UnitedHealthcare Navigate

Frequently Asked Questions

Overview

UnitedHealthcare Navigate is a commercial benefit plan built on patient-centered care, with the goal of enhancing the patient-doctor relationship and promoting better health and lower costs. Navigate places the focus on primary care, with members choosing a primary care provider (PCP) to help manage their health care needs.

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

Frequently Asked Questions

Navigate Plan

How is Navigate different from other health benefit plans?

UnitedHealthcare Navigate focuses on primary care as the key to helping people live healthier lives. Members must select a PCP who will manage and coordinate their care, as well as make electronic referrals to other network specialist physicians.

How are UnitedHealthOne Navigate individual plans different from UnitedHealthcare Navigate plans?

The Navigate benefit plans share the same plan features and networks when administered by UnitedHealthcare or UnitedHealthOne. UnitedHealthOne Navigate's key differences are:

- UnitedHealthOne is printed on the front of the member's ID card.
- You must use the Payer ID number on the ID card when submitting electronic claims.

Key Points

UnitedHealthcare Navigate features a customized, narrow network of care providers.

Members are required to select a PCP to help manage their health care needs.

The member's PCP must submit electronic referrals before the member sees a network specialist physician.

Standard prior authorization and notification requirements apply.

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- The UnitedHealthOne Individual Supplemental Guide applies, except for referral and prior authorization/notification transactions, for which care providers should consult the commercial section of the UnitedHealthcare Care Provider Administrative Guide.
- Contact information for UnitedHealthOne is listed on the back of the member's ID card and at **myuhone.com**.

Do Navigate plans offer tiered benefits for UnitedHealth Premium® designated care providers?

Yes. In some states, UnitedHealthcare Navigate plans may feature tiered benefits for UnitedHealth Premium® designated care providers. Members with tiered benefits for Navigate benefit plans can be identified when checking eligibility and on the ID card. For more information about tiered benefit features, go to **UHCprovider.com/plans** > (State) > Commercial > UnitedHealthcare Tiered Benefit Plans.

Provider Network

How do I know if I'm in-network for Navigate benefit plans?

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

Do UnitedHealthcare Navigate benefit plans use the same network as UnitedHealthcare Choice/Choice Plus?

No. UnitedHealthcare Navigate features a customized, narrow network to better meet our members' needs.

PCPs

What is the role of the PCP in Navigate benefit plans?

PCPs oversee their patients' care and actively manage referrals to network specialists. The PCP helps guide their patients along the best care path.

How do members choose a PCP?

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 is also listed on the member's health plan ID card.

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Can members change their PCP?
A member may request to change their designated PCP by calling the Customer Care number on their 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.

If a PCP practices at more than one location, does it matter which location the member visits?
Since some PCPs have multiple tax ID numbers (TINs) 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 TIN as the member's assigned PCP. You can view the TIN when using Link to check eligibility.

Where can I find a list of members assigned to my practice?
You can generate a PCP roster report using the Document Vault tool on Link. To learn more about Document Vault and to access the tool, go to **UHCprovider.com/documentvault**.

Specialist Referral Requirement

Who is responsible for submitting referrals?
The member's assigned PCP or a PCP within the same TIN are the only care providers who may submit referrals. If the PCP doesn't follow the electronic referral requirements, the member will have no coverage for UnitedHealthcare Navigate or significantly higher copayments and coinsurance for UnitedHealthcare Navigate Balanced and UnitedHealthcare Navigate Plus.

Which services do not require a referral?
Covered health services must be provided by or referred by the patient's primary physician. If care from another network physician is needed, the primary physician will provide the patient with a referral. The referral must be submitted before the services are rendered. The exception is that the patient does **not** need a referral from their primary physician for:

- Any services from network physicians who share any tax ID number (TIN) as the member's PCP or is the PCP's covering network physicians
- Any services from a network OB/GYN specialists, nurse practitioners, nurse midwives, and physician assistants
- Routine refractive eye exam from a network provider
- Network optometrists
- Mental health/substance use disorder 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 (Note: services billed by a network specialist require referral.)

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- Network rehabilitative services (PT, OT, ST, aural therapy, cognitive therapy) with exception of manipulative treatment and vision therapy (physician services) (Note: services billed by a network specialist require referral.)
- Any other network services as required by state mandates

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

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

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

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.

Can referrals be viewed online?

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

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

Yes. Specialists must confirm a referral is on file before seeing the member, since Navigate 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 Navigate or the member will incur a much higher cost-share if they have UnitedHealthcare Navigate Balanced or UnitedHealthcare Navigate Plus.

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?

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

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Referral Submission Requirements

How do PCPs submit specialist referrals?

The member's PCP must submit an electronic referral at **UHCprovider.com**, by using 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. For more information on how to submit referrals, go to **UHCprovider.com/referrals**.

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

Yes. If you've assigned the pre-defined role type, "All Transactions on UHCprovider.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/Link** > Get Started With Link.

Advance Notification/Prior Authorization

Do these health plans require advance notification or prior authorization?

Advance notification/prior authorization are required for some services. Prior authorization is granted only for services determined to be medically necessary, according to the member's benefit plan and applicable policies and guidelines. Advance notification/prior authorization policies and procedures are outlined in the Notification Requirements section of the UnitedHealthcare Administrative Guide, located at **UHCprovider.com/guides**. Information about prior authorization is also available at **UHCprovider.com/priorauth**.

Is admission notification required?

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 UnitedHealthcare Administrative Guide.

What if a member requires care that's not available from a network specialist or facility?

When services aren't available from a network care provider, the member's network physician 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 phone number on 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. UnitedHealthcare will send written confirmation of the final decision to the requesting physician and the member.

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Member Billing

Can members be billed for non-covered services?

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 that 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

Who should I contact if I have additional questions about these plans?

If you have questions, please contact Provider Services at **877-842-3210** or go to **UHCprovider.com/plans** > (State) > Commercial > UnitedHealthcare Navigate. For UnitedHealthOne Navigate individual benefit plans, contact the number on the back of the member's ID card or go to myuhone.com.

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