OCTOBER 2018

network bulletin

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

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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.

UnitedHealthcare®

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claim. Hospital payments will be adjusted if UnitedHealthcare determines, after reviewing the member's medical record and Sepsis-3, that sepsis was not present and sepsis treatment services should not have been included as part of the member's claim. Sepsis-3 will be used for all UnitedHealthcare benefit plans including commercial, Medicare Advantage and Medicaid plans. ›

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 for UnitedHealthcare commercial at UHCprovider.com/pharmacy. ›

Changes in Advance Notification and Prior Authorization Requirements

Changes in advance notification and prior authorization requirements are part of UnitedHealthcare's ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. Using evidence-based medicine to guide coverage decisions supports quality patient care and reflects our shared commitment to the Triple Aim of better care, better health outcomes and lower costs. ›

Primary Care Provider UnitedHealthcare Optum D-SNP Policy

This policy establishes the guidelines and process for clinical integration, cooperation, and collaboration of and with respect to the care of members of UnitedHealthcare Dual Special Needs Plans managed by our affiliate Optum (UnitedHealthcare Optum D-SNPs). UnitedHealthcare or Optum will advise Primary Care Providers (PCPs) about which specific D-SNPs are UnitedHealthcare Optum D-SNPs (managed by Optum) and which members are enrolled in those plans. ›

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Stay up to date with the latest news and information.

Join Our New Data Exchange and Medical Record Collection Programs

UnitedHealthcare values the care you provide to our members — which is why we're always searching for new ways we can make it easier for you to do business with us. As part of that effort, we want to share with you some innovative new programs involving medical record collection and data exchange. Our new programs will help alleviate the burden of medical record collection, get your claims processed faster and support your patient care plans. ›

Radiology Program Procedure Code Changes — Effective Jan. 1, 2019

Effective Jan. 1, 2019, UnitedHealthcare is updating the procedure code list for the Radiology Notification and Prior Authorization programs to include a set of temporary codes related to Coronary Fractional Flow Reserve Using Computed Tomography (FFR-CT) assigned by the American Medical Association (AMA). Claims with dates of service on or after Jan.1, 2019 are subject to these changes. ›

Updates to Notification/ Prior Authorization Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

We're making some updates to our coverage review requirements for certain specialty medications for many of our UnitedHealthcare commercial, Community Plan and Medicare Advantage 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. ›

Requesting a Peer to Peer

Starting Oct. 1, 2018, care providers who previously called the Peer to Peer support team at 800-955-7615 to initiate a Peer to Peer request should submit by sending a secure email through res.cisco.com/websafe to UHC_PeerToPeer_Scheduling@uhc.com or by calling the UnitedHealthcare Peer-to-Peer Support Team and leaving a voicemail at 800-955-7615. ›

Retiring Fax Numbers Used for Medical Prior Authorization – Phase 2 Fax Numbers Released

In September 2018, we announced that we're retiring certain fax numbers used for medical prior authorization requests. We're releasing the second set of fax numbers to retire on Jan. 1, 2019. Instead of faxing the requests, please use the Prior Authorization and Notification tool on Link. ›

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Stay up to date with the latest news and information.

Fulphila Will Require Prior Authorization

Beginning Jan. 1, 2019, the biosimilar Fulphila (Q5108) and Nivestym (Q5110) will require prior authorization when administered to patients with a cancer diagnosis in the outpatient setting. This requirement is for members of UnitedHealthcare Commercial, UnitedHealthcare Oxford and UnitedHealthcare Community Plan who currently require prior authorization for outpatient injectable chemotherapy and other colony stimulating factors. Care providers will use the online prior authorization tool to obtain the prior authorization for Fulphila and Nivestym. ›

Dental Clinical Policy & Coverage Guideline Updates ›

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Link Self-Service Updates and Enhancements

Link is your online self-service tool that is proven to be **faster than calling**. We're continuously making improvements to Link apps to better support your needs. Here are some recent enhancements:

Prior Authorization and Notification Tool

- When checking eligibility to start a case, you'll receive a message if you enter a member's date of birth that is a current or recent date. This is to help ensure that you're entering the correct date of birth.
- A message has been added to inform you about how the follow-up contact information will be used.
- Now the tool will display and allow users to select from multiple NPIs for UHC West care providers when a user's Optum ID is associated with more than one NPI.
- DME Cost and Procurement Type fields are now available for data entry to support prior authorization requirements.
- System logic has been improved to enable the ability to check case status and make updates to the case.

Getting Started

An Optum ID is required to access Link and perform online transactions, such as eligibility verification, claims status, claims reconsideration, referrals and prior authorizations. To get an Optum ID, go to UHCprovider.com and click on ***New User*** to register for Link access.

For help with Link, call the UnitedHealthcare Connectivity Helpdesk at **866-842-3278**, option 1, Monday through Friday, 7 a.m. to 9 p.m. Central Time.

Tell Us What You Think of Our Communications

Your opinion is important to us. We'd like to get your thoughts about The Network Bulletin. Please take a few minutes today to complete the survey online at **uhcresearch.az1.qualtrics.com/jfe/form/SV_08sAsRnUY2Kb153**. Thank you for your time.

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UnitedHealthcare Adopts Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) and Supports the Surviving Sepsis Campaign International Guidelines for Management of Sepsis and Septic Shock

Effective Jan. 1, 2019, Sepsis-3 will be used as part of UnitedHealthcare's clinical claim reviews to validate that sepsis was present and sepsis treatment services were appropriately submitted as part of the member's claim. Hospital payments will be adjusted if UnitedHealthcare determines, after reviewing the member's medical record and Sepsis-3, that sepsis was not present and sepsis treatment services should not have been included as part of the member's claim. Sepsis-3 will be used for all UnitedHealthcare benefit plans including commercial, Medicare Advantage and Medicaid plans.

Sepsis is a syndrome of physiologic, pathologic and biochemical abnormalities induced by infection, and is a major public health concern. The reported incidence of sepsis is increasing and is recognized as a leading cause of mortality and critical illness worldwide.

UnitedHealthcare adopted Sepsis-3, which is the most recent evidence-based definition of Sepsis and supports the Surviving Sepsis Campaign International Guidelines as part of its effort to promote accurate diagnosis and treatment of sepsis as well as appropriate billing and coding.

Sepsis-3 defines sepsis as ***life-threatening organ dysfunction caused by a dysregulated host response to infection***.

Sepsis-3 was developed because definitions for sepsis and septic shock were last revised in 2001. Since that time, considerable advances in pathobiology (changes in organ function, morphology, cell biology, biochemistry, immunology and circulation), management and epidemiology of sepsis have led to an update of previous sepsis definitions and are based on updated evidence-based medicine. In clinical operation, the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality >10 percent, should be used in defining sepsis.

"Septic shock should be defined as a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone. Patients with septic shock can be clinically identified by a vasopressor requirement to maintain a mean arterial pressure of 65 mm Hg or greater and serum lactate level greater than 2 mmol/L (>18 mg/dL) in the absence of hypovolemia. This combination is associated with hospital mortality rates greater than 40%."
Source: ***Journal of the American Medical Association. 2016 Feb 23; 315(8): 801–810. doi: 10.1001/jama.2016.0287***

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UnitedHealthcare Adopts Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) and Supports the Surviving Sepsis Campaign International Guidelines for Management of Sepsis and Septic Shock

UnitedHealthcare's position on sepsis is that Sepsis-1 and 2 lack sensitivity and specificity in defining sepsis. Sepsis-1 and 2 are based on Systemic Inflammatory Response (SIRS) criteria. SIRS does not, necessarily, indicate a dysregulated, life-threatening response. SIRS criteria are present in many hospitalized patients, including those who never develop infection and never incur adverse outcomes.

Sepsis-3 is endorsed by 31 medical societies and provides the most clinically relevant definition of sepsis with a SOFA score of 2 or more as an adjunct in clinical diagnosis of sepsis.

UnitedHealthcare supports the Surviving Sepsis Campaign International Guidelines for Management of Sepsis and Septic Shock (2016)

These guidelines were developed by a consensus committee of 55 international experts representing 25 international organizations in 2016. Experts searched for best available evidence and then followed the principles of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to assess the quality of evidence and to formulate recommendations as best practice statements.

UnitedHealthcare believes adherence to these management guidelines will result in improved quality of care and outcomes.

Resources:

Surviving Sepsis Campaign/Society of Critical Care Medicine: ncbi.nlm.nih.gov/pmc/articles/PMC4968574/

Surviving Sepsis Campaign/Society of Critical Care Medicine: journals.lww.com/ccmjournal/Fulltext/2017/03000/Surviving_Sepsis_Campaign___International.15.aspx

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**.

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Changes in Advance Notification and Prior Authorization Requirements

Code Additions to Prior Authorization

Effective for dates of service on or after **Dec. 1, 2018**, the following procedure codes will require prior authorization due to state mandate for **UnitedHealthcare Community Plan of Florida (MMA, LTC Plans):**

Category	Codes
Acupuncture	97810, 97811, 97813, 97814
Chiropractic Services	98940, 98941, 98942, 98943
Massage Therapy for Pain Management	97010, 97112, 97140, 97124

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will modify prior authorization requirements for **UnitedHealthcare Medicare Advantage Plans** (UnitedHealthcare West, UnitedHealthcare Community Dual Special Needs Plans, UnitedHealthcare Community Plan Massachusetts Senior Care Options, UnitedHealthcare Community Plans-Medicare; excludes Medica and Preferred Care of Florida health plan):

Category	Codes
Durable Medical Equipment (DME) – *Regardless of Billed Amount* (changed from "when billed with accumulative rental or purchase price of >$1K")	E0466

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Texas (StarPlus Plan):**

Category	Codes
Orthotics/Prosthetics	L1810, L1831, L1843, L1932, L1951, L1960, L2280, L2999, L3000, L3010, L3020, L3216, L3221, L3960, L4631, L5000, L5611, L5620, L5624, L5629, L5631, L5637, L5645, L5647, L5649, L5650, L5671, L5673, L5679, L5685, L5700, L5701, L5704, L5705, L5707, L5845, L5910, L5920, L5940, L5962, L5972, L5986, L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8031, L8032, L8035, L8039, L8420, L8499, L8500

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will now require prior authorization when billed with the defined diagnosis codes for **UnitedHealthcare Community Plan of Maryland (Medicaid Plan)**:

Category	Codes	Diagnosis Codes
Gender Dysphoria Treatment	14021, 14061, 14301, 14302	F64.0, F64.1, F64.2, F64.8, F64.9, Z87.890

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Changes in Advance Notification and Prior Authorization Requirements

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Louisiana (Medicaid Plan)**:

Category	Codes
Durable Medical Equipment (DME)	E1220

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of California (Medicaid Plan)**:

Category	Codes
Dental Anesthesia	00170

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of New York (Medicaid, HARP, CHIP, EPP, LTSS Plan)**:

Category	Codes
Experimental/ Investigational	A9274

Effective for dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Mississippi (Medicaid, CHIP Plans)**:

Category	Codes
Speech Therapy	92507

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Commercial Plans** (UnitedHealthcare Mid Atlantic Health Plan, Navigate, Neighborhood Health Partnership, UnitedHealthOne, UnitedHealthcare Commercial, UnitedHealthcare of the River Valley and UnitedHealthcare West):

Category	Codes
DME	E0466

Effective for dates of service on or after **Jan. 1, 2019**, the following procedure codes will require prior authorization to obtain the face-to-face documentation for **UnitedHealthcare Community Plan of Kansas (Medicaid, CHIP, LTSS Plan)**:

Category	Codes
Incontinence Supplies	T4521-T4535, T4543

Correction to claims processing systems: It has been identified that claims processed for UHCWest Medicare have not been applying prior authorization rules for many services under the DME/Orthotic/Prosthetic categories. The claims platform has been fixed and the rules will be applied effective immediately. As a result, care providers may experience claim denials for lack of prior authorization when claims previously allowed without authorization. The published Provider Notification document, posted on UHCprovider.com, has continued to include these services as prior authorization requirements, which contracted servicing care providers are to adhere to.

Changes will be published prior to implementation. The most up-to-date Advance Notification lists are available online at **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > Plan Requirements and Procedure Codes.

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Primary Care Provider UnitedHealthcare Optum D-SNP Policy

This policy establishes the guidelines and process for clinical integration, cooperation, and collaboration of and with respect to the care of members of UnitedHealthcare Dual Special Needs Plans managed by our affiliate Optum. UnitedHealthcare or Optum will advise Primary Care Providers (PCPs) about which specific Dual Special Needs Plans are managed by Optum and which members are enrolled in those plans. This policy does not apply to members who are attributed or assigned to an ACO based on the member's PCP or whose PCP is compensated pursuant to a global capitation or risk-sharing arrangement with UnitedHealthcare.

UnitedHealthcare D-SNPs managed by Optum include the Optum At Home Program, which is an integrated care delivery program that coordinates the delivery and provision of clinical care of members in their place of residence. When members participate in this program their care providers are obligated to follow a communications structure that helps ensure better coordination of their medical care. To promote the best possible outcomes, the program supports sharing information between care team members, including performance reviews, tracking clinical outcomes and communicating evidence-based guidelines.

The Optum At Home Program's Interdisciplinary Care Team includes an Optum trained Advanced Practice Clinicians (ARNP/PA), the member's PCP and other care providers as appropriate, in addition to the member and the member's family. Together they provide care customized to the member's needs and goals of care. Optum clinicians conduct annual evaluations, provide longitudinal care management for high risk members to ensure medical, behavioral and socioeconomic concerns are addressed, and help ensure care coordination for members experiencing a care transition. All member evaluations, care management and care coordination is done in conjunction with the member's PCP as well as other members of the Interdisciplinary Care Team.

The Optum At Home Program supplements care provided by our members' PCPs. It is not intended to replace the care provided by our members' PCPs.

Policy provisions

PCPs who participate in the network for UnitedHealthcare D-SNPs managed by Optum will:

1. Collaborate and cooperate with the Optum At Home Program, including Optum Advanced Practice Clinicians and other staff assigned to UnitedHealthcare D-SNP Plan members managed by Optum.
2. Attend PCP meetings when requested by Optum.
3. Participate in review of information provided by Optum, including provider performance reviews, tracking of clinical outcomes and communication of evidence-based guidelines to team members.
4. Collaborate with other members of the Interdisciplinary Care Team designated by UnitedHealthcare and other treating professionals to provide and arrange for the provision of covered services to our UnitedHealthcare D-SNP Plan members managed by Optum.

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Join Our New Data Exchange and Medical Record Collection Programs

UnitedHealthcare values the care you provide to our members — which is why we're always searching for new ways we can make it easier for you to do business with us. As part of that effort, we want to share with you some innovative new programs involving medical record collection and data exchange.

We've heard your feedback: you want us to request fewer medical records. You also want us to stop requesting the same information multiple times. We know these requests can delay your claims processing and take up your staff's time. We also know that faster access to valuable information can help make our teams and yours more effective. That's why our new programs will help alleviate the burden of medical record collection, get your claims processed faster and support your patient care plans.

We're doing this in several ways:

Direct EMR access: By downloading clinical information straight from your EMR system, we'll be able to collect the medical records we need to process your claims and conduct medical necessity and other reviews — without needing assistance from you and your staff.

Clinical data exchange: Through an automated data exchange process, you can easily share Admit, Discharge, Transfers (ADTs), Discharge Summaries and prescribed medication lists, so we can help spot any medication errors to help lower the risk for adverse interactions.

Point of Care solutions: You'll access valuable data during the point of care. Programs like PreCheck My Script will help you access real-time pharmacy benefit information like copays, drug costs and prior authorization requirements — so you can prescribe the most appropriate and lowest cost medication before your patients leave the office.

These changes are gradually expanding across our organization to bring you the following benefits:

- You'll see fewer pended or denied claims that require clinical information submission — and faster timeframe for your accounts receivables.
- Because we're building a centralized database for medical records we receive, we can use these records multiple times instead of making duplicate requests.
- You'll receive accurate, real-time data for greater efficiency and better patient outcomes.
- Your staff can spend more time on patient care than administrative work.
- You can also leverage your EMR investment.
- You can stay secure and compliant, since our technologies meet **HIPAA** privacy statutes and other regulatory requirements. All data is stored and exchanged safely.

To find out more about our programs, visit UHCprovider.com > Menu > Resource Library > **UnitedHealthcare Enterprise Medical Records Program**. To get started, visit Link on UHCprovider.com and choose the Remote EMR Access tool. You can also ask your Provider Advocate for additional assistance.

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Radiology Program Procedure Code Changes — Effective Jan. 1, 2019

Effective Jan. 1, 2019, UnitedHealthcare is updating the procedure code list for the Radiology Notification and Prior Authorization programs to include a set of temporary codes related to Coronary Fractional Flow Reserve Using Computed Tomography (FFR-CT) assigned by the American Medical Association (AMA). Claims with dates of service on or after Jan.1, 2019 are subject to these changes.

The following Category III CPT codes are being added to the Radiology Notification and Prior Authorization list:

Code	Code Description
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report

For the most current list of CPT codes for which notification/prior authorization is required, go to **UHCprovider.com/Radiology** > Specific Radiology Programs.

For complete details on this radiology protocol, please refer to the current **UnitedHealthcare Care Provider Administrative Guide** available online at UHCprovider.com > **Administrative Guides and Manuals**.

These requirements do not apply to advanced imaging procedures provided in the emergency room, urgent care center, observation unit or during an inpatient stay.

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Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

We're making some updates to our coverage review requirements for certain specialty medications for many of our UnitedHealthcare commercial, Community Plan and Medicare Advantage 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.

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 drugs listed below are appropriate for the individual member, taking into account:

- Terms of the member's benefit plan
- Our drug coverage policy
- Applicable Medicare guidance (for Medicare Advantage plans)
- Applicable state Medicaid guidelines (for Community plans)
- The member's treatment history
- Dosage recommendation from the FDA-approved labeling
- Medically necessary site of care (not applicable for Medicare Advantage plans)

Additional criteria 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.
As a reminder, self-administered medications should be submitted to the Pharmacy Benefit Manager to determine coverage under the pharmacy benefit plan. For commercial plans, self-administered medications are typically a medical benefit plan exclusion.

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Updates to Notification/Prior AuthorizationRequirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

For UnitedHealthcare Community 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 for your patients before submitting the prior authorization request or administering the medication.

Submitting Notification/Prior Authorization Requests

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

- **Online:** Use the Prior Authorization and Notification tool on Link. Go to **UHCprovider.com/priorauth** for more information.
- **Call: Use the Provider Services phone number** on the member's health care identification card.
- **Send your request by fax (option for Community and Commercial plans):** Complete a prior authorization form and fax it to the number provided on the form. Some states require the notification/ prior authorization to be submitted on a designated request form.

For UnitedHealthcare commercial plans, you can access forms at **UHCprovider.com/priorauth**. Go to UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs > Forms and Additional Resources.

For UnitedHealthcare Community plans, you can access forms at **UHCprovider.com** > Health Plans By State > Select your state.

When Making Referrals

If you're referring a member to other care providers for these medications, please refer to in-network care providers. If you have any questions, please call the Provider Service number on the member's ID card.

Reminder: Please consider requesting pre-service coverage reviews for medications listed on UnitedHealthcare's Review at Launch Commercial or Community Plan Medication Lists.

UnitedHealthcare adds certain new drugs to the Review at Launch Commercial or Community Medication Lists once they are approved by the U.S. Food and Drug Administration (FDA). Drugs will remain on the Review at Launch List until we communicate otherwise.

Under some benefit plans, a member may not be eligible for coverage for medications on the Review at Launch Commercial or Community Medication Lists for a period of time. For medications on the Lists, 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 also help avoid starting a patient on therapy that may later be denied due to lack of medical necessity. Your claims may be denied if a pre-service coverage review is not completed.

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:

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Updates to Notification/Prior AuthorizationRequirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

For dates of service on or after Jan. 1, 2019, we'll require notification/prior authorization for the following medications:

- **Onpattro** — The FDA recently approved Onpattro as a treatment for hereditary transthyretin amyloidosis-associated polyneuropathy.
- **Ilumya** — The FDA recently approved Ilumya for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. When Ilumya is self-administered it will be evaluated for coverage under the pharmacy benefit, consistent with our standard benefit plan design.
- **Hemlibra** — The FDA approved Hemlibra to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients with hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors. When Hemlibra is self-administered it will be evaluated for coverage under the pharmacy benefit, consistent with our standard benefit plan design.

