An important message from UnitedHealthcare to health care professionals and facilities.

UnitedHealthcare respects the expertise of the physicians, health care professionals and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Network Bulletin was developed to share important updates regarding UnitedHealthcare procedure and policy changes, as well as other useful administrative and clinical information.

Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.
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Front & Center
Stay up to date with the latest news and information.

**New Webinar Series on Autism Spectrum Disorder**
UnitedHealthcare and OptumHealth Education are starting an accredited medical education series on autism spectrum disorder (ASD). The six-part webinar series, which begins May 1, 2018, will offer free continuing medical education (CME) and continuing education unit (CEU) credits.

**Further Updates on Smart Edits**
UnitedHealthcare is using a new capability in the EDI workflow, known as Smart Edits, which auto-detects claims with potential errors and delivers feedback within 24 hours of submission, so care providers can proactively repair and submit accurate, complete claims more expediently.

**Link Self-Service Updates**
We’ve made more updates and enhancements to Link, the gateway to online self-service tools for UnitedHealthcare care providers. Visit Link for Prior Authorization and Notification App enhancements and a new video that explains the benefits of self-service using Link.

**Discontinued Claim Payer IDs to be Disabled**
On June 1, 2018, UnitedHealthcare will disable payer IDs that were discontinued in the past and should no longer be used for claims submissions or any other Electronic Data Interchange (EDI) transaction. A message will be returned indicating “Invalid Payer ID” if used on or after this date.

**Reminder on Claims Review of Durable Medical Equipment, Prosthetics, Orthotics and Supplies**
Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims may be subject to medical necessity and coding review. Recent enhancements have helped UnitedHealthcare to improve this process. As a result, care providers may receive requests for additional documentation. To expedite the claim review process, care providers are encouraged to submit relevant supporting documentation with their DMEPOS claims.

**Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs**
We’re implementing these requirements because it’s important to provide our members access to care that’s medically appropriate as we work toward the Triple Aim of improving health care services, health outcomes and overall cost of care.

**Tell Us What You Think of Our Communications**
Please take a few minutes to complete an online survey and give us your thoughts about the Network Bulletin and UnitedHealthcare Communications.
Front & Center
Stay up to date with the latest news and information.

**Denosumab (HCPCS code J0897) Requires Prior Authorization**
On June 1, 2018, we'll begin requiring prior authorization for Denosumab (HCPCS code J0897: SC injection, denosumab, 1 mg) for members with a cancer diagnosis who are insured by UnitedHealthcare commercial plans, UnitedHealthcare Oxford and some UnitedHealthcare Community Plans. This change will affect UnitedHealthcare Community Plans in Arizona, Florida, Maryland, Michigan, Mississippi, New Jersey, New York, Ohio, Pennsylvania, Tennessee, Texas, Washington and Wisconsin.

**Pharmacy Update: Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and Oxford**
A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial. Go to UHCprovider.com/pharmacy.

**Special Needs Plan Model of Care Training**
The Centers for Medicare & Medicaid Services (CMS) requires all care providers who treat patients in a Special Needs Plan (SNP) to complete annual SNP Model of Care (MOC) training. SNPs are a type of Medicare Advantage plan that adheres to the MOC design. SNPs help to ensure that unique health care needs of each SNP member are identified, addressed and measured. These plans are designed to improve continuity and coordination of care. UnitedHealthcare offers the 2018 SNP MOC training as a pre-recorded session that takes about 15 minutes to complete. Please complete this year’s training by Oct. 1, 2018.
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New Webinar Series on Autism Spectrum Disorder

UnitedHealthcare and OptumHealth Education are starting an accredited medical education series on autism spectrum disorder (ASD). The six-part webinar series will offer free continuing medical education (CME) and continuing education unit (CEU), Certified Case Manager (CCM), American Social Worker Board (ASWP) and American Psychological Association (APA) credits and will be available on-demand at the OptumHealth Education website at [optumhealtheducation.com](http://optumhealtheducation.com) under pediatrics.

Beginning May 1, 2018, the webcasts will be conducted on the first Tuesday of each month from 1 p.m. – 2 p.m. Eastern Time. Registration for the May 1 webcast is available at optumhealtheducation.com/autism-part-I-2018-live and for the June 5 webcast at optumhealtheducation.com/autism-part-II-2018-live.

UnitedHealthcare is committed to supporting families of children with special health care needs, helping them navigate and thrive within the complex health care system. This educational series has been developed to provide an overview of ASD with the goal of developing an understanding of the disorder and promoting optimal outcomes and compassionate care for these individuals and their families. Topics that will be addressed during the webinars include symptoms, screening, diagnosis, genomics, treatment planning, therapies, autism-sensitive care, community resources, advocating and self-advocacy, medical home care and transition to adulthood.

OptumHealth Education is one of the few jointly accredited organizations in the world, having been simultaneously accredited to provide medical, nursing and pharmacy continuing education activities by the Accreditation Council for Continuing Medical Education (ACCME), American Nurses Credentialing Center (ANCC) and Accreditation Council for Pharmacy Education (ACPE). They are dedicated to providing interprofessional education that leads to improved health care delivery and better patient outcomes.

If you have questions about this educational series, please contact your Provider Advocate. For technical issues related to optumhealtheducation.com, send an email to moreinfo@optumhealtheducation.com.
Further Updates on Smart Edits

In the April 2018 Network Bulletin, we shared with you that UnitedHealthcare has a new capability in the EDI workflow, known as Smart Edits, which auto-detects claims with potential errors and delivers feedback within 24 hours of submission. This capability is now available for a limited number of commercial professional claims submitted to Payer ID 87726. For a list of health plans by payer ID, please visit UHCprovider.com/content/dam/provider/docs/public/resources/edi/Payer-List-UHC-Affiliates-Strategic-Alliances.pdf.

