

Frequently Asked Questions

UnitedHealthcare Compass

Key Points

- Specifically designed for Individual Exchanges
- Customized, more focused network of care providers
- Members are required to select a primary care provider (PCP) to manage their health care needs
- The member's PCP must submit electronic referrals for members to see a network specialist physician
- Standard prior authorization and notification requirements apply

Overview

UnitedHealthcare Compass is a suite of health insurance products designed for Individual Exchange benefit plans. Compass is built on the fundamentals of patient-centered care, with the goal of enhancing the patient-doctor relationship and promoting better health and lower costs. Compass places the focus on primary care, with members choosing a PCP as their trusted partner to help them understand the increasingly complex health care system and actively promote quality and more efficient care.

The three product options within the Compass suite offer varying levels of coverage and plan designs to help meet the needs of our members.

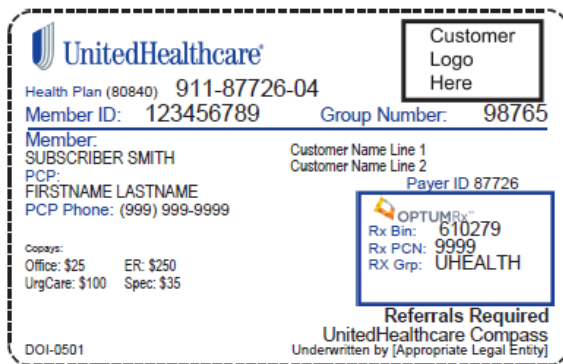
| Plan models | Network physicians with required referral | Network physicians without required referral | Non-network care provider |
|------------------|---|--|---------------------------|
| Compass | Network benefits | No coverage* | No coverage* |
| Compass Balanced | Network benefits | Lower-level benefits | No coverage* |
| Compass Plus | Network benefits | Lower-level benefits | Non-network benefits |

* Except for emergency services and related admissions

Sample ID Card

Look for key differences on the member's ID card to identify plan type and benefit features:

1. Individual Exchange identifier
2. Plan requires PCP assignment; find the member's assigned PCP by using the eligibilityLink tool on Link. To access eligibilityLink, sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com
3. Type of Compass plan and "Referrals Required" indicator
4. W500 logo identifying plans with additional network benefits that have access to an additional network of care providers that provide urgent care, emergency services and pre-approved services



Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements.

Frequently Asked Questions and Answers

Provider Network

Q1. How do I know if I'm a network care provider for Compass benefit plans?

- A. If you participate in other UnitedHealthcare commercial benefit plans, you're considered a network care provider for UnitedHealthcare Compass benefit plans, unless Compass is specifically excluded in your Participation Agreement. If Compass isn't an excluded plan, you'll be listed in our Compass provider directory. Please confirm your participation status when verifying patient eligibility and benefits using the eligibilityLink tool on Link or the online provider directory.

Q2. Can my participation status vary by health plan?

- A. Yes, not all care providers are included in every network. You can view your network status using the eligibilityLink tool on Link, or by checking the online provider directory for Compass benefit plans at **UHCprovider.com** > Menu > Find a Care Provider.

Q3. Do UnitedHealthcare Compass benefit plans use the same network as UnitedHealthcare Choice/Choice Plus?

- A. No. UnitedHealthcare Compass features a customized, more focused network to better meet consumer needs around access to quality and efficient care for local communities. To find network care providers, including hospitals and independent labs, please refer to the provider directory for Compass plans at **UHCprovider.com** > Menu > Find a Care Provider.

Primary Care Physician

Q4. What is the role of the PCP in Compass benefit plans?

- A. PCPs oversee their patients' overall health care and actively manage referrals to network specialists. The PCP's in-depth knowledge of their patients' health helps them guide their patients along the best path to health and well-being. This helps enable Compass members to avoid the costly missteps and hassles of an increasingly complex health care system, so members can get the care that's right for them.

Q5. How do members choose a PCP?

- A. Members must select a PCP upon enrollment. Each family member may select a different PCP, depending on their needs. Subscribers and all dependents must select a PCP in the market in which the subscriber lives or works, including dependents that live out of state. Once a PCP is selected, both the care provider and member can view the member's selection online. The PCP name will not be listed on the member's health plan ID card.

