

Medicare Advantage Referral-Required Plans

UnitedHealthcare is dedicated to providing innovative health and well-being solutions to help our members live healthier lives. One way we do that is by offering Medicare Advantage referral-required plans. To help you better understand Medicare Advantage referral-required plans, we've gathered common questions and answers about the referral process for these members. UnitedHealthcare Medicare Advantage plans with a referral requirement are listed at the end of this document in Appendix A.

Overview

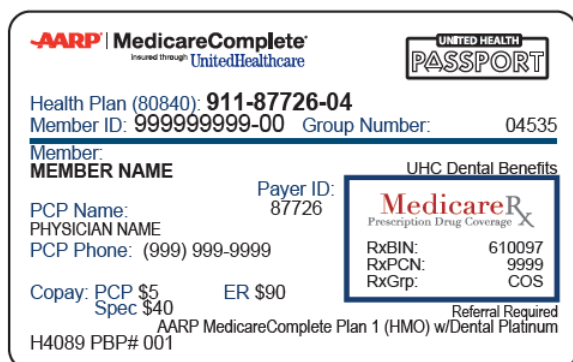
UnitedHealthcare Medicare Advantage referral-required plans emphasize the role of the primary care physician (PCP). Members choose a PCP to oversee their health care needs and manage referrals to network specialists and other health care professionals.

Key Features

- Members must choose a PCP.
- Referrals are required for specialty care.
- Admission notification protocols apply.
- Prior authorization and advance notification requirements apply.

Sample Member ID Cards

Referral-required plans are identified by plan name, plan benefit package number and the words “referral required” on the front of the member’s health care ID card.



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

Medicare Advantage Frequently Asked Questions

Q1. How do I identify members who have a referral-required plan?

A1. Referral-required plans can be identified by the following:

- A “referral required” identifier is shown in the lower right corner on the front of the member’s ID card.
- The plan number is listed in EDI 271 response transactions and can be found when checking patient eligibility using the eligibilityLink tool on Link. To sign in to Link, click on the Link button at the top of UHCprovider.com. Then, select the eligibilityLink tool on your Link dashboard.

Q2. Can members in a referral-required plan seek care outside their plan service area?

A2. Yes, in limited circumstances. Members of all referral-required plans have coverage for worldwide emergency and urgent care services. Depending on the member’s benefit plan, they may also have a UnitedHealth Passport Program benefit that lets them seek health care from contracted providers within the Passport service area. Members with Passport can receive services while traveling in participating Passport counties for the same copay or coinsurance they pay at home. Although members in referral-required plans must get a referral from their PCP for specialty care in their service area, they’re not required to get a referral when using their Passport benefit. Members with Passport are identified by a Passport logo in the front top right corner of their ID card.

Q3. How do I know if I’m in network for these referral-required benefit plans?

A3. You can check your participation status by visiting UHCprovider.com > Menu> [Find a Care Provider](#). You’re listed in the provider directory under each benefit plan you participate in. You can also confirm your status when you verify member eligibility and benefits using eligibilityLink. To access eligibilityLink, sign in to UHCprovider.com to access Link. Then select the eligibilityLink tool from your Link dashboard.

Q4. How can administrative staff members search for physicians, facilities or other health care professionals who participate in the member’s network?

A4. Go to UHCprovider.com > Menu> [Find a Care Provider](#) and:

1. Select the member’s plan.
2. Search for a physician by name, specialty and/or condition.
3. Narrow the search by ZIP code.

Q5. Do members in a referral-required plan need to select a PCP?

A5. Yes, members in a referral-required plan must choose a PCP within the market area of their permanent residence. If a member doesn’t choose a PCP, we’ll assign one for them. The assigned PCP name and phone number is on the front of the member’s ID card, on EDI 271 response transactions and on eligibilityLink. To access eligibilityLink, sign in to UHCprovider.com to access Link. Then select the eligibilityLink tool from your Link dashboard.

Q6. How often can members change their PCP?

A6. Members may request to change their PCP at any time. Referrals previously submitted by the member's PCP are not affected by PCP changes.