Smart Edits will continue to roll out to the rest of our plans during the second half of 2018. The list of active Smart Edits can be found at UHCprovider.com/content/dam/provider/docs/public/resources/edi/ACE-Edits.pdf.

If you have a claim returned with a Smart Edit, you’ll have five calendar days to correct the claim before it’s automatically processed. This five-day limit helps ensure timely processing of claims. Interacting with Smart Edits helps you submit accurate, complete claims more quickly, reducing potential claims denials or rework.

UnitedHealthcare’s Smart Edits Solution identifies claims with potential errors in the pre-adjudication workflow so that you don’t have to wait for days to receive claims denials. It’s expected to increase the rate of clean and complete claims submissions, improve the claims cycle time, and reduce claims denial and post-adjudication rework volume.

Smart Edit messages explain why the claim was returned and provide direction on how to correct the claim for re-submission. Re-submit the claim electronically with the modifications suggested by Smart Edit notifications to minimize potential denials or rework.

Smart Edit messages delivered via the 277CA report are usually mapped by your software vendor so that edit messages appear on the same claim status reports you receive for HIPAA edit rejections. Smart Edits currently apply to UnitedHealthcare commercial, professional claims for Payer ID 87726. If you aren’t receiving edit messages for these plans on your clearinghouse rejection reports, please contact your software vendor. UnitedHealthcare is working with providers and vendors to help ensure that messages are accessible. Please refer to our Vendor List to see if your vendor supports Smart Edit messages. Regardless of what software vendor you use, you can always find Smart Edit messages in your raw EDI transaction data.

For Smart Edits to correctly categorize claims and act accordingly, you’ll need to include your group number on your claim submissions. The group number can be identified on an insurance card as shown on the following sample card:

If you’re experiencing issues with Smart Edits, visit our website for further information. If issues persist, please contact EDI Support online at EDI Transaction Support Form, by email at SupportEDI@uhc.com or call 800-842-1109.
**Front & Center**

**Link Self-Service Updates**

We’ve made more updates and enhancements to Link, the gateway to online self-service tools for UnitedHealthcare care providers.

**New Video Demonstrates the Power of Self-Service**

Link’s self-service tools can help increase your staff’s productivity and bring value to your organization by quickly providing the comprehensive information you need for most UnitedHealthcare benefit plans – without the extra step of calling. *The average phone call is six and a half minutes while the average Link transaction takes less than one minute.* Link also provides better documentation than a phone call and helps you to reduce paper expenses. Be sure to watch this video today to learn how Link can benefit your organization.

**Live Training and Pre-Recorded Videos**

We offer live instructor-led webinars with Q&A on six Link topics every month:

- Link registration and multi-TIN access
- Link core apps – claimsLink and eligibilityLink
- Prior authorization and notification overview
- Electronic Payments & Statements
- My Practice Profile
- Billing company training

We also offer short pre-recorded videos in the UHC On Air app so you can watch them on your schedule:

- There are now 16 videos and more are on the way!
- Some Link videos are only available on UHC On Air.
- These aren’t recordings of the live webinar sessions; most take less than 2.5 minutes to review and many focus on a single app feature. For example, there are eligibilityLink videos for therapy accumulators and tier 1 status and claimsLink videos for claim status and claim reconsideration.

- Some video topics may be covered briefly during a live webinar or not at all – for example, Paperless Delivery Options and Document Vault.

To watch these videos, go to UHC On Air > UHC News Now Channel > Link & Provider Self-Service series. The profile form has been eliminated so you can start using UHC On Air faster!

**Take the Quickest Path to the App You Need**

Do you use the UnitedHealthcare Online tile a lot? You may be able to access Link apps quicker and with fewer clicks. Many functions that you used to access from UnitedHealthcare Online are right on the Link dashboard. For example:

- With just three clicks you can access the Prior Authorization and Notification app. Just sign in to Link from UHCprovider.com and then open the app on your Link dashboard.

To learn more about these webinars and register for an upcoming session, please visit UHCprovider.com/training.

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Link Self-Service Updates

• Another route is to sign in to Link from UHCprovider.com and open the UnitedHealthcare Online tile. Then select the transaction you want from the Notifications/Prior Authorizations menu. You then can click a button that says Go to Prior Authorization and Submission (to open the Prior Authorization and Notification app that’s on the dashboard).

Functions that can be accessed on your Link dashboard include: Claim Estimator, Claim Reconsideration (claimsLink), Claim Status (claimsLink), Claim Research Project, Electronic Payments & Statements, Fee Schedule Lookup, OneNet PPO Pricing, OptumRx (PreCheck MyScript), Patient Eligibility (eligibilityLink), Prior Authorization and Notification (including cardiology, oncology and radiology), Referral Submission & Status (eligibilityLink), Reports (Document Vault) and Single EOB Search. To see more app tiles and get information, visit UHCprovider.com/Link.

Link Enhancements

We use care provider feedback to add enhancements to apps at least once per month. Please give us your input using the feedback buttons in each app or by responding to surveys. In the Network Bulletin each month, we highlight some of the enhancements that have been made. Recent changes include:

Prior Authorization and Notification App Enhancements

Now you can view what clinical documentation is needed for each procedure code in a new case. Cases in cancelled status can now be viewed in the app. Case status has been improved with greater visibility of coverage determinations. Each field is defined.

