcare to provide care at a contracted rate. A network care provider agrees to file claims and handle other paperwork for UnitedHealthcare member. A network care provider accepts the negotiated rate as payment in full for services rendered.

Non-network Health Care Provider: A non-network provider does not have an agreement with UnitedHealthcare, but is certified to provide care to UnitedHealthcare members. There are two types of non-network care providers: participating and nonparticipating.

1. Nonparticipating care provider: A nonparticipating care provider is a UnitedHealthcare-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to UnitedHealthcare members but who does not have an agreement and does not accept the UnitedHealthcare allowable charge or file claims for UnitedHealthcare members. A nonparticipating care provider may only charge up to 15 percent above the UnitedHealthcare allowable charge.

2. Participating care provider: A health care provider who has agreed to file claims for UnitedHealthcare members, accept payment directly from UnitedHealthcare, and accept the UnitedHealthcare allowable charge as payment in full for services received. Non-network care providers may participate on a claim-by-claim basis. Participating care providers may seek payment of applicable copayments, cost-shares and deductibles from the member. Under the UnitedHealthcare outpatient prospective payment system, all Medicare participating care providers and hospitals must, by law, also participate in UnitedHealthcare for inpatient and outpatient care.

Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

Optum: A UnitedHealth Group company that designs and implements custom information technology systems, and offers management consulting, in the health care industry nationwide.

Out-Of-Area Care: Care received by a UnitedHealthcare enrollee when they are outside of their geographic territory.

Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.
Primary Care Provider (PCP): A physician such as a family practitioner, pediatrician, internist, general practitioner, or obstetrician, who serves as a gatekeeper for their assigned members’ care. Other providers may be included as primary physicians such as nurse practitioners and physician assistants as allowed by state mandates.

Primary Care Team: a team comprised of a care manager, a PCP, and a Nurse Practitioner or Physician Assistant.

Prior Authorization and Notification: A unit under the direction of the UnitedHealthcare Health Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare policy.

Provider Group: A partnership, association, corporation, or other group of providers.

Provider Manual: This document is referred to as a care provider manual or guide. It may also be referred to as the provider administrative guide or handbook.

Quality Management (QM): A methodology used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Reinsurance: The contract made between an insurance company and a third party to protect the insurance company from losses.

Secondary Payer: A source of coverage that pays after the primary insurance benefit has been applied.

Self-Funded Plan: Self-funded health care also known as Administrative Services Only (ASO) is a self insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds.

Self-Insured: A self-insured group health benefit plan is one in which the employer assumes the financial risk for providing health care benefits to its employees.

Service Area: A geographic area serviced by a UnitedHealthcare contracted provider, as stated in the health care provider’s agreement with us.

Skilled Nursing Facility: A Medicare-certified nursing facility that (a) provides skilled nursing services and (b) is licensed and operated as required by applicable law.

Stop-loss: A product that provides protection against catastrophic or unpredictable losses. It is purchased by employers who have decided to self-fund their employee benefit health benefit plans, but do not want to assume 100% of the liability for losses arising from the benefit plans.

Subrogation: A health plan’s right, to the extent permitted under applicable state and federal law and the applicable benefit plan, to recover benefits paid for a member’s health care services when a third party causes the member’s injury or illness.

Subscriber: Person who owns an insurance policy.

Supplemental Benefits: Supplemental insurance includes health benefit plans specifically designed to supplement UnitedHealthcare standard benefits.

Third Party Administrator (TPA): An organization that provides or manages benefits, claims or other services, but it does not carry any insurance risk.

Transitional Care: A program that is designed for members to help ensure a coordinated approach takes place across the continuum of care.

UnitedHealthcare Assisted Living Plan: A Medicare Advantage Institutional Special Needs Plan that:
1. Exclusively enrolls special needs individuals who living in a contracted Assisted Living Community, have Medicare A and B, and meet the local state’s criteria for “institutional level of care”.
2. Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare’s affiliates; and
3. Is offered through our UnitedHealthcare Medicare Solutions business unit, as indicated by a reference to Assisted Living Plan name listed on the face of the valid health care ID card.

UnitedHealthcare Nursing Home Plan: A Medicare Advantage Institutional Special Needs Plan benefit plans that:
1. Exclusively enrolls special needs individuals who for 90 calendar days or longer, have had or are expected to need the level of service requiring an institutional level of care (as such term is defined in 42 CFR 422.2);
2. Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare’s affiliates; and
3. Is offered through our UnitedHealthcare Medicare Solutions business unit, as indicated by a reference to Nursing Home Plan name listed on the face of the valid health care ID card of any UnitedHealthcare Nursing Home Plan Institutional member eligible for and enrolled in such benefit plan.

UnitedHealthcare Nursing Home Plan Member: A Medicare member who for 90 calendar days or longer has had or is receiving an institutional level of care is enrolled in a UnitedHealthcare Nursing Home Plan.

Us: “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.
**Glossary**

**Utilization Management (UM):** The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

**Waste:** The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

**Workers’ Compensation:** Workers’ compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee’s right to sue their employer for the tort of negligence.

**You:** “You,” “your” or “provider” refers to any health care provider subject to this guide, including physicians, health care professionals, facilities and ancillary providers; except when indicated all items are applicable to all types of providers subject to this Guide.