PCP change requests for members in California received before the 24th of the month are effective the first day of the next month. California PCP change requests received after the 24th of the month are effective the first day of the month following the next month.

Q7. Who is responsible for submitting referrals?

A7. The member's PCP is responsible for submitting referrals before the member seeks care from a network specialist or other health care professional. If a referral is not submitted, claims will be denied and the member cannot be billed for the balance.

Q8. Which services require a referral?

A8. Referrals are required when a member seeks care from a network specialist or other health care professional. Referrals are not required for facilities, ancillary providers or for certain services.

Eligible services that do not require a referral include the following.

- Any service provided by a network PCP or a network physician practicing under the same tax ID number as the member's PCP
- Any service from a network obstetrician/gynecologist, chiropractor, audiologist, oncologist, nutritionist, podiatrist, optometrist, ophthalmologist, optician, disease management or infectious disease specialist
- Services performed in an observation setting
- Allergy immunotherapy
- Mental health/substance abuse services with behavioral health clinicians
- Any service from a pathologist or inpatient consulting physician, including hospitalists
- Any services from an anesthesiologist, excluding office-based services or pain management services obtained in an office or in an outpatient setting
- Services rendered in an emergency room, emergency ambulance, network urgent care center, convenience clinic or virtual visit
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, vision or hearing exams
- Any lab services and radiological testing service, excluding radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies or Medicare Part B drugs
- Additional coverage that may be included by some Medicare Advantage plans but are not covered by Medicare such as hearing aids, routine eyewear, fitness memberships or outpatient prescription drugs
- Services obtained under the UnitedHealth Passport® Program, which allows for services while traveling

For more information about UnitedHealthcare Medicare Advantage plans, please visit the Provider Administrative Guide at UHCprovider.com > Menu > [Administrative Guides](#).

Q9. How many visits are included with each referral?

A9. The member's PCP determines the appropriate number of visits for each referral within a specified timeframe. After initial visits are used, or if unused visits expire, the PCP can submit another referral.

Q10. Can I view member referrals online?

A10. Yes. You may securely view a member's referrals on eligibilityLink. To access eligibilityLink, sign in to UHCprovider.com to access Link. Then select the eligibilityLink tool from your Link dashboard.

Q11. Do care providers need to confirm that a referral is approved by UnitedHealthcare?

A11. Before seeing a member for services requiring a referral, specialists and other health care professionals should confirm a referral is approved by UnitedHealthcare. Services provided without a referral are the care provider's responsibility and the member cannot be billed.

Q12. What happens if a member needs to see another care provider for services that require a referral, or return for additional visits after the referral has expired?

A12. In both cases, the member or specialist should contact the member's PCP so the PCP can decide whether to request an additional referral.

Q13. How do PCPs complete specialist referrals?

A13. You can submit prior authorization requests online using the Prior Authorization and Notification tool on Link. Sign in to Link by going to UHCprovider.com and clicking on the Link button in the top right corner. Then, select the Prior Authorization and Notification tool on your Link dashboard. You can backdate referrals up to five calendar days prior to the date of submission. Referrals are effective immediately upon submission.

Please visit UHCprovider.com/paan for more information on how to submit referrals using the tool.

Q14. Does my office staff need specific access to submit or view referrals on Link?

A14. Yes. If you are a password owner or ID administrator for your practice, you can manage access for your organization's users using the Link Self-Service tool on Link. If you have assigned your staff as "All listed above," they 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" and/or the "Referral Status Role."

For more information on Link access and roles, please visit UHCprovider.com> Menu > Resource Library > [Link Self-Service Tools](#).

Q15. Do referral-required plans require prior authorization or advance notification?

A15. Yes. Prior authorization is required for certain planned services so UnitedHealthcare can determine if the services are covered by the member's benefit plan. Prior authorization is approved only for services determined to be medically necessary according to the member's benefits and applicable policies and guidelines.

You can find the list of services requiring prior authorization and the process for providing advance notification in the Medical Management section of the Administrative Guide located at UHCprovider.com > Menu > [Administrative Guides](#).

Q16. Is admission notification required?

A16. Yes. Admission notification is required for every inpatient visit and applies even if a referral or prior authorization is on file. Admission notification is the responsibility of the hospital, as outlined in the current Administrative Guide at UHCprovider.com. > Menu > [Administrative Guides](#).

Q17. Can I bill members for non-covered services?

A17. Yes. According to your participation agreement, members can be billed for non-covered services if they have been informed of the non-coverage before the date of service and have agreed in writing to accept financial responsibility for those services. The written agreement must state that the member understands UnitedHealthcare has determined the service is not covered and the member chooses to receive the service and be responsible for payment. Members must have received a pre-service Integrated Denial Notice (IDN), which includes their appeal rights, prior to accepting financial responsibility unless there is a clear exclusion in the Evidence of Coverage. In this case, the member may not be required to receive an IDN. For more information about how to bill members, please visit the Provider Administrative Guide at UHCprovider.com > Menu > [Administrative Guides](#).

Q18. Who do I contact if I have additional questions about a health plan?

A18. If you have questions, please contact Provider Services at **877-842-3210**. You can also find information at UHCprovider.com/plans.

Appendix A

2019 Medicare Advantage Referral-Required Plans Administered by UnitedHealthcare

Arizona

H5253 PBP#036 AARP® MedicareComplete®

Florida

H1045 PBP#026 AARP® MedicareComplete®
H1045 PBP#028 AARP® MedicareComplete®
H1045 PBP#030 AARP® MedicareComplete®
H1045 PBP#031 AARP® MedicareComplete®
H1045 PBP#032 AARP® MedicareComplete®
H1045 PBP#033 AARP® MedicareComplete®
H1045 PBP#034 AARP® MedicareComplete® Plan 2
H1045 PBP#035 AARP® MedicareComplete®
H1045 PBP# 036 AARP® MedicareComplete® Focus
*H1045 PBP#041 AARP® MedicareComplete®
H1045 PBP#042 AARP® MedicareComplete®
H1045 PBP#043 AARP® MedicareComplete®
*H1045 PBP#045 AARP® MedicareComplete® Focus

Illinois

*H2802 PBP#024 AARP® MedicareComplete® Access
H2802 PBP#025 AARP® MedicareComplete® Plan 1
H2802 PBP#026 AARP® MedicareComplete® Plan 2

Louisiana

H4089 PBP#001 AARP® MedicareComplete® Plan 1
H4089 PBP#002 AARP® MedicareComplete® Plan 2

*New plans for 2019

Massachusetts

H1944 PBP#001 AARP® MedicareComplete® Plan 1
H1944 PBP#004 AARP® MedicareComplete® Plan 2
H1944 PBP#005 AARP® MedicareComplete® Plan 1
H1944 PBP#006 AARP® MedicareComplete® Plan 2
H1944 PBP#021 AARP® MedicareComplete® Plan 3
H1944 PBP#022 AARP® MedicareComplete® Plan 3

Rhode Island

H1944 PBP#014 AARP® MedicareComplete® Plan 2
H1944 PBP#015 AARP® MedicareComplete® Essential
H1944 PBP#016 AARP® MedicareComplete® Plan 1
H1944 PBP#020 AARP® MedicareComplete® Plan 3

Texas

H4514 PBP#007 AARP® MedicareComplete® Plan 2
H4527 PBP#001 AARP® MedicareComplete® Focus
H4527 PBP #002 AARP® MedicareComplete® Focus
H4527 PBP#013 AARP® MedicareComplete® Focus
H4527 PBP#037 AARP® MedicareComplete® Plan 1
H4527 PBP# 024 AARP® MedicareComplete® Focus Essential®
H4527 PBP# 038 AARP® MedicareComplete®

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. AARP® Medicare Complete® Plans carry the AARP® name, and UnitedHealthcare Insurance Company pays royalty fees to AARP® for the use of its intellectual property. These fees are used for the general purposes of AARP®.

Doc#: PCA-2-013931-02212019_02272019

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