HRA, POC and RSA Moved to Care Conductor on Link

Health Risk Assessment (HRA), Patient Plan of Care (POC) and Risk Stratification Assessment (RSA) have been removed from UnitedHealthcareOnline.com. If you don’t have the Care Conductor app on your Link dashboard, please open the UnitedHealthcare Online tile. Then go to Patient Eligibility & Benefits and select Health Risk Assessment, Patient Plan of Care or Risk Stratification Assessment. Click on “Go to Care Conductor” to add the app to your dashboard and open it.

Practice/Facility Profile Moved to Link

Link users with access to My Practice Profile can use that app to make demographic updates. Facilities and other users without My Practice Profile will need to add the UnitedHealthcare Practice/Facility Profile app to their dashboards. To do this, open the UnitedHealthcare Online tile, click on Practice/Facility Profile and then on “Go to Practice/Facility Profile Now.”

Registration Information and Live Help

Link registration is a two-part process. First, you create an Optum ID and then you connect it to your tax identification number (TIN). To get started, go to UHCprovider.com and click on New User. Then follow the on-screen instructions. Videos and other resources are also available on that page.

For live help with Link, call the UnitedHealthcare Connectivity Helpdesk at 866-842-3278, option 1, Monday through Friday, 8 a.m. to 10 p.m. Eastern Time.

*Average call time was calculated from a UnitedHealthcare call study in June 2016 for pre-service and claims follow-up calls and doesn’t include hold time. Average Link transaction times were based on user app testing in February 2016.
Discontinued Claim Payer IDs to be Disabled

Effective June 1, 2018, UnitedHealthcare will disable payer IDs that were previously discontinued and shouldn’t be used for claims submissions or any other Electronic Data Interchange (EDI) transaction. A message will be returned indicating “Invalid Payer ID” if used on or after this date.

Please review the following list of health plans and make the appropriate updates in your system to route claims from the former payer ID to the current one. Please contact your software vendor or clearinghouse if you need assistance. We appreciate that you use EDI and submit claims electronically.

<table>
<thead>
<tr>
<th>Former Payer ID</th>
<th>Current Payer ID</th>
<th>Brand Name/Plan Name or Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>25175</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
<tr>
<td>32006</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
<tr>
<td>33053</td>
<td>87726</td>
<td>OptumHealth Behavioral Solutions (formerly United Behavioral Health and PacifiCare Behavioral Health)</td>
</tr>
<tr>
<td>62183</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
<tr>
<td>64159</td>
<td>87726</td>
<td>UnitedHealthcare/Definity Health Plan</td>
</tr>
<tr>
<td>86001</td>
<td>86047</td>
<td>UnitedHealthcare Community Plan/NJ (formerly AmeriChoice NJ Medicaid, NJ Family Care, NJ Personal Care Plus)</td>
</tr>
<tr>
<td>86002</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
<tr>
<td>86003</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
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<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
<tr>
<td>86049</td>
<td>87726</td>
<td>UnitedHealthcare Community Plan/CA, DE, FL, HI, IA, LA, MA, MD, MS, NC, NE, NM, NY, OH, OK, PA, RI, TX, VA, WA, WI (formerly AmeriChoice or Unison)</td>
</tr>
</tbody>
</table>
Discontinued Claim Payer IDs to be Disabled

<table>
<thead>
<tr>
<th>Former Payer ID</th>
<th>Current Payer ID</th>
<th>Brand Name/Plan Name or Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>95962</td>
<td>87726</td>
<td>UnitedHealthcare West/UnitedHealthcare of CA, OK, OR, TX, WA and PacifiCare of AZ, CO, NV</td>
</tr>
<tr>
<td>95964</td>
<td>87726</td>
<td>UnitedHealthcare West/UnitedHealthcare of CA, OK, OR, TX, WA and PacifiCare of AZ, CO, NV</td>
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<tr>
<td>95999</td>
<td>87726</td>
<td>UnitedHealthcare West/UnitedHealthcare of CA, OK, OR, TX, WA and PacifiCare of AZ, CO, NV</td>
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<td>COFHP</td>
<td>87726</td>
<td>UnitedHealthcare West/UnitedHealthcare of CA, OK, OR, TX, WA and PacifiCare of AZ, CO, NV</td>
</tr>
<tr>
<td>M3432</td>
<td>03432</td>
<td>UnitedHealthcare Community Plan/AZ, Long Term Care, Children's Rehabilitative Services (CRS)</td>
</tr>
</tbody>
</table>

View the complete UnitedHealthcare claims payer list at UHCprovider.com/EDI. If you have any questions, please contact EDI Support.

**EDI Support Contacts**

| UnitedHealthcare commercial | EDI issue reporting form or supportedi@uhc.com or 800-842-1109 |
| UnitedHealthcare Medicare | |
| UnitedHealthcare West | |

| UnitedHealthcare Community Plan | EDI issue reporting form or ac_edi_ops@uhc.com or 800-210-8315 |

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Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs

We’re making some updates to our coverage review requirements for certain specialty medications for many of our UnitedHealthcare commercial and Community Plan members. Implementing these requirements is important to us to provide our members access to care that’s medically appropriate as we work toward the Triple Aim of improving health care services, health outcomes and overall cost of care. These requirements will apply whether members are new to therapy or have already been receiving these medications.

If you administer any of these medications without first completing the notification/prior authorization process, the claim may be denied. Members can’t be billed for services denied due to failure to complete the notification/prior authorization process.

What’s Changing for UnitedHealthcare Commercial Plans

The following requirements will apply to UnitedHealthcare commercial plans, including affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare of the River Valley, UnitedHealthcare Oxford and Neighborhood Health Partnership:

For dates of service on or after Oct. 1, 2018, we’ll require notification/prior authorization for the following medication:

• **Crysvita (burosumab)** – The U.S. Food and Drug Administration (FDA) recently approved Crysvita as a treatment for X-linked hypophosphatemia in children and adults.