For dates of service before Jan. 1, 2019, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

Onpattro and Ilumya have been added to the Review at Launch List. Some members may not be eligible for coverage of these medications at this time. Please reference the Review at Launch for New to Market Medications drug policy for additional details.

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

We'll be adding prior authorization requirements for the following drugs for UnitedHealthcare Community Plan members. Additionally, for some of the drugs, we'll evaluate services requested in the outpatient hospital setting for medical necessity.

Effective Oct. 15, 2018

State	Drug	Authorization
Arizona Maryland Ohio	Actemra Entyvio Infliximab (Inflectra, Remicade, Renflexis) Orencia Simponi Aria	Prior authorization plus Site of Care review for the outpatient hospital setting. *All listed drugs apply to Arizona, Maryland and Ohio.*

Effective Dec. 1, 2018

State	Drug	Authorization
Florida MMA	Spinraza	Prior authorization

Effective Jan. 1, 2019

For dates of service on or after Jan. 1, 2019, we'll require prior authorization for the following drugs for UnitedHealthcare Community Plan members in many states:

- **Ilumya**
- **Onpattro**

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Updates to Notification/Prior AuthorizationRequirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

Additionally, if Ilumya is requested in the outpatient hospital setting, this site of care will be reviewed for medical necessity.

Onpattro and Ilumya have been added to the **Review at Launch Drug List** for UnitedHealthcare Community Plan which is located at **UHCprovider.com/en/policies-protocols/comm-planmedicaid-policies/medicaid-community-state-policies.html** through the *Review at Launch for New to Market Medications* drug policy.

All codes that would be used to bill for **Onpattro and Ilumya** will require prior authorization, including any Q or C codes that CMS may assign to these medications. If **Onpattro and Ilumya** are currently not covered in a state, but then become covered, prior authorization will be required upon coverage.

Also beginning Jan. 1, 2019, some states will have additional prior authorization requirements. **Actemra, Entyvio, Infliximab (Inflectra, Remicade, Renflexis), Orencia**, and **Simponi Aria** will require prior authorization in the following states:

Prior Authorization	Prior Authorization plus Site of Care Review for the Outpatient Hospital Setting
California	Hawaii
Florida	Kansas
Iowa	Nebraska
Louisiana	Texas
Michigan	
Mississippi	
New York	
Rhode Island	
Tennessee	
Virginia	
Washington	

For dates of service before Jan. 1, 2019, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

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Updates to Notification/Prior AuthorizationRequirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

What's Changing for UnitedHealthcare Medicare Advantage Plans

The following requirement will apply to UnitedHealthcare Medicare Advantage Plans, including UnitedHealthcare Dual Complete Plans, UnitedHealthcare Connected Plans, Medica and Preferred Care Partners of Florida groups. For dates of service on or after Jan. 1, 2019, we'll require notification/prior authorization for the following medication:

- **Onpattro**

If you would like to review the updated policy, please go to **UHCprovider.com > Policies and Protocols**. If you have questions, please call the Provider Service number on the back of the member's ID card.

Requesting a Peer to Peer

Starting Oct. 1, 2018, care providers who previously called the Peer to Peer support team at 800-955-7615 to initiate a Peer to Peer request should submit by sending a secure email through res.cisco.com/websafe to **UHC_PeerToPeer_ Scheduling@uhc.com** or by calling the UnitedHealthcare Peer-to-Peer Support Team and leaving a voicemail at **800-955-7615**. For more information, you can locate the Peer to Peer Request Form at **UHCprovider.com/prior-auth**.

Front & Center

Retiring Fax Numbers Used for Medical Prior Authorization — Phase 2 Fax Numbers Released

In September 2018, we announced that we're retiring certain fax numbers used for medical prior authorization requests. We're releasing the second set of fax numbers to retire on Jan. 1, 2019. ***Instead of faxing the requests, please use the Prior Authorization and Notification tool on Link***. Go to UHCprovider.com/priorauth for full program details.

Retiring fax numbers for medical prior authorization requests support the challenge issued by Seema Verma, CMS Administrator, at the 2018 ONC Interoperability Forum on Aug. 6, 2018 in Washington, D.C. In her keynote address, she said, "If I could challenge the developers in this room here today to achieve one mission, it would be this: help us make every doctor's office in America a fax free zone by 2020!" Read the full transcript of her keynote address.

Some Fax Numbers Won't Retire

Some plans have a state requirement for fax capability and will continue to use their existing fax number for their members. ***However, you can still use the Prior Authorization and Notification tool on Link to submit requests for those members.***

The fax numbers retiring on Jan. 1, 2019, are:

Phase 1	Phase 2
877-269-1045	866-537-9371
866-362-6101	800-789-0714
866-892-4582	800-352-0049
866-589-4848	800-538-1339
866-255-0959	800-676-4798

More numbers will be added to this list over the next several months. We'll let you know which numbers are being retired in the Network Bulletin and at UHCprovider.com/priorauth.

Requests for Additional Information

If we ask you for more information about a prior authorization request, you can attach it directly to the case using the Prior Authorization and Notification tool on Link. If you can't access Link, you can use the fax number included on the request for more information.

New Fax Numbers for Admission Notifications

While we encourage the use of the Prior Authorization and Notification tool on Link or EDI (278N) electronic transaction for Admission Notifications, we will continue to maintain a fax channel for these notifications. Effective Jan. 1, 2019, the following new fax numbers replace the retiring fax numbers for Admission Notifications:

- UnitedHealthcare Commercial Admission Notifications: **844-831-5077** is replacing 800-789-0714 and 800-352-0049.
- UnitedHealthcare Medicare Advantage and Medicare Special Needs Plans Admission Notifications: **844-211-2369** is replacing 800-538-1339 and 800-676-4798.

Please do not use these fax numbers for prior authorization request submissions as this will result in a misdirect and delay processing of your request.

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Front & Center

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Retiring Fax Numbers Used for Medical Prior Authorization — Phase 2 Fax Numbers Released

Other Ways to Submit a Prior Authorization Request

If you're unable to use the Prior Authorization and Notification tool on Link, you can continue to call Provider Services at **877-842-3210** to submit a request by phone.

Quick Start: Using the Prior Authorization and Notification Tool

Access the tool by clicking on the Link button in the top right corner of this screen and signing in. Learn more at UHCprovider.com/paan.

With the Prior Authorization and Notification tool on Link, you can check if prior authorization or notification is required, submit your request and check status – all in one place. Use it to:

- Submit a new prior authorization request or inpatient admission notification.
- Get a reference number for each submission, even when prior authorization or notification isn't required.
- Add frequently selected care providers and procedures to your favorites list for quick submissions.
- View medical records requirements for common services, and add an attachment to a new or existing submission.
- Update an existing request with attachments, add clinical notes or make changes to case information.

Access the Prior Authorization and Notification tool by clicking on the Link button in the top right corner of this screen and signing in. New to Link? Click on New User or go to UHCprovider.com/newuser.

Register for training at UHCprovider.com/training to learn about using the Prior Authorization and Notification tool. Learn more at UHCprovider.com/paan or watch one of our short video tutorials:

- Prior Authorization and Notification Submission
- Prior Authorization and Notification Inquiry
- Prior Authorization and Notification Status and Update

Fulphila Will Require Prior Authorization

Beginning Jan. 1, 2019, the biosimilar Fulphila (**Q5108**) and Nivestym (**Q5110**) will require prior authorization when administered to patients with a cancer diagnosis in the outpatient setting. This requirement is for members of UnitedHealthcare Commercial, UnitedHealthcare Oxford and UnitedHealthcare Community Plan who currently require prior authorization for outpatient injectable chemotherapy and other colony stimulating factors. Care providers will use the online prior authorization tool to obtain the prior authorization for Fulphila and Nivestym.

Front & Center

Dental Clinical Policy & Coverage Guideline Updates

For complete details on the policy updates listed in the following table, please refer to the **September 2018 UnitedHealthcare Dental Policy Update Bulletin** at **UHCprovider.com > Policies and Protocols > Dental Clinical Policies and Coverage Guidelines > Dental Policy Update Bulletins**.

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Labial Veneers	Coverage Guideline	Sept. 1, 2018
Oral Surgery: Alveoloplasty and Vestibuloplasty	Coverage Guideline	Sept. 1, 2018
Oral Surgery: Miscellaneous Surgical Procedures	Clinical Policy	Oct. 1, 2018
Oral Surgery: Non-Pathologic Excisional Procedures	Coverage Guideline	Oct. 1, 2018
Oral Surgery: Orthodontic Related Procedures	Clinical Policy	Sept. 1, 2018

Note: The inclusion of a dental service (e.g., procedure or technology) on this list does not imply that UnitedHealthcare provides coverage for the dental 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 Commercial

Learn about program revisions and requirement updates.

Medical Record Review – ACA-Covered Commercial Plans for 2018 Dates of Service

We're required by the Department of Health & Human Services (HHS), under the Affordable Care Act (ACA), to submit complete diagnostic information about members enrolled in certain Commercial ACA-covered health plans. We may request medical records from you to comply with this requirement from Dec. 3, 2018 through March 15, 2019. ›

Site of Care Reviews for Certain Advanced Outpatient Imaging Procedures – Effective Jan. 1, 2019

For dates of service on or after Jan. 1, 2019, once prior authorization is requested for certain advanced outpatient imaging procedures pursuant to our Outpatient Radiology Notification/Prior Authorization Protocol, we'll review the site of care and issue a medical necessity determination for the site of care, under the terms of the member's benefit plan, if the procedure will be performed in an outpatient hospital setting. We're also implementing a utilization review guideline to facilitate our site of care reviews. ›

Prior Authorization for Select Musculoskeletal and Pain Management Procedures

Effective Jan. 1, 2019, All Savers members on policies 908867 and 908868 and Oxford Individual members on policy 908410 will require prior authorization for select musculoskeletal and pain management procedures. ›

Prior Authorization Required for Therapeutic Radiopharmaceuticals

Effective Jan. 1, 2019, UnitedHealthcare will require prior authorization for therapeutic radiopharmaceuticals administered on an outpatient basis. This will be required for all UnitedHealthcare commercial members. ›

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates ›

UnitedHealthcare Commercial

Medical Record Review – ACA-Covered Commercial Plans for 2018 Dates of Service

We're required by the Department of Health & Human Services (HHS), under the Affordable Care Act (ACA), to submit complete diagnostic information about members enrolled in certain Commercial ACA-covered health plans. We may request medical records from you to comply with this requirement from **Dec. 3, 2018** through **March 15, 2019**.