You can view the member's assigned PCP using the eligibilityLink app on Link. Sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com.

Q6. Can members change their PCP?

- A. A member may request to change their designated PCP by calling the Customer Care number on the back of the health plan ID card or by submitting a PCP change request at **myuhc.com**. Members can make changes once per month. These changes are effective the first of the month.

Q7. If a PCP practices at more than one location, does it matter which location the member visits?

- A. Since some PCPs have multiple tax ID numbers that may not participate for the member's benefit plan, members are required to see their PCP or a covering physician at the address location that shares the same tax ID number as the member's assigned PCP. You can view the tax ID number when checking eligibility using the eligibilityLink tool on Link.

Q8. Where can I find a list of members assigned to my practice?

- A. You can generate a PCP roster report by going into the Document Vault on UHCprovider.com. For step-by-step instructions on accessing reports, please go to UHCprovider.com > Menu > Reports > UnitedHealthcare Capitation, Claim, Quality, Roster and Profile Reports.

Specialist Referral Requirement

Q9. Who is responsible for generating referrals?

- A. The member's assigned PCP or a PCP within the same tax ID number are the only care providers allowed to submit referrals. If the PCP doesn't follow the electronic referral requirements, the member will have no coverage for UnitedHealthcare Compass or significantly higher copayments and co-insurance for UnitedHealthcare Compass Balanced and UnitedHealthcare Compass Plus.

Q10. Which services do not require a referral?

A. The following services do not require a referral:

- Services from physicians with the same Tax ID as the member's PCP
- Hospital-based physicians (e.g., pathology, radiology, anesthesiology)
- Non-physician type services, not billed by a physician:
 - Any outpatient lab, X-ray or diagnostics
 - Physical therapy, rehab services with the exception of manipulative treatment and vision therapy (e.g., physician services)
 - Durable medical equipment, home health services, prosthetic devices and hearing aids
- Services from participating OB-GYNs – this includes any network OB-GYN or gynecology specialist, nurse midwife, and nurse practitioners/physician assistants that are part of the gynecology practice regardless of their area of practice or sub-specialty (e.g., perinatology, gyn/oncology, reproductive endocrinology, etc.)
- Routine refractive eye exams from participating physicians, e.g., network optometrists
- Mental health/substance use disorder services with participating behavioral health clinicians
- Services rendered in any emergency room or network urgent care center or network convenience clinic or designated network online “virtual clinic visits”
- Physician services for emergency/unscheduled admissions or services billed as observation
- Any services from inpatient consulting physicians associated with eligible admissions
- Any other services for which applicable law doesn't allow a referral requirement

Q11. Can members seek care outside the state in which they live?

A. Members may be referred to a network provider located in another state when standard referral and prior authorization protocols are followed.

Q12. What if a member requires care that isn't available from a network specialist or facility?

A. When services aren't available from a network care provider or a care provider listed in the W500 Additional Network Directory, the member's PCP can request services by a non-network care provider at the in-network benefit level. The member's care provider may request the exception by calling the number on the back of the member's ID card. UnitedHealthcare will review the request and determine whether a care provider in the member's network is available to treat the condition and whether the request should be approved to cover eligible services at the in-network level. We'll send written confirmation of the final decision to the requesting physician and the member.

Before submitting a request for an exception, confirm there isn't a network care provider available by searching the Compass provider directory and, for members that have the Additional Network Benefit, the W500 Additional Network Benefits Directory.

Q13. How many visits are included with each referral to a specialist?

- A. Each referral may include up to six visits. Unused visits expire six months from the referral start date. After the six visits are used or expire, the PCP may submit another referral to the network specialist for up to six visits.

For members with certain chronic conditions, the online referral screen allows standing referrals to be entered for 99 visits if the member's diagnosis code is included in the Referrals for Chronic Conditions policy.

Chronic conditions eligible for standing referrals of up to 99 visits

- Allergy rhinitis
- AIDS/HIV
- Amyotrophic lateral sclerosis
- Anemia
- Cancer
- Cystic fibrosis
- Epileptic seizure
- Fracture care*
- Glaucoma
- Myasthenia gravis
- Multiple sclerosis
- Parkinson's disease
- Renal failure (acute)
- Seizure
- Thrombotic microangiopathy

** It's not necessary to specify the fracture care procedure performed on the referral.*

Q14. Can referrals be viewed online?

- A. Yes. You may securely view a member's referrals using the eligibilityLink tool on Link. Information includes the network specialist the member is referred to, number of visits authorized and number of visits remaining.

Q15. Do specialists and facilities have to confirm a referral is on file from the member's PCP before seeing the member?

- A. Yes. Specialists must confirm a referral is on file before seeing the member since Compass plans either have no benefit or a higher member cost share if a referral isn't obtained.

Facilities should also confirm the referral is on file for the member to see the admitting specialist for planned admissions. If the member doesn't have a referral, the facility and specialist claims will be denied for no referral if the member has UnitedHealthcare Compass, or the member will incur a much higher cost share if they have UnitedHealthcare Compass Balanced or UnitedHealthcare Compass Plus.

Q16. Is a new referral needed if a member needs to see another specialist, return for additional visits after the referral has expired, or all visits have been used?

- A. Yes. In each case, the member's PCP must be contacted to consider an additional referral.

Referral Submission Requirements

Q17. How do PCPs submit specialist referrals?

- A. The member's PCP must submit an electronic referral on UHCprovider, by using the eligibilityLink tool on Link or through EDI278R transactions before a member can see the network specialist. The referral is effective immediately and will be viewable online within 48 hours.

Referrals can't be accepted by phone, fax or paper, unless required by state law. Referrals may be entered on Link with a referral start date up to five calendar days prior to the date of entry. Follow these steps to submit referrals using Link:

Step 1: To see if a referral is needed, search for a member using the eligibilityLink tool on Link. To access eligibilityLink, sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com.

Step 2: PCPs can submit referrals if they're required by the member's benefit plan. If a referral is required, select Submit New Referral from My Actions.

Step 3: After the referral is completed, you'll get a referral number that you can record in your system or save as a screenshot.

Step 4: The referring or servicing care provider can check the status of a referral request by searching for the member and then selecting Referral Status from My Actions.

For more information on how to submit referrals, go to **UHCprovider.com** > Menu > Referrals.

Q18. Does my office staff need security access to submit and view referrals?

- A. Yes. If you've assigned the pre-defined role type, "All Transactions on UnitedHealthcareOnline.com and Link" for your staff, they'll have access to submit and view referrals for members. If your practice has customized roles, be sure the appropriate staff members in your practice have the "Referral Submission Role" for Link. For more information on access and roles, go to **UHCprovider.com** > Menu > Resource Library > Link Self-Service Tools > Getting Started With Link.

Advance Notification / Prior Authorization

Q19. Do these health plans require advance notification or prior authorization?

- A. Advance notification and prior authorization is required for certain planned services so we can determine if the services are covered under the member's benefits. Prior authorization is granted only for services determined to be medically necessary according to the member's benefit plan and applicable policies and guidelines. It's the physician's responsibility to follow the advance notification or prior authorization procedures as outlined in the Notification Requirements section of the UnitedHealthcare Care Provider Administrative Guide located at **UHCprovider.com** > Menu > Administrative Guides and Manuals.

Q20. Is admission notification required?

- A. Yes, admission notification is required for every inpatient admission. The admission notification requirement applies even if a referral or prior authorization is on file. Admission notification is the hospital's responsibility, as outlined in the current UnitedHealthcare Care Provider Administrative Guide.

Member Billing

Q21. Can members be billed for non-covered services?

- A. Yes, according to the terms of your Participation Agreement, you may bill members for non-covered services under certain circumstances.

For example, while joint replacements are generally covered benefits, a medical necessity review may determine a particular joint replacement for a member isn't covered. If the services you provide aren't covered under the member's benefit plan for reason of not being medically necessary, you may bill the member only if they've been informed of the decision of non-coverage prior to the date of the service and have specifically agreed in writing to accept financial responsibility. The written agreement must indicate the member understands UnitedHealthcare has determined the service is non-covered and the member chooses to receive the service and be financially responsible for payment.

Resources

Q22. What if I have questions about these health plans?

- A. Please contact Provider Services at **877-842-3210** or go to **UHCprovider.com** > Menu > Health Plans by State > New York > Commercial > UnitedHealthcare Compass.

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