**Crysvita** has been added to the Review at Launch Drug List for UnitedHealthcare commercial plans. The Review at Launch Drug List can be accessed at [UHCprovider.com](http://UHCprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/review-at-launch-new-to-market-medications.pdf) through the Review at Launch for New to Market Medications policy. For dates of service before Oct. 1, 2018, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. Clinical coverage reviews can help to avoid starting a patient on therapy that may later be denied due to lack of medical necessity. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

**Clinical Coverage Reviews**

Clinical coverage reviews will be conducted as part of our prior authorization process. If the member’s benefit plan requires that services be medically necessary to be covered, the reviews will evaluate whether the drug is appropriate for the individual member, taking into account:

• Our drug coverage policy

• Dosage recommendation from the FDA-approved labeling
Front & Center

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Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs

Additional criteria also may be considered. We encourage you to submit any information you want reviewed as part of your prior authorization request. When a coverage determination is made, we’ll inform you and the member of the coverage determination. If an adverse determination is made, we’ll provide you with appeal information.

Submitting Notification/Prior Authorization Requests

To submit notification/prior authorization requests for these medications, please use one of the following methods:

• Go to UHCprovider.com/priorauth

• Call the Provider Services phone number on the back of the member’s health care identification card.

• Send your request by fax: Complete a prior authorization form and fax it to 866-756-9733. Go to UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs > Forms and Additional Resources.

For UnitedHealthcare commercial plans, you can access forms at UHCProvider.com/priorauth. Some states require the notification/prior authorization to be submitted on a designated request form.

When Making Referrals

If you’re referring a member to other care providers for these medications, we encourage you to refer to in-network care providers. If a non-participating care provider prescribes treatment, members may pay higher out-of-pocket costs. Members who don’t have out-of-network benefits may be responsible for the entire cost of services from non-participating care providers.

For more information about the UnitedHealthcare commercial notification/prior authorization requirements for specialty medications, please refer to the Physician Health Care Professional, Facility and Ancillary Provider Administrative Guide at UHCprovider.com > Menu > Administrative Guides.

What’s Changing for UnitedHealthcare Community Plan

Reminder on Prior Authorization Requirements for Medical Injectable Drugs

For injectable medications that require prior authorization, all Healthcare Common Procedure Coding System (HCPCS) and CPT codes related to the drug require prior authorization, including unclassified codes (J3490, J3590, or C9399) and temporary C-Codes.

Fasenra (benralizumab) currently requires prior authorization. On April 1, 2018, a C code for Fasenra (C9466) became available. Beginning July 1, 2018, Fasenra claims submitted using C9466 may be denied if the prior authorization process is not completed.

For dates of service before July 1, 2018, we encourage you to request pre-service coverage reviews for C9466 so you can check whether Fasenra is covered before providing services. Clinical coverage reviews can help to avoid starting a patient on therapy that may later be denied due to lack of medical necessity. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

**Front & Center**

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**Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs**

For dates of service before Oct. 1, 2018, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. Clinical coverage reviews can help to avoid starting a patient on therapy that may later be denied due to lack of medical necessity. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

For dates of service on or after Oct. 1, 2018, we’ll require prior authorization for **Crysvita** for UnitedHealthcare Community Plan Medicaid members in many states. All codes used to bill for **Crysvita** will require prior authorization, including any Q or C codes that CMS may assign to this medication.

The following chart outlines the prior authorization requirement for UnitedHealthcare Community Plan Medicaid members in each state:

<table>
<thead>
<tr>
<th>State</th>
<th>Specialty Medication</th>
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<tbody>
<tr>
<td>Arizona</td>
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<td>California</td>
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<td>Florida</td>
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<td>Hawaii</td>
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<td>Kansas</td>
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<td>Mississippi</td>
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<td>New York</td>
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<td>Ohio</td>
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<td>Pennsylvania</td>
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<td>Rhode Island</td>
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<tr>
<td>Tennessee</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td><strong>Crysvita</strong></td>
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<td>Virginia</td>
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<tr>
<td>Washington</td>
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</table>

The prior authorization requirement for this medication does not apply to UnitedHealthcare Dual Complete® plans.

Coverage of these products is also dependent on State Medicaid program decisions. Certain state Medicaid programs may choose to cover a drug through the state’s fee-for-service program and not the managed care organizations such as UnitedHealthcare or they may provide other coverage guidelines and protocols. We encourage you to verify benefits before submitting the prior authorization request or administering the medication.

**Clinical Coverage Reviews**

Clinical coverage reviews conducted as part of our prior authorization process will evaluate whether the drug is appropriate for the individual member, taking into account:

- Terms of the member’s benefit plan
- Our drug coverage policy
- Applicable state Medicaid guidelines
- The member’s treatment history
- Dosage recommendation from the FDA-approved labeling

Additional criteria also may be considered. We encourage you to submit any information you want reviewed as part of your prior authorization request. When a coverage determination is made, we’ll inform you and the member of the coverage determination. If an adverse determination is made, we’ll provide you with appeal information.

CONTINUED >
Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs

Submitting Prior Authorization Requests

To submit prior authorization requests for this medication, please use one of the following methods:

• Go to UHCprovider.com/priorauth

• Call the Provider Services phone number on the back of the member’s health care identification card.

• Send your request by fax, complete a prior authorization form and fax it to the number provided on the form.

For United-Healthcare Community Plan, you can access forms at UHCCommunityPlan.com > For Health Care Professionals > Select your state > Provider Forms.