What This Means to You

If you're selected for a medical record review, UnitedHealthcare will ask you to provide information for 2018 dates of service for a certain number of your patients. To reduce the potential for administrative burden on your office, we use the records received through this request for other appropriate health care operations, for example, monitoring compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) measures. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Optum and CIOX Health (CIOX) will conduct these medical record reviews, coordinate record retrieval and clinical coding reviews on UnitedHealthcare's behalf. They will request records for members in Commercial ACA-covered health plans.

What You Will Need to Do

All requested medical records and documentation will need to be completed **March 15, 2019** to meet the HHS deadline for these record requests. This is unlike Medicare record requests you may have had in the past, as we need to adhere to a tighter window with one retrieval wave for our UnitedHealthcare commercial members.

Medical Record Documentation Required:

When you get the medical record request, you'll be asked to provide the following documentation:

- Consult notes
- Discharge summary
- Emergency department records
- History and physical notes
- Operative and pathology notes
- Patient demographics sheet
- Physical, speech and/or occupational therapist reports
- Physician orders
- Problem list
- Procedure notes/reports
- Progress notes and/or SOAP notes for face-to-face office visit
- Signature Log*

*HHS requires us to validate care providers' signatures and qualifications for each medical record we review. ***It's important that you provide a signature log, with credentials to identify signatures of physicians, physician assistants, and nurse practitioners who are mentioned in or have annotated medical records.***

If you have any questions about the scheduling of the medical record review:

- Call CIOX Health at **877-445-9293**, between 7 a.m. to 8 p.m., CST, Monday through Friday, or
- Email **chartreview@cioxhealth.com**.

UnitedHealthcare Commercial

Site of Care Reviews for Certain Advanced Outpatient Imaging Procedures – Effective Jan. 1, 2019

UnitedHealthcare aims to minimize out-of-pocket costs for UnitedHealthcare members and to improve cost efficiencies for the overall health care system. For dates of service on or after Jan. 1, 2019, once prior authorization is requested for certain advanced outpatient imaging procedures pursuant to our Outpatient Radiology Notification/ Prior Authorization Protocol, we'll review the site of care. We will issue a medical necessity determination for the site of care, under the terms of the member's benefit plan, if permitted by state law and if the procedure will be performed in an outpatient hospital setting. We're also implementing a utilization review guideline to facilitate our site of care reviews. The guideline will be available at **UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determinations for UnitedHealthcare Commercial Plans >** Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) – Site of Care.

We will not conduct site of care reviews if the procedure is planned to be performed in a free-standing diagnostic radiology center or an office setting.

Site of care reviews will apply to providers in all states, except Iowa, Kentucky and Utah.

Site of Care reviews will apply to UnitedHealthcare commercial benefit plans, including exchange benefit plans and the following benefit plans:

- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley
- UnitedHealthcare

Site of care reviews will apply to the following procedure codes, which are currently subject to notification/prior authorization requirements:

MR	CT
70336, 70540, 70542, 70543 70544, 70545, 70546, 70547 70548, 70549	70450, 70460, 70470, 70480
70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552	70481, 70482, 70486, 70487, 70488

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UnitedHealthcare Commercial

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Site of Care Reviews for Certain Advanced Outpatient Imaging Procedures – Effective Jan. 1, 2019

MR	CT
72141, 72142, 72146, 72147, 72148, 72149	70490, 70491, 70492, 70496, 70498
72156, 72157, 72158, 72195, 72196, 72197	71250, 71260, 71270, 71275
73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723	72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194
74181, 74182, 74712, 74713, 75557, 75559	73200, 73201, 73202, 73206
75561, 75563, 76498, 77021	73700, 73701, 73702
77084, 71555, 72159*, 72198	73706, 74150, 74160, 74170
73225*,73725, 74183, 74185	74174, 74175, 74176, 74177, 74178
77058, 77059	74261, 74262, 74263*
C8900, C8901, C8902, C8903	75571*, 75572, 75573, 75574
C8904, C8905, C8906, C8907	75635, 76380
C8908, C8909, C8910, C8911	76497, S8092*, G0297
C8912, C8913, C8914, C8918	
C8919, C8920, C8931*	
C8932*, C8933*, C8934*	
C8935*, C8936*	
S8037*, S8042*	

To view a complete list of procedure codes for which notification/prior authorization is required pursuant to our Outpatient Radiology Notification/Prior Authorization Protocol, please visit: **UHCprovider.com** > Prior Authorization and Notification > **Radiology**.

As a reminder, care providers are not required to complete the notification/prior authorization process for any advanced outpatient imaging procedure rendered in the emergency room, urgent care center, observation unit or during an inpatient stay.

You may complete the notification/prior authorization process or confirm a coverage decision online or by phone:

- Online at **UHCprovider.com/radiology**. Select the Go to Prior Authorization and Notification App, or
- Call **866-889-8054** (7 a.m. to 7 p.m., local time, Monday – Friday)

UnitedHealthcare Commercial

Prior Authorization for Select Musculoskeletal and Pain Management Procedures

Effective Jan. 1, 2019, All Savers members on policies 908867 and 908868 and Oxford Individual members on policy 908410 will require prior authorization for select musculoskeletal and pain management procedures.

Prior authorization will be required for:

Procedure Class	Procedure Category	Codes Added to Prior Authorization - All Savers 908867 & 908868 and Oxford Individual 908410
Arthroplasty	Knee Arthroplasty	27437, 27438, 27440, 27441, 27442, 27443, 27445
Arthroscopy	Shoulder Arthroscopy	29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828
	Elbow Arthroscopy	29830, 29834, 29835, 29836, 29837, 29838
	Wrist Arthroscopy	29840, 29843, 29844, 29845, 29846, 29847, 29848
	Hip Arthroscopy	29860, 29861, 29862, 29863
	Knee Arthroscopy	29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889
	Ankle Arthroscopy	29891, 29892, 29893, 29894, 29895, 29897, 29898, 29899
Foot Surgery	Foot Hammertoe	28285
	Foot Hallux Rigidis/Valgus	28289, 28291, 28292, 28296, 28297, 28298, 28299
Spinal Cord Stimulators	Neurostimulators	63661, 63662, 63663, 63664, 63688
Spine Surgery	Vertebroplasty	22510, 22511, 22512
	Kyphoplasty	22513, 22514, 22515
	Fusion	22534, 22552, 22585, 22614, 22632, 22634, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22853, 22854, 22857, 22859, 22862, 27279, 27280, 0195T, 0196T, 0309T
	Decompression	63035, 63043, 63044, 63048, 63051, 63057, 63066, 63076, 63078, 63082, 63086, 63088, 63091, 63103, 63197, 63266, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63287, 63290, 63295

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UnitedHealthcare Commercial

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Prior Authorization for Select Musculoskeletal and Pain Management Procedures

Prior authorization can be requested in the following ways:

- Go to UHCprovider.com > **Prior Authorization and Notification**. The automated process will guide you through a series of questions and review time may be faster.
- Fax the request to **855-705-4842**
- Call **800-999-3404**

Standard prior authorization guidelines apply. The prior authorization process must be completed before performing these procedures or claims will be administratively denied and the member cannot be billed for the service.

Prior Authorization Required for Therapeutic Radiopharmaceuticals

Effective Jan. 1, 2019, UnitedHealthcare will require prior authorization for therapeutic radiopharmaceuticals administered on an outpatient basis. This will be required for all UnitedHealthcare commercial members.

The following products require authorization:

- Lutetium Lu 177 (Lutathera)
- Radium RA-233 dichloride (Xofigo)
- All therapeutic radiopharmaceuticals that have not yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS).

HCPCS codes impacted by this prior authorization include:

- A9606 Radium RA-223 dichloride, therapeutic, per microcurie
- A9699 Radiopharmaceutical, therapeutic, not otherwise classified
- Lutetium Lu 177, dotatate, therapeutic, 1 mCi

UnitedHealthcare Commercial

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

For complete details on the policy updates listed in the following table, please refer to the **September 2018 Medical Policy Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > Commercial Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletins**.

Policy Title	Policy Type	Effective Date
NEW		
Onpattro™ (Patisiran)	Drug	Sept. 1, 2018
UPDATED/REVISED		
Bariatric Surgery	Medical	Nov. 1, 2018
Botulinum Toxins A and B	Drug	Sept. 1, 2018
Botulinum Toxins A and B	Drug	Oct. 1, 2018
Breast Reduction Surgery	CDG	Sept. 1, 2018
Chromosome Microarray Testing (Non-Oncology Conditions)	Medical	Oct. 1, 2018
Computed Tomographic Colonography	Medical	Sept. 1, 2018
Core Decompression for Avascular Necrosis	Medical	Oct. 1, 2018
Crysvita® (Burosumab-Twza)	Drug	Sept. 1, 2018
Emergency Health Care Services and Urgent Care Center Services	CDG	Sept. 1, 2018
Exondys 51™ (Eteplirsen)	Drug	Oct. 1, 2018
Functional Endoscopic Sinus Surgery (FESS)	Medical	Sept. 1, 2018
Habilitative Services for Essential Health Groups	CDG	Oct. 1, 2018
Hepatitis Screening	Medical	Oct. 1, 2018
High Frequency Chest Wall Compression Devices	Medical	Oct. 1, 2018
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Drug	Sept. 1, 2018

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UnitedHealthcare Commercial

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

Policy Title	Policy Type	Effective Date
Lithotripsy for Salivary Stones	Medical	Sept. 1, 2018
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	Medical	Sept. 1, 2018
Neurophysiologic Testing and Monitoring	Medical	Sept. 1, 2018
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Drug	Sept. 1, 2018
Osteochondral Grafting	Medical	Sept. 1, 2018
Panniculectomy and Body Contouring Procedures	CDG	Sept. 1, 2018
Percutaneous Vertebroplasty and Kyphoplasty	Medical	Sept. 1, 2018
Plagiocephaly and Craniosynostosis Treatment	Medical	Oct. 1, 2018
Preventive Care Services	CDG	Oct. 1, 2018
Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®)	Drug	Sept. 1, 2018
Sensory Integration Therapy and Auditory Integration Training	Medical	Sept. 1, 2018
Somatostatin Analogs	Drug	Sept. 1, 2018
Specialty Medication Administration – Site of Care Review Guidelines	URG	Oct. 1, 2018
Vagus Nerve Stimulation	Medical	Sept. 1, 2018
Virtual Upper Gastrointestinal Endoscopy	Medical	Oct. 1, 2018
White Blood Cell Colony Stimulating Factors	Drug	Sept. 1, 2018
Xolair® (Omalizumab)	Drug	Sept. 1, 2018

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 Reimbursement Policies

Learn about policy changes and updates.