When Making Referrals

If you’re referring a member to other care providers for these medications, we encourage you to refer to in-network care providers. If a non-participating care provider prescribes treatment, members may pay higher out-of-pocket costs. Members who don’t have out-of-network benefits may be responsible for the entire cost of services obtained from non-participating care providers.

For more information about prior authorization requirements, please refer to the Community Plan Provider Manual by visiting UHCCommunityPlan.com > For Health Care Professionals > Select your state.
Reminder on Claims Review of Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims may be subject to medical necessity and coding review. Recent enhancements have helped UnitedHealthcare to improve this process. As a result, care providers may receive requests for additional documentation. To expedite the claim review process, care providers are encouraged to submit relevant supporting documentation with their DMEPOS claims.


If you have any questions about claimsLink or using any of its features, please call the UnitedHealthcare Connectivity Help Desk at 866-842-3278, option 1, available from Monday – Friday, 7 a.m. – 9 p.m. Central Time.

Tell Us What You Think of Our Communications

As a regular reader of The Network Bulletin, your opinion is important to us. We’d like to get your thoughts about The Network Bulletin and UnitedHealthcare communications related to network changes, quality initiatives and other issues. Please take a few minutes today to complete the survey online at [uhcresearch.az1.qualtrics.com/jfe/form/SV_08sAsRnUY2Kb153](http://uhcresearch.az1.qualtrics.com/jfe/form/SV_08sAsRnUY2Kb153). Thank you for your time.
Denosumab (HCPCS code J0897) Requires Prior Authorization

On June 1, 2018, we’ll begin requiring prior authorization for Denosumab (HCPCS code J0897: SC injection, denosumab, 1 mg) for members with a cancer diagnosis who are insured by UnitedHealthcare commercial plans, UnitedHealthcare Oxford and some UnitedHealthcare Community Plans. This change will affect UnitedHealthcare Community Plans in Arizona, Florida, Maryland, Michigan, Mississippi, New Jersey, New York, Ohio, Pennsylvania, Tennessee, Texas, Washington and Wisconsin.

Requests for denosumab (Brand names Xgeva and Prolia) will be reviewed by clinical staff using the clinical criteria outlined in our Denosumab Medical Benefit Drug Policy. This policy is now available online at UHCprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/denosumab-prolia-xgeva.pdf.

Please note: If the member received denosumab in an outpatient setting from March 1, 2018 through May 31, 2018, you DON’T need to submit a prior authorization request. The prior authorization to cover denosumab the member was receiving prior to June 1, 2018 will be effective until May 31, 2019.

How to Submit Prior Authorization

To submit an online notification request for denosumab, go to UHCprovider.com.


A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial. Go to UHCprovider.com/pharmacy.
Special Needs Plan Model of Care Training

The Centers for Medicare & Medicaid Services (CMS) requires all care providers who treat patients in a Special Needs Plan (SNP) to complete annual Model of Care (MOC) training. SNPs are a type of Medicare Advantage plan that operates under CMS’ MOC structure to help ensure that the unique health care needs of each SNP member are identified, met and measured. These plans help to ensure that unique health care needs of each SNP member are identified, addressed and measured. A SNP provides targeted care, improved care coordination and continuity of care to members with special needs.

The training includes information about the different types of SNPs tailored to individual needs. If you see UnitedHealthcare members who have benefits under Medicare or Medicaid or both, you are probably a SNP care provider.

UnitedHealthcare offers the 2018 SNP MOC training as a pre-recorded session that takes about 15 minutes to complete. Please complete this year’s training by Oct. 1, 2018.

- If you do not have an Optum ID, you may register for one at UHCprovider.com. Click on New User and follow the directions listed there. Please allow 24-48 hours for your new Optum ID to allow you access. If you experience a problem with registration, please contact your security administrator.
- Once registered with your Optum ID, you may access the following link at UHCprovider.com/en/resource-library/training.html or UHCprovider.com > Menu > Resource Library > Training > 2018 Special Needs Plan Model of Care Training Special Needs > UHC on Air (bit.ly/SNPMOC18).
- Enter your Optum ID and the session will begin.

For questions, please email us at snp_moc_providertraining@uhc.com or contact us at 888-878-5499.
UnitedHealthcare Commercial

Learn about program revisions and requirement updates.

Product and Sourcing Information for Luxturna™

For dates of service on or after July 1, 2018, Luxturna™ (voretigene neparvovec-rzyl) must be acquired from Accredo Specialty Pharmacy for members covered under a UnitedHealthcare commercial plan. As of that date, UnitedHealthcare will no longer reimburse care providers or facilities that purchase Luxturna directly and bill UnitedHealthcare.

Risk Adjustment Data Validation (RADV) Audit Program

In compliance with the Risk Adjustment Data Validation (RADV) audit program under the Affordable Care Act (ACA), we are required by the U.S. Department of Health and Human Services (HHS) to provide supporting medical documentation to be used for the annual medical claims review audit for UnitedHealthcare commercial members. To comply with HHS, we will be requesting medical records within a specific 2017 service date(s) starting in June 2018. Since only a number of members will be randomly selected, not all care providers will receive this request.

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates
Product and Sourcing Information for Luxturna™

For dates of service on or after July 1, 2018, Luxturna™ (voretigene neaparvovec-rzyl) must be acquired from Accredo Specialty Pharmacy for members covered under a UnitedHealthcare commercial plan. As of that date, UnitedHealthcare will no longer reimburse care providers or facilities that purchase Luxturna directly and bill UnitedHealthcare. If we deny payment for this reason, you may not balance bill the member.

These updated sourcing requirements apply to all UnitedHealthcare Commercial plans, including affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare Oxford, Neighborhood Health Partnerships and UnitedHealthcare of the River Valley. This protocol doesn’t apply to UnitedHealthcare West, Sierra, Student Resources, Rocky Mountain Health Plans, New York State Empire Plan and UnitedHealthcare Community Plan.

To obtain Luxturna through Accredo Specialty Pharmacy, you will need to work with Spark Therapeutics Generation Patient Services. Please follow these steps:

1. Access the specialty pharmacy protocol information for members at UHCprovider.com/guides. You also can obtain information by calling Spark Therapeutics at 833-772-7577.

2. Fax information to Spark Therapeutics at 678-727-1501. Provide the member’s prescription order and clinical records to support the prior authorization review.

3. Once Spark Therapeutics verifies the member case, they will issue an order notice to the Accredo Luxturna Team. The Accredo Luxturna team will bill UnitedHealthcare directly for these products within 30 days of dispensing them to your facility or the hospital. You should only bill for the administration of Luxturna.

In the January 2018 Network Bulletin, we communicated our Prior Authorization/Notification requirements for Luxturna. Luxturna will now be added to the Administrative Guide Protocol as outlined. Physicians, care providers and facilities that do not follow these protocols will not be reimbursed for services.
UnitedHealthcare Commercial

Risk Adjustment Data Validation (RADV) Audit Program

In compliance with the Risk Adjustment Data Validation (RADV) audit program under the Affordable Care Act (ACA), we are required by the U.S. Department of Health and Human Services (HHS) to provide supporting medical documentation to be used for the annual medical claims review audit for UnitedHealthcare commercial plan members.

To comply with HHS, we will be requesting medical records within a specific 2017 service date(s) starting in June 2018. Since only a number of members will be randomly selected, not all care providers will receive this request.

What’s being requested from you?

If your claim is in the sample, you will be contacted to submit the medical records as outlined here. Please include only the minimum HIPAA necessary documentation:

- Demographics sheet
- Progress notes/face to face office visits
- Consultation reports/notes
- Discharge summary
- Emergency room records
- History and physical exam
- Medication list
- Operative/Procedure notes
- Prescription for laboratory services
- Problem list
- Radiology and pathology services
- Radiology reports

UnitedHealthcare will be using a vendor, CIOX Health, to conduct the request for medical records. CIOX Health can be reached at 877-445-9293.

UnitedHealthcare Network Bulletin May 2018

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For more information, call 877-842-3210 or visit UHCprovider.com.
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UnitedHealthcare Commercial Reimbursement Policies

Learn about policy changes and updates.

Unless otherwise noted, the following reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all factors that affect reimbursement for services rendered to UnitedHealthcare members, including legislative mandates, member benefit coverage documents, UnitedHealthcare medical or drug policies, and the UnitedHealthcare Care Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Once implemented, the policies may be viewed in their entirety at UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > Reimbursement Policies for Commercial Plans. In the event of an inconsistency between the information provided in the Network Bulletin and the posted policy, the posted policy prevails.

**Supply Policy – Informational Update**

As a reminder, UnitedHealthcare’s Supply Policy does not allow separate reimbursement for specific HCPCS codes representing supplies, purchased durable medical equipment (DME), orthotics, prosthetics, biologicals and drugs when submitted on a CMS-1500 claim form by any physician or other qualified health care professional in the facility places of service 19, 21, 22, 23 and 24. >
Supply Policy – Informational Update

As a reminder, UnitedHealthcare’s Supply Policy does not allow separate reimbursement for specific HCPCS codes representing supplies, purchased durable medical equipment (DME), orthotics, prosthetics, biologicals and drugs when submitted on a CMS-1500 claim form by any physician or other qualified health care professional in the facility places of service 19, 21, 22, 23 and 24. Additionally, separate reimbursement is not allowed when supplies are provided on the same day as an evaluation and management service and/or procedure performed in a physician’s or other qualified health care professional’s office and other non-facility places of service.

Effective for claims processed Aug. 1, 2018 and after, an edit code maintenance gap to include codes with Outpatient Prospective Payment System (OPPS) Status Indicators ‘A’ or ‘N’, and Ambulatory Surgical Center (ASC) Status Indicators ‘K1’ or ‘N2’ will be adjusted to help ensure alignment with the existing policy. UnitedHealthcare will not pursue recoveries for any overpayments that may have occurred prior to Aug. 1, 2018 relating to payment of these supplies.

UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates
UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates


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UnitedHealthcare Medicare Advantage

Learn about Medicare policy and guideline changes.

Coverage of Annual Wellness Visits and Routine Physicals

The Annual Wellness Visit (or Personalized Prevention Plan Services) is a yearly visit covered by Original Medicare to develop or update the member’s personalized prevention plan. UnitedHealthcare offers the Medicare-covered Annual Wellness Visit to all Medicare Advantage Plan members and an additional Annual Routine Physical Exam to many plan members.

UnitedHealthcare Medicare Advantage Policy Guideline Updates

UnitedHealthcare Medicare Advantage Coverage Summary Updates
UnitedHealthcare Medicare Advantage

Coverage of Annual Wellness Visits and Routine Physicals

The Annual Wellness Visit (or Personalized Prevention Plan Services) is a yearly visit covered by Original Medicare to develop or update the member’s personalized prevention plan. UnitedHealthcare offers the Medicare-covered Annual Wellness Visit to all Medicare Advantage Plan members and an additional Annual Routine Physical Exam to many, but not all, plan members.

Because Medicare Advantage plan enrollment is based on a calendar year, UnitedHealthcare covers both the Annual Wellness Visit and the Routine Physical once every calendar year, and the visits do not need to be 12 months apart. For example, if a member received their Annual Wellness Visit and/or Routine Physical in September 2017, they don’t need to wait until September 2018 for their next visit but can get one again anytime in 2018.

For more information on determining the appropriate submission codes for these wellness visits and other preventive services, visit UHCprovider.com > Menu > Health Plans by State > Choose your state > Medicare > Select plan name > Tools & Resources > Medicare Advantage Preventive Services Coding Guidelines.
UnitedHealthcare Medicare Advantage Policy Guideline Updates

The following UnitedHealthcare Medicare Advantage Policy Guidelines have been updated to reflect the most current clinical coverage rules and guidelines developed by the Centers for Medicare & Medicaid Services (CMS). The updated policies are available for your reference at [UHCprovider.com > Menu > Policies and Protocols > Medicare Advantage Policies > Policy Guidelines](http://UHCprovider.com).

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<td>Category III CPT Codes</td>
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<tr>
<td>Chiropractic Services</td>
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<tr>
<td>Colonic Irrigation (NCD 100.7)</td>
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<tr>
<td>Gastric Freezing (NCD 100.6)</td>
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<td>Gravlee Jet Washer (NCD 230.5)</td>
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<tr>
<td>Histocompatibility Testing (NCD 190.1)</td>
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<tr>
<td>Implantation of Anti-Gastroesophageal Reflux Device (NCD 100.9)</td>
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<tr>
<td>Laboratory Tests - CRD Patients (NCD 190.10)</td>
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<tr>
<td>Melodic Intonation Therapy (NCD 170.2)</td>
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<tr>
<td>Molecular Pathology/Molecular Diagnostics/Genetic Testing</td>
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<tr>
<td>Non-Implantable Pelvic Floor Electrical Stimulator (NCD 230.8)</td>
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<tr>
<td>Percutaneous Coronary Interventions</td>
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<tr>
<td>Percutaneous Image-Guided Breast Biopsy (NCD 220.13)</td>
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<td>Portable Hand-Held X-Ray Instrument (NCD 220.10)</td>
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<td>Vertebral Axial Decompression (VAX-D) (NCD 160.16)</td>
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**RETIRED (Approved on March 14, 2018)**

- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

**Note:** The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.
# UnitedHealthcare Medicare Advantage Coverage Summary Updates


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<td><strong>Allergy Testing and Allergy Immunotherapy</strong></td>
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<td><strong>Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest</strong></td>
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<td><strong>Cosmetic and Reconstructive Procedures</strong></td>
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<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid</strong></td>
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<td><strong>Gastroesophageal and Gastrointestinal (GI) Services and Procedures</strong></td>
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<td><strong>Percutaneous Transluminal Angioplasty and Stenting</strong></td>
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<td><strong>Rehabilitation: Medical Rehabilitation (OT, PT and ST, Including Cognitive Rehabilitation)</strong></td>
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# UnitedHealthcare Medicare Advantage Coverage Summary Updates

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<tr>
<td>Wound Treatments</td>
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Doing Business Better

Learn about how we make improved health care decisions.

2017 Quality Improvement Program Overview

UnitedHealthcare maintains a Quality Improvement (QI) program to help improve our members’ and care providers’ health care experience. We annually measure member experience using the CAHPS survey tool. The most recent member satisfaction results showed improvement in rating of the specialist, care coordination, rating of personal doctor and rating of health care.

Collaboration between Primary Care Physicians and Behavioral Health Clinicians Can Make a Difference

Continuity and coordination of care take on greater importance for patients with severe and persistent mental health and/or substance abuse problems.
Doing Business Better

2017 Quality Improvement Program Overview

UnitedHealthcare maintains a Quality Improvement (QI) program to help improve our members’ and providers’ health care experience. In 2017, our QI Program included the important activities described below.

Supporting Delivery of Evidence-Based Care

• We informed our network physicians about their patients who might need care like cancer screening or diabetes tests.

• We encouraged doctors and other healthcare professionals to provide the care according to the most current scientific evidence (“evidence-based medicine”). For example, we offered website links to nationally accepted guidelines from the American Diabetes Association, the American Heart Association, American College of Cardiology, United States Preventive Services Task Force and other organizations. We monitored performance against these clinical guidelines.

• Throughout the year, we contacted members who may be overdue for needed care, suggesting that they contact their doctor for tests or treatment.

Monitoring and Improving Clinical Performance and Service Measures

We measured our care and service results using HEDIS® (The Healthcare Effectiveness Data and Information Set) and the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) Survey. Each year, we use the results to set new goals to improve performance based on external benchmarks from National Committee for Quality Assurance’s (NCQA) Quality Compass® (QC).

The following table shows two measures by region. The dark blue bar shows the percent of plans in each region that reached the Health and Human Services (HHS) next performance percentile from 2016 to 2017. The light blue bar reflects the percentage of plans in each region that scored at the NCQA QC 75th percentile performance measure.

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1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
2 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
3 Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA)
**Doing Business Better**

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### 2017 Quality Improvement Program Overview

The most improved HEDIS measures were:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI (total)
- Adult BMI Assessment
- Medication Management for People with Asthma
- Prenatal & Postpartum Care: Postpartum

**Measuring Member Experience**

We annually measure member experience using the CAHPS survey tool. The most recent member satisfaction results showed improvement in the areas of:

- Rating of the Specialist
- Care Coordination
- Rating of Personal Doctor
- Rating of Health Care

CAHPS measures identified as potential opportunities for improvement were:

- Claims Processing
- Getting Care Quickly
- Customer Service

For Marketplace, we measure member experience using the Key Member Indicator (KMI) Survey and QHP Enrollee Survey. The most recent surveys show improvements in the areas of:

- Care Coordination
- Getting Care Quickly
- Rating of the Specialist

KMI Survey and QHP Enrollee Survey measures identified as potential opportunities for improvement were:

- Customer Service
- Rating of Health Care

**Measuring Provider Experience**

We conducted a Physician and Practice Manager survey to measure provider satisfaction. Results from the most recent survey showed improvement in the areas of:

- Care Providers’ intent to renew with UnitedHealthcare
- Care Providers’ desire to see more UnitedHealthcare members
- Care Providers’ perception of the UnitedHealthcare brand as “trustworthy”

Related to our utilization management processes the most recent analysis showed improvement in provider satisfaction with:

- Ease and timeliness of notification/prior authorization processes for radiology procedures and services
- Ease and timeliness of clinical review process for radiology, inpatient and outpatient procedures
- Ease of the appeal process

Efforts are underway to improve performance related to:

- Simplifying provider communications, including those related to utilization management processes
- Improving quality of calls to provider service centers
- Increasing satisfaction with notification/prior authorization process

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**Doing Business Better**

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**2017 Quality Improvement Program Overview**

**Accreditation**

The National Committee for Quality Assurance (NCQA) Health Plan Accreditation is a nationally recognized evaluation that purchasers, regulators and consumers can use to assess health plans. Many of UnitedHealthcare’s Commercial HMO/POS, PPO and Marketplace plans hold NCQA accreditation in 2017. In 2017, the percentage of our Commercial health plans that attained Commendable Accreditation Status increased from 7.3% to 33.9%.

Please visit NCQA’s website to see the current accreditation status of our health plans at ncqa.org.

UnitedHealthcare also maintained URAC Health Utilization Management accreditation.

**Credentialing of Network Providers**

In compliance with governmental and NCQA requirements, UnitedHealthcare assesses the credentials of doctors and key health care professionals who participate in our networks. Assessments are conducted before the professional is added to our network and on a regular basis after joining.

---

**Collaboration between Primary Care Physicians and Behavioral Health Clinicians Can Make a Difference**

Continuity and coordination of care take on greater importance for patients with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when patients have been hospitalized for a medical or psychiatric condition. Please discuss with members the benefits of sharing essential clinical information. When applicable, we encourage you to obtain a signed release from each UnitedHealthcare member to allow you to share appropriate treatment information with the member’s behavioral health clinician.
UnitedHealthcare Affiliates

Learn about updates with our company partners.

SignatureValue/
UnitedHealthcare Benefits
Plan of California Benefit
Interpretation Policy
Updates →

SignatureValue/
UnitedHealthcare Benefits
Plan of California Medical
Management Guideline
Updates →

Oxford® Medical and
Administrative Policy
Updates →
**Oxford® Medical and Administrative Policy Updates**

For complete details on the policy updates listed in the following table, please refer to the [April 2018 Policy Update Bulletin](https://OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin).

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<th>Policy Title</th>
<th>Policy Type</th>
<th>Effective Date</th>
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<td><strong>NEW</strong></td>
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<td>Trogarzo™ (Ibalizumab-Uiyk)</td>
<td>Clinical</td>
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<tr>
<td>17-Ahpha-Hydroxyprogesterone Caproate (Makena™ and 17P)</td>
<td>Clinical</td>
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<td>Ambulance</td>
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<tr>
<td>Ambulance</td>
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<tr>
<td>Assisted Administration of Clotting Factors and Coagulant Blood Products</td>
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<td>Bone or Soft Tissue Healing and Fusion Enhancement Products</td>
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<td>Buprenorphine (Probuphine® &amp; Sublocade™)</td>
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<tr>
<td>Buprenorphine (Probuphine® &amp; Sublocade™)</td>
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<td>Carrier Testing for Genetic Diseases</td>
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<td>Clotting Factors and Coagulant Blood Products</td>
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<td>Collagen Crosslinks and Biochemical Markers of Bone Turnover</td>
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<td>Drug Coverage Criteria - New and Therapeutic Equivalent Medications</td>
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<tr>
<td>Drug Coverage Criteria - New and Therapeutic Equivalent Medications</td>
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<td>Drug Coverage Guidelines</td>
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<td>Drug Coverage Guidelines</td>
<td>Clinical</td>
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<tr>
<td>Eloctate™ (Antihemophilic Factor (Recombinant), FC Fusion Protein) for</td>
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<td>Connecticut Lines of Business</td>
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<td>Exondys 51™ (Eteplirsen)</td>
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<td>From – To Date Policy</td>
<td>Reimbursement</td>
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# Oxford® Medical and Administrative Policy Updates

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<tr>
<th>Policy Title</th>
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<tbody>
<tr>
<td>Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-</td>
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<tr>
<td>Implantable</td>
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<tr>
<td>Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors</td>
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<td>Infliximab (Remicade®, Inflectra™, Renflexis™)</td>
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<td>Lemtrada (Alemtuzumab)</td>
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<td>Manipulation Under Anesthesia</td>
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<td>Maximum Dosage</td>
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<tr>
<td>Maximum Dosage</td>
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<td>Spinraza™ (Nusinersen)</td>
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<td>Stelara® (Ustekinumab)</td>
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<tr>
<td>Time Span Codes</td>
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## Oxford® Medical and Administrative Policy Updates

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Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.
## SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Updates


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<td>Family Planning: Infertility Services</td>
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# SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates


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<td>Thermography</td>
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| **RETIRED**                                                                  |                |
| Durable Medical Equipment and Related Supplies, Prosthetics, Orthotic Policy | April 1, 2018  |
| Thermal Capsulorrhaphy/Thermal Shrinkage Therapy                             | April 1, 2018  |

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