UnitedHealthcare Community Plan Reimbursement Policy:

Reimbursement policies that apply to UnitedHealthcare Community Plan members are located here: UHCprovider.com > Menu > **Health Plans by State > [Select State]** > "View Offered Plan Information" under the Medicaid (Community Plan) section > Bulletins and Newsletters. We encourage you to regularly visit this site to view reimbursement policy updates.

UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

UnitedHealthcare Community Plan Significantly Expanding Dual Special Needs Program – UnitedHealthcare Dual Complete®

On Jan. 1, 2019, UnitedHealthcare will begin serving eligible members in a Dual Special Needs Plan (DSNP) – UnitedHealthcare Dual Complete®, a Medicare Advantage plan – in almost 250 new counties across the United States. This expansion includes two states new to the Dual Complete offering – Maryland and Kentucky – new to the Dual Complete offering and 16 states that will be expanding coverage by entering new service areas. ›

UnitedHealthcare Community Plan Outpatient Injectable Cancer Therapy Authorization Program for UnitedHealthcare Community Plan — Process Change

Effective Nov. 1, 2018, Optum, an affiliate company of UnitedHealthcare, will begin managing our prior authorization requests for outpatient injectable chemotherapy, and related cancer therapies listed below. Previously, eviCore managed these prior authorization requests. This change applies to UnitedHealthcare Community Plan members with a cancer diagnosis in Arizona, Florida, Maryland, Michigan, Mississippi, Ohio, Tennessee, Washington and Wisconsin. Any active prior authorizations requested via the former process will remain in place. Prior authorization will be required for injectable chemotherapy and cancer therapy starting Nov. 1, 2018, for UnitedHealthcare Community Plan members in Nebraska and Rhode Island. ›

UnitedHealthcare Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement

Effective Jan. 1, 2019, UnitedHealthcare will require prior authorization/notification for genetic and molecular testing performed in an outpatient setting for UnitedHealthcare Community Plan members in Maryland, Michigan, Missouri, New Jersey, New York, Rhode Island and Tennessee. ›

UnitedHealthcare Community Plan 4th Quarter 2018 Preferred Drug List

UnitedHealthcare Community Plan's Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Not all medications will be added, modified or deleted in each state, so please check the state's PDL for a state-specific list of preferred drugs. ›

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

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Significantly Expanding Dual Special Needs Program – UnitedHealthcare Dual Complete®

On Jan. 1, 2019, UnitedHealthcare will begin serving eligible members in a Dual Special Needs Plan (DSNP) – UnitedHealthcare Dual Complete,® a Medicare Advantage plan – in almost 250 new counties across the United States. This expansion includes two states new to the Dual Complete offering — Maryland and Kentucky — new to the Dual Complete offering and 16 states that will be expanding coverage by entering new service areas. This is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid. DSNPs are a specialized type of Medicare Advantage Prescription Drug Plan (MAPD) and must follow existing Centers for Medicare & Medicaid Services (CMS) rules.

Here's a list of these states and counties launching the plan on Jan. 1, 2019:

New State: Kentucky – Boone, Bullitt, Campbell, Fayette, Franklin, Hardin, Jefferson, Jessamine, Kenton, Larue, Madison, Marion, Nelson, Oldham, Shelby, Spencer and Woodford

New State: Maryland – Montgomery

Colorado – Larimer

Delaware – Kent and Sussex

Iowa – Appanoose, Benton, Black Hawk, Boone, Bremer, Buchanan, Butler, Carroll, Cedar, Chickasaw, Clarke, Clayton, Clinton, Davis, Delaware, Des Moines, Fayette, Floyd, Greene, Grundy, Guthrie, Hamilton, Hardin, Henry, Iowa, Jackson, Jefferson, Johnson, Jones, Keokuk, Linn, Louisa, Lucas, Mahaska, Marion, Mills, Monroe, Muscatine, Pottawattamie, Poweshiek, Scott, Tama, Van Buren, Wapello, Washington, Wayne and Webster

Louisiana – Acadia, Assumption, Bienville, Bossier, Caddo, Claiborne, De Soto, Evangeline, Iberia, Lafayette, Ouachita, Pointe Coupee, Rapides, Red River, St. Landry, St. Mary, Vermilion, Webster and West Feliciana

Michigan – Allegan, Barry, Bay, Calhoun, Kalamazoo, Kent, Mecosta, Montcalm, Newaygo, Ottawa, Saginaw, Sanilac, St. Joseph and Van Buren

Mississippi – George, Holmes, Lawrence, Marion, Quitman, Scott, Simpson, Smith, Stone and Yazoo

Missouri – Andrew, Audrain, Barry, Barton, Bates, Caldwell, Camden, Carroll, Clinton, Cooper, Howard, Iron, Madison, Maries, McDonald, Moniteau, Monroe, Montgomery, Pike, St. Clair and Vernon

Nebraska – Adams, Buffalo, Burt, Dodge, Gage, Hall, Madison, Otoe, Saline, Saunders, Seward and Washington

New Mexico – Chaves, Colfax, Curry, Quay and Torrance

New York – Allegany, Cattaraugus, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Genesee, Greene, Hamilton, Herkimer, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Putnam, Saratoga, Schenectady, Schoharie, Schuyler,

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UnitedHealthcare Community Plan

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UnitedHealthcare Community Plan Significantly Expanding Dual Special Needs Program – UnitedHealthcare Dual Complete

Seneca, Steuben, Sullivan, Warren, Washington, Wayne, Wyoming and Yates

Ohio – Knox, Richland, Ross, Scioto and Washington

Oklahoma – Adair, Cherokee, Craig, Creek, Delaware, Grady, Muskogee, Osage, Seminole, Sequoyah, Tulsa and Wagoner

Pennsylvania – Cumberland, Forest, Franklin, Huntingdon, Jefferson, Juniata, Monroe, Perry, Snyder, Susquehanna, Venango and Wyoming

Texas – Anderson, Bandera, Cherokee, Clay, Cooke, Delta, Ector, Falls, Fannin, Hill, Hopkins, Howard, Hunt, Matagorda, Medina, Midland, Montague, Rains, Red River, Starr, Tom Green, Wharton, Wise and Zavala

Washington – Benton, Walla Walla and Whatcom

Wisconsin - Clark, Door, Iron, Juneau and Lafayette

The UnitedHealthcare Dual Complete Program will reimburse claims according to your UnitedHealthcare contractual Medicare Advantage payment appendix. Visit UHCprovider.com for additional information on the Dual Complete Plan.

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Outpatient Injectable Cancer Therapy Authorization Program for UnitedHealthcare Community Plan – Process Change

Effective Nov. 1, 2018, Optum, an affiliate company of UnitedHealthcare, will begin managing our prior authorization requests for outpatient injectable chemotherapy, and related cancer therapies listed below. Previously, eviCore managed these prior authorization requests.

- This change applies to UnitedHealthcare Community Plan members with a cancer diagnosis in Arizona, Florida, Maryland, Michigan, Mississippi, Ohio, Tennessee, Washington and Wisconsin. Any active prior authorizations requested via the former process will remain in place.
- Prior authorization will be required for injectable chemotherapy and cancer therapy starting Nov. 1, 2018, for UnitedHealthcare Community Plan members in Nebraska and Rhode Island. **Please note:** Prior Authorization will not be required for UnitedHealthcare Community plan members in Iowa.

To submit an online request for prior authorization via the new process, sign in to Link and access the Prior Authorization and Notification app. From the app, select the "Radiology, Cardiology + Oncology" box. After answering two short questions about the state you are working in, you will be directed to a new website we're using to process these authorization requests. Prior authorization/notification requests for UnitedHealthcare Commercial, Oxford, Medicare and other Community Plan members not listed above will continue to be requested though the existing eviCore process until future notice.

Prior authorization will continue to be required for:

- Chemotherapy and biologic therapy injectable drugs (J9000 – J9999), Leucovorin (J0640) and Levoleucovorin (J0641)
- Chemotherapy and biologic therapy injectable drugs that have a Q code
- Chemotherapy and biologic therapy injectable drugs that have not yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code
- Colony Stimulating Factors: J2505 (neulasta), J1442 (neupogen), J2820 Leukine® (sargramostim), Q5101 (Filgrastim– biosimilar Zarxio), J1447 Granix (tbo-filgrastim)
- Denosumab (Brand names Xgeva and Prolia): J0897

Prior authorization will be required when adding a new injectable chemotherapy drug or cancer therapy to an existing regimen.

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UnitedHealthcare Community Plan

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UnitedHealthcare Community Plan Outpatient Injectable Cancer Therapy Authorization Program for UnitedHealthcare Community Plan – Process Change

We'll offer training sessions and overviews of the Optum process beginning Oct. 19, 2018.

The training schedule will be available at UHCprovider.com > **Prior Authorization and Notification > Oncology > Prior Authorization for Chemotherapy, Colony Stimulating Factors and Denosumab**. You'll also find frequently asked questions, quick references guides and other resources at this site.

For UnitedHealthcare Community Plan in Nebraska and Rhode Island, if the member receives injectable chemotherapy drugs in an outpatient setting from Aug. 1, 2018 through Oct. 31, 2018, you DO NOT need to submit a prior authorization request until a new chemotherapy drug will be administered. We'll authorize the chemotherapy regimen the member was receiving prior to Nov. 1, 2018 and the authorization will be effective until Oct. 31, 2019 unless a change in treatment is needed.

UnitedHealthcare Community Plan

UnitedHealthcare Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement

Effective Jan. 1, 2019, UnitedHealthcare will require prior authorization/notification for genetic and molecular testing performed in an outpatient setting for UnitedHealthcare Community Plan members in Maryland, Michigan, Missouri, New Jersey, New York, Rhode Island and Tennessee.

Care providers will use the Genetic and Molecular Lab Test tool on Link to submit the notification/prior authorization request. You'll fill in the member's information and choose the test and the lab to perform the test. Ordering providers will need to submit requests for tests that require authorization. Labs may submit their own notification requests for tests that only require notification.

Beginning Jan. 1, 2019, an approved notification/prior authorization will be required for tests such as:

- Tier 1 Molecular Pathology Procedures
- Tier 2 Molecular Pathology Procedures
- Genomic Sequencing Procedures
- Multianalyte Assays with Algorithmic Analyses that include Molecular Pathology Testing
- These CPT® codes are:
  - 0001U
  - 0018U - 0019U
  - 0022U - 0023U
  - 0026U - 0034U
  - 0036U - 0037U
  - 0040U
  - 0045U - 0050U
  - 0055U - 0057U
  - 0060U
  - 0004M
  - 0006M - 0007M
  - 0009M
  - 0011M - 0013M
  - 81105 - 81111
  - 81120 - 81121
  - 81161 - 81420
  - 81425 - 81479
  - 81507
  - 81519 - 81521
  - 81545
  - 81595 - 81599
  - S3870

You'll get a decision right away when you submit your request online if your request meets UnitedHealthcare's clinical and coverage guidelines. If more information or clinical documentation is needed, we'll contact you.

You can find more information on the Genetic and Molecular Lab Test tool on Link at **UHCprovider.com/genetics**. Determinations for notification/prior authorization requests will be made based on UnitedHealthcare's clinical policy requirements for coverage. Our clinical policies are at **UHCprovider.com/policies**.

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan 4th Quarter 2018 Preferred Drug List

UnitedHealthcare Community Plan's Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Please review the changes and update your references as necessary.

Not all medications will be added, modified or deleted in each state, so please check the state's PDL for a state-specific list of preferred drugs. You may also view the changes at UHCprovider.com > Menu > **Health Plans by State [select your state]**.

We provided a list of available alternatives to UnitedHealthcare Community Plan members whose current treatment includes a medication removed from the PDL. Please provide affected members a prescription for a preferred alternative in one of the following ways:

- Call or fax the pharmacy.
- Use e-Script.
- Write a new prescription and give it directly to the member.

If a preferred alternative is not appropriate, call **800-310-6826** for prior authorization for the UnitedHealthcare Community Plan member to remain on their current medication.

Changes will be effective Oct. 1, 2018 for: Arizona, California, Florida, Hawaii, Kansas, Maryland, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Texas and Virginia. Changes will be effective Dec. 1, 2018 for Louisiana, Nebraska and Washington.

These changes don't apply to UnitedHealthcare Community Plans in Iowa.

PDL Additions

Brand Name	Generic Name	Comments
Biktarvy©	Bictegravir-emtricitabine-tenofovir alafenamide tablet	Indicated for the treatment of HIV-1 infection. Prior authorization required.
Cimduo™	Lamivudine-tenofovir disoproxil tablet	Indicated for the treatment of HIV-1 infection. Diagnosis required.
Evotaz™	Atazanavir-cobicistat tablet	Indicated for the treatment of HIV-1 infection. Diagnosis required.
Symdeko™	Tezacaftor-ivacaftor tablet	Indicated for the treatment of cystic fibrosis. Prior authorization required. Available through specialty pharmacy.
Symfi/Symfi Lo™	Efavirenz-lamivudine-tenofovir disoproxil tablet	Indicated for the treatment of HIV-1 infection. Diagnosis required.

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UnitedHealthcare Community Plan

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UnitedHealthcare Community Plan 4th Quarter 2018 Preferred Drug List

PDL Additions (continued)

Brand Name	Generic Name	Comments
Strattera*™	Atomoxetine capsule	Indicated for the treatment of attention-deficit hyperactivity disorder (ADHD). Diagnosis required.
Trulance™	Plecanatide tablet	Indicated for the treatment of chronic idiopathic constipation and irritable bowel syndrome with constipation (IBS-C). Diagnosis required.

*Only generics are preferred.

PDL Modifications

Brand Name	Generic Name	Comments
Chantix™	Varenicline tartrate tablet and starter pack	Indicated for the treatment of smoking cessation. Starting Oct. 1, 2018, prior authorization will be required. Current users will be grandfathered.

Removed from PDL

Brand Name	Generic Name	Comments
Atripla™	Efavirenz-emtricitabine-tenofovir disoproxil tablet	Alternative agents are available including Symfi, Symfi Lo, Triumeq, Cimduo plus Isentress/Isentress HD or Tivicay. Current users will be grandfathered.
Non-BD Insulin Syringes and Pen Needles	Non-BD Insulin Syringes and Pen Needles	BD insulin syringes and pen needles will remain preferred. All other manufacturer's insulin syringes and pen needles will be non-preferred. Current utilizers will not be grandfathered.
Xarelto®	Rivaroxaban tablet and starter pack	Alternative agents are available including Eliquis® and Savaysa™. Current users will be grandfathered.

PDL Update Training on UHC On Air

Be sure to go to UHC On Air to check out an on-demand video highlighting this quarter's more impactful PDL changes:

- UnitedHealthcare Link users can access UHC On Air by selecting the UHC On Air tile on their Link dashboard. From there, go to your state, and click on UnitedHealthcare Community Plan. You'll find the Preferred Drug List Q3 Update in the video listings.
- To access Link, sign in to **UHCprovider.com** by clicking the Link button in the top right corner. If you don't have access to Link, select the New User button.

If you have any questions, please call UnitedHealthcare Community Plan's Pharmacy Department at **800-310-6826**.

UnitedHealthcare Community Plan

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

For complete details on the policy updates listed in the following table, please refer to the **September 2018 Medical Policy Update Bulletin** at **UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletins**.

Policy Title	Policy Type	Effective Date
NEW		
Onpattro™ (Patisiran)	Drug	Sept. 1, 2018
UPDATED/REVISED		
Bariatric Surgery	Medical	Nov. 1, 2018
Botulinum Toxins A and B	Drug	Sept. 1, 2018
Botulinum Toxins A and B	Drug	Oct. 1, 2018
Breast Reduction Surgery	CDG	Sept. 1, 2018
Chromosome Microarray Testing (Non-Oncology Conditions)	Medical	Oct. 1, 2018
Computed Tomographic Colonography	Medical	Sept. 1, 2018
Core Decompression for Avascular Necrosis	Medical	Nov. 1, 2018
Crysvita® (Burosumab-Twza)	Drug	Sept. 1, 2018
Emergency Health Care Services and Urgent Care Center Services (Maryland Only)	CDG	Sept. 1, 2018
Erythropoiesis-Stimulating Agents	Drug	Sept. 1, 2018
Exondys 51™ (Eteplirsen)	Drug	Oct. 1, 2018
Exondys 51™ (Eteplirsen) (for Pennsylvania Only)	Drug	Oct. 1, 2018
Functional Endoscopic Sinus Surgery (FESS)	Medical	Sept. 1, 2018
Hepatitis Screening	Medical	Oct. 1, 2018
High Frequency Chest Wall Compression Devices	Medical	Nov. 1, 2018

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UnitedHealthcare Community Plan

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

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Hospice Care (for Florida, Louisiana, Mississippi and Tennessee)	CDG	Nov. 1, 2018
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Drug	Sept. 1, 2018
Lithotripsy for Salivary Stones	Medical	Sept. 1, 2018
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	Medical	Sept. 1, 2018
Neurophysiologic Testing and Monitoring	Medical	Sept. 1, 2018
Ocrevus™ (Ocrelizumab)	Drug	Sept. 1, 2018
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Drug	Sept. 1, 2018
Osteochondral Grafting	Medical	Sept. 1, 2018
Panniculectomy and Body Contouring Procedures	CDG	Nov. 1, 2018
Plagiocephaly and Craniosynostosis Treatment	Medical	Nov. 1, 2018
Repository Corticotropin Injection (H.P. Acthar Gel®) (for Pennsylvania Only)	Drug	Sept. 1, 2018
Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®)	Drug	Sept. 1, 2018
Sensory Integration Therapy and Auditory Integration Training	Medical	Sept. 1, 2018
Somatostatin Analogs	Drug	Sept. 1, 2018
Vagus Nerve Stimulation	Medical	Sept. 1, 2018
Virtual Upper Gastrointestinal Endoscopy	Medical	Nov. 1, 2018
White Blood Cell Colony Stimulating Factors	Drug	Sept. 1, 2018
Xolair® (Omalizumab)	Drug	Sept. 1, 2018

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

Learn about Medicare Advantage policy, reimbursement and guideline changes.

New Preclusion List Policy

The Centers for Medicare & Medicaid Services (CMS) is developing a Preclusion List effective for claims with dates of service on or after Jan. 1, 2019. The list will apply to both UnitedHealthcare Medicare Advantage plans and Part D plans. ›

MACRA Amendment about CMS Quality Payment Program

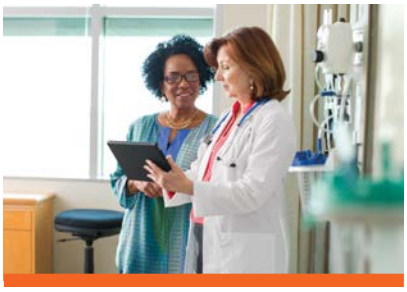
For care providers subject to the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act (MACRA) and who participate in UnitedHealthcare's network for Medicare Advantage plans, UnitedHealthcare is amending the Participation Agreement due to recent statutory and regulatory changes. With the passage of MACRA, the Centers for Medicare & Medicaid Services (CMS) implemented the Quality Payment Program, which changes the way CMS pays clinicians for additional compensation programs under Original Medicare. ›

Step Therapy Prior Authorization Requirements for Medicare Advantage Plans – Effective Jan. 1, 2019

For dates of service on or after Jan. 1, 2019, we'll require step therapy prior authorization for some Part B medications and other Part B covered items that are non-preferred products. ›

UnitedHealthcare Medicare Advantage Policy Guideline Updates ›

UnitedHealthcare Medicare Advantage Coverage Summary Updates ›



Prior Authorization for Post-Acute Inpatient Care Required for Medicare Advantage Benefit Plans

Effective Jan. 1, 2019, UnitedHealthcare Medicare Advantage Benefit Plans including UnitedHealthcare Dual Complete, UnitedHealthcare Community Plan Massachusetts Senior Care Options, UnitedHealthcare Connected- TX (Medicare-Medicaid Plan) and UnitedHealthcare Connected for MyCareOhio (Medicare-Medicaid Plan) will require prior authorization for post-acute inpatient services. ›

UnitedHealthcare Medicare Advantage

New Preclusion List Policy

The Centers for Medicare & Medicaid Services (CMS) is developing a Preclusion List effective for claims with dates of service on or after Jan. 1, 2019. The list will apply to both UnitedHealthcare Medicare Advantage plans and Part D plans.

The Preclusion will be comprised of a list of prescribers and individuals or entities in the following categories:

- Currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

Care providers will receive notification from CMS of their placement on the Preclusion List by letter and will have the opportunity to appeal with CMS before the preclusion is effective. There will be no opportunity to appeal with UnitedHealthcare. Once the preclusion date is effective, claims will no longer be paid, pharmacy claims will be rejected and the care provider will be terminated from the UnitedHealthcare network if they are contracted until such time they are removed from the preclusion status.

As contracted care providers of UnitedHealthcare, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information, go to **cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html**.

UnitedHealthcare Medicare Advantage

MACRA Amendment about CMS Quality Payment Program

For care providers subject to the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act (MACRA) and who participate in UnitedHealthcare's network for Medicare Advantage plans, UnitedHealthcare is amending the Participation Agreement due to recent statutory and regulatory changes. With the passage of MACRA, the Centers for Medicare & Medicaid Services (CMS) implemented the Quality Payment Program, which changes the way CMS pays clinicians for additional compensation programs under Original Medicare.

This MACRA change does not impact how Medicare Advantage plans are paid by UnitedHealthcare.

The Quality Payment Program's Merit Based Incentive Payments System and the eligible Advanced Alternative Payment Models are replacing multiple CMS existing quality programs. These additional compensation programs that the Quality Payment Program is replacing haven't been part of UnitedHealthcare's payments to care providers in our Medicare Advantage network. Because the Quality Payment Program regulations change how CMS pays its additional compensation programs, an amendment to our Participation Agreement is necessary to clarify that UnitedHealthcare's payment to care providers in its Medicare Advantage network will continue to exclude these CMS additional compensation program adjustments, both positive and negative.

UnitedHealthcare will continue to offer opportunities for eligible care providers to participate in our value-based programs. Through these programs, we collaborate more closely with care providers to offer technology, timely patient data and financial rewards as resources to help in the care of patients.

If you have questions or would like more information about our value-based programs, call Provider Services at **877-842-3210**.

UnitedHealthcare Medicare Advantage

Step Therapy Prior Authorization Requirements for Medicare Advantage Plans – Effective Jan. 1, 2019

For dates of service on or after Jan. 1, 2019, we'll require step therapy prior authorization for the following Part B medications and other Part B covered items that are non-preferred products:

Step Therapy Category	Preferred	Drug/Medical Device Name	HCPCS Code
Hyaluronic Acid Polymers *(FDA approved as medical devices)*	**yes**	***Gelsyn**	J7328
	yes	***Durolane**	J3490/C9465
	yes	***Synvisc or Synvisc-One**	J7325
	no	Genvisc 850	J7320
	no	Hyalgan, Supartz, Supartz FX, Visco-3	J7321
	no	Hymovis	J7322
	no	Euflexxa	J7323
	no	Orthovisc	J7324
	no	Gel-One	J7326
	no	Monovisc	J7327
	no	Trivisc	J3490
Immunomodulators	**yes**	***Inflectra (Infliximab-DYYB)**	Q5103
	yes	***Renflexis (Infliximab-ABDA)**	Q5104
	no	Remicade (Infliximab)	J1745
Erythropoiesis-Stimulating Agents	**yes**	***Retacrit (Epoetin Alfa - EPBX)**	Q5106
Note: Epogen (Epoetin Alfa) and Mircera (Methoxy PEG-Epoetin Beta) are not subject to step therapy requirement	**no**	Procrit (Epoetin Alfa)	J0885
	no	Aranesp (Darbepoetin Alfa)	J0881

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UnitedHealthcare Medicare Advantage

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Step Therapy Prior Authorization Requirements for Medicare Advantage Plans – Effective Jan. 1, 2019

Step therapy prior authorization requirements do not apply for members who are currently and actively receiving medications/medical devices (members with a paid claim within the past 120 days) on the list.

Step therapy prior authorizations apply to UnitedHealthcare Medicare Advantage plans, including UnitedHealthcare Dual Complete plans and Medica HealthCare and Preferred Care Partners plans of Florida. Plans excluded from Step therapy prior authorizations include Medicare Advantage plans offered in Arizona, California, Colorado, Hawaii, Nevada and Washington; employer group Medicare Advantage plans nationwide; Erickson Advantage plans; UnitedHealthcare Connected plans; UnitedHealthcare Dual Complete plans in New Jersey and Tennessee; and UnitedHealthcare Senior Care Options in Massachusetts.

When members receive a lower cost preferred drug, the savings to the plan will be shared with the member as part of their participation in the care coordination program. Members will receive information about the shared savings program after their 2019 plan effective date. (Medical devices like Hyaluronic Acid Polymers are excluded from the shared savings program).

How the Step Therapy Prior Authorization Process Will Work for UnitedHealthcare Medicare Advantage Plans

The process of requesting authorization for coverage of a Part B medication covered by this policy is called a coverage determination. A coverage determination conducted as part of our prior authorization process will evaluate whether the drug is appropriate for the individual member, taking into account several factors, to include:

- Terms of the member's benefit plan
- Trial and failure of preferred products
- Applicable Medicare guidance
- The member's treatment history
- Dosage recommendation from the FDA-approved labeling

Additional criteria may be considered. We encourage you to submit any information you would like us to review as part of your step therapy prior authorization request. We will inform you and our member once a decision on the coverage determination request has been made. This will take no more than 14 days (72 hours for expedited requests). This notification will include appeal rights if the coverage decision is unfavorable.

How to Submit a Step Therapy Prior Authorization Requests

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.

UnitedHealthcare Medicare Advantage

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**.

Policy Title
UPDATED/REVISED (Approved on Aug. 8, 2018)
Anterior Segment Aqueous Drainage Device
Artificial Hearts and Related Devices (NCD 20.9)
Blood Platelet Transfusions (NCD 110.8)
Blood Transfusions (NCD 110.7)
Corneal Topography
Coverage of Drugs and Biologicals for Label and Off-Label Uses
Durable Medical Equipment Reference List (NCD 280.1)
Electrical Nerve Stimulators (NCD 160.7)
Electrosleep Therapy (NCD 30.4)
Excision of Rectal Tumor
Extracorporeal Immunoadsorption (ECI) Using Protein A Columns (NCD 20.5)
Heart Transplants (NCD 260.9)
High Dose Rate Electronic Brachytherapy
Institutional and Home Care Patient Education Programs (NCD 170.1)
Intensive Behavioral Therapy for Cardiovascular Disease (NCD 210.11)
Intrapulmonary Percussive Ventilator (IPV) (NCD 240.5)
Leadless Pacemakers (NCD 20.8.4)
Lung Volume Reduction Surgery (Reduction Pneumoplasty) (NCD 240.1)

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UnitedHealthcare Medicare Advantage

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UnitedHealthcare Medicare Advantage Policy Guideline Updates

Policy Title
UPDATED/REVISED (Approved on Aug. 8, 2018)
Neuromuscular Electrical Stimulation (NMES) (NCD 160.12)
Osteopathic Manipulations (OMT)
Pediatric Liver Transplantation (NCD 260.2)
Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (NCD 150.13)
Phaco-Emulsification Procedure – Cataract Extraction (NCD 80.10)
Scalp Hypothermia During Chemotherapy to Prevent Hair Loss (NCD 110.6)
Screening for Depression in Adults (NCD 210.9)
Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (NCD 160.13)
Thermogenic Therapy (NCD 30.2)
Thoracic Duct Drainage (TDD) in Renal Transplants (NCD 20.3)
Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (NCD 10.2)
Tumor Treatment Field Therapy
Vertebral Augmentation Procedure (VAP)/Percutaneous Vertebroplasty
Zoledronic Acid (Zometa® & Reclast®)

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

UnitedHealthcare Medicare Advantage Coverage Summary Updates

For complete details on the policy updates listed in the following table, please refer to the **September 2018 Medicare Advantage Coverage Summary Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries > Coverage Summary Update Bulletins**.

Policy Title
UPDATED/REVISED (Approved on Aug. 21, 2018)
Cochleostomy with Neurovascular Transplant for Meniere's Disease
Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ)
Educational Programs
Experimental Procedures and Items, Investigational Devices and Clinical Trials
Genetic Testing
Home Health Services and Home Health Visits
Hospital Services (Inpatient and Outpatient)
Impotence Treatment
Infertility Services
Medications/Drugs (Outpatient/Part B)
Observation Care (Outpatient Hospital)
Orthopedic Procedures, Devices and Products
Varicose Veins Treatment and Other Vein Embolization Procedures
Vision Services, Therapy and Rehabilitation

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

Prior Authorization for Post-Acute Inpatient Care Required for Medicare Advantage Benefit Plans

Effective Jan. 1, 2019, UnitedHealthcare Medicare Advantage Benefit Plans including UnitedHealthcare Dual Complete, UnitedHealthcare Community Plan Massachusetts Senior Care Options, UnitedHealthcare Connected- TX (Medicare-Medicaid Plan) and UnitedHealthcare Connected for MyCareOhio (Medicare-Medicaid Plan) will require prior authorization for post-acute inpatient services.

Changes to prior authorization requirements are part of UnitedHealthcare's ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. Using evidence-based medicine to guide coverage decisions supports quality patient care and reflects our shared commitment to the Triple Aim of better care, better health outcomes and lower costs.

What this means to you

Please know that facilities providing post-acute inpatient services will now need to request prior authorization for these services, and receive a determination rendered by Unitedhealthcare before a UnitedHealthcare Medicare Advantage member is admitted to a facility or a post-acute care bed within a facility. Payment to the service provider may be denied if this important step is not taken. Facilities that may provide post-acute inpatient services include:

- Acute inpatient rehabilitation (AIR) facilities
- Long-term acute care (LTAC) hospitals
- Skilled nursing facilities (SNF)
- Critical access hospitals
- Acute care hospitals

For your convenience, prior authorization for post-acute inpatient services can be initiated in the following ways:

- **Online:** Look for the Prior Authorization and Notification app on Link by going to **UHCprovider.com** and clicking on the Link button in the top right corner. Then, just select the Prior Authorization and Notification app tile on your Link dashboard. Or,
- **Phone:** If you are having trouble accessing the app, please call Provider Services at **877-842-3210**.

Admission notification requirements continue to apply as they have, and will not be changing as a result of this new prior authorization requirement. To that end, thank you for continuing to notify UnitedHealthcare of post-acute inpatient admissions in accordance with our protocols.

Once prior authorization is requested, our nurse and physician team will review clinical documentation to make clinical coverage determinations. To help facilitate this review, please include the following, when appropriate:

- A copy of the physician's orders
- Medication list
- Initial physical, occupational or speech therapy evaluation and any pertinent progress notes from the referring hospital or physician

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UnitedHealthcare Medicare Advantage

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Prior Authorization for Post-Acute Inpatient Care Required for Medicare Advantage Benefit Plans

- Proposed length of the member's stay or treatment plan
- Other medical information, such as lab results, diagnostics, wound care assessments or psychosocial assessments

Once your request is submitted, you'll receive a reference number to use to track status using the Link Prior Authorization and Notification (PAAN) app. This reference number is neither a coverage determination nor a guarantee of payment but just a number to help you easily track the status of your request.

If you have questions, please call Provider Services at **877-842-3210**.

UnitedHealthcare Affiliates

Learn about updates with our company partners.

Oxford Participating Surgeons Using Non-Participating Assistant Surgeons and Co-Surgeons

Beginning Jan. 1, 2019, UnitedHealthcare network physicians and other qualified health care professionals in Connecticut and New York will be required to use network care providers for assistant surgeon and co-surgeon services for UnitedHealthcare Oxford members unless a member has made an informed decision to use a non-participating care provider and you've followed the process to document that decision or we've granted an in-network exception. ›

Oxford Voice Portal Changes

Beginning Jan. 1, 2019, the Oxford Voice Portal options will be changing. Please refer to the Quick Reference Guide online at oxhp-provider.uhc.com/secure/materials/providers/Oxford_Voice_QRG.pdf ›

Oxford® Medical and Administrative Policy Updates ›

Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

Effective Oct. 1, 2018, for Oxford Health Plan members, participating hospitals in Connecticut, New Jersey and New York will be required to purchase certain multiple sclerosis and anti-inflammatory specialty medications from the specialty pharmacy, BriovaRx. BriovaRx will bill Oxford Health Plans directly for these medications. Hospitals will only need to bill Oxford Health Plans the appropriate code for administration of the medication and should not bill us for the medication itself. ›

Reminder for Your Patients in UnitedHealthcare Oxford Commercial Plans

In December 2017, we let care providers know that we would be taking steps to streamline the administrative experience for UnitedHealthcare Oxford commercial plans. These steps have begun and will continue over the next 24 to 36 months as employer groups renew health coverage for their employees. ›

Stay Organized with Safe and Paperless Payments from UnitedHealthcare Oxford

You can enroll in Optum's Electronic Payments and Statements (EPS) now to improve cash flow by eliminating five to seven days of mail time and check float, eliminate any bank fees for depositing paper checks or lockbox processing, access your organization's payment information on a secure, easy to use website, and post payments manually or take advantage of automated posting capabilities to streamline your administrative process. ›

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

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

UnitedHealthcare Affiliates

Oxford Participating Surgeons Using Non-Participating Assistant Surgeons and Co-Surgeons

Beginning Jan. 1, 2019, UnitedHealthcare network physicians and other qualified health care professionals in Connecticut and New York will be required to use network care providers for assistant surgeon and co-surgeon services for UnitedHealthcare Oxford members unless:

- A member has made an informed decision to use a non-participating care provider and you've followed the process to document that decision; or
- We've granted an in-network exception

Before arranging for assistant or co-surgeon services from a non-participating care provider, you must:

1. Discuss participating and non-participating care provider options with the member and provide them with a copy of UnitedHealthcare Oxford's Consent Form. As part of the discussion, you must explain:
    - If the member has out-of-network benefits, the assistant surgeon/co-surgeon claim will be paid according to those benefits and their out-of-network cost shares will be applied.
    - If the member doesn't have out-of-network benefits, they'll be responsible for the full cost of the assistant surgeon/co-surgeon services performed by the non-participating provider.
2. After the discussion, the member must complete Oxford's Consent Form, indicating their choice. You must follow the member's instruction. If there are no participating care providers available to perform the service, you must follow the in-network exception process.
3. Keep a standard or electronic copy of the Assistant Surgeon Services Consent Form in the member's medical record. We may request a copy of the completed form.

Additional details on the requirements, including care provider penalties for non-compliance and a downloadable copy of the consent form, will be available in the full policy.

If you already work with a participating assistant surgeons and co-surgeons, there will be no additional requirements after Jan. 1, 2019.

Oxford Voice Portal Changes

Beginning Jan. 1, 2019, the Oxford Voice Portal options will be changing. Please refer to the Quick Reference Guide online at **oxhp-provider.uhc.com/secure/materials/providers/Oxford_Voice_QRG.pdf**.

UnitedHealthcare Affiliates

Oxford® Medical and Administrative Policy Updates

For complete details on the policy updates listed in the following table, please refer to the **September 2018 Policy Update Bulletin** at **OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin**.

Policy Title	Policy Type	Effective Date
NEW		
Onpattro™ (Patisiran)	Clinical	Sept. 1, 2018
Specialty Pharmacy for Certain Specialty Medications Administered in an Outpatient Hospital Setting	Reimbursement	Oct. 1, 2018
UPDATED/REVISED		
Abnormal Uterine Bleeding and Uterine Fibroids	Clinical	Sept. 1, 2018
Abortions (Therapeutic and Elective)	Administrative	Oct. 1, 2018
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Clinical	Oct. 1, 2018
Add-On Policy	Reimbursement	Oct. 1, 2018
After Hours and Weekend Care	Reimbursement	Oct. 1, 2018
Ambulance	Reimbursement	Sept. 1, 2018
Autism	Administrative	Oct. 1, 2018
Behavioral Health Services	Administrative	Oct. 1, 2018
Botulinum Toxins A and B	Clinical	Oct. 1, 2018
Care Plan Oversight	Reimbursement	Oct. 1, 2018
Carrier Testing for Genetic Diseases	Clinical	Oct. 1, 2018
Chemosensitivity and Chemoresistance Assays in Cancer	Clinical	Sept. 1, 2018
Chromosome Microarray Testing (Non-Oncology Conditions)	Clinical	Oct. 1, 2018
Co-Surgeon/Team Surgeon	Reimbursement	Oct. 1, 2018
Co-Surgeon/Team Surgeon (CES)	Reimbursement	Oct. 1, 2018
Crysvita® (Burosumab-Twza)	Clinical	Oct. 1, 2018
Discogenic Pain Treatment	Clinical	Oct. 1, 2018
Drug Coverage Criteria – New and Therapeutic Equivalent Medications	Clinical	Oct. 1, 2018

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UnitedHealthcare Affiliates

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Oxford® Medical and Administrative Policy Updates

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Drug Coverage Guidelines	Clinical	Oct. 1, 2018
Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency (CES)	Reimbursement	Oct. 1, 2018
Electrical Bioimpedance for Cardiac Output Measurement	Clinical	Sept. 1, 2018
Entyvio® (Vedolizumab)	Clinical	Oct. 1, 2018
Exondys 51™ (Eteplirsen)	Clinical	Oct. 1, 2018
Follow-Up Care Rendered in an Emergency Room Site of Service	Administrative	Oct. 1, 2018
From – To Date Policy	Reimbursement	Oct. 1, 2018
Gender Dysphoria Treatment	Clinical	Sept. 1, 2018
Genetic Testing for Hereditary Cancer	Clinical	Oct. 1, 2018
Home Health Care	Clinical	Sept. 1, 2018
Infliximab (Remicade®, Inflectra™, Renflexis™)	Clinical	Oct. 1, 2018
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Clinical	Oct. 1, 2018
Lemtrada (Alemtuzumab)	Clinical	Oct. 1, 2018
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	Clinical	Oct. 1, 2018
New Patient Visit	Reimbursement	Oct. 1, 2018
Obstetrical Ultrasonography	Clinical	Oct. 1, 2018
Occipital Neuralgia and Headache Treatment	Clinical	Oct. 1, 2018
Ocrevus™ (Ocrelizumab)	Clinical	Oct. 1, 2018
Omnibus Codes	Clinical	Oct. 1, 2018
Orencia® (Abatacept) Injection for Intravenous Infusion	Clinical	Oct. 1, 2018
Orthopedic Services	Administrative	Oct. 1, 2018
Otoacoustic Emissions Testing	Clinical	Oct. 1, 2018
Pharmacogenetic Testing	Clinical	Oct. 1, 2018
Precertification Exemptions for Outpatient Services	Administrative	Oct. 1, 2018
Preventive Care Services	Clinical	Oct. 1, 2018
Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®)	Clinical	Oct. 1, 2018

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UnitedHealthcare Affiliates

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Oxford® Medical and Administrative Policy Updates

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Sandostatin LAR® Depot (Octreotide Acetate)	Clinical	Oct. 1, 2018
Services and Modifiers Not Reimbursable to Healthcare Professionals	Reimbursement	Sept. 1, 2018
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Clinical	Oct. 1, 2018
Skilled Care and Custodial Care Services	Administrative	Sept. 1, 2018
Skin and Soft Tissue Substitutes	Clinical	Oct. 1, 2018
Specialty Medication Administration – Site of Care Review Guidelines	Clinical	Oct. 1, 2018
Speech Therapy and Early Intervention Programs/Birth to Three	Administrative	Oct. 1, 2018
Stelara® (Ustekinumab)	Clinical	Oct. 1, 2018
Whole Exome and Whole Genome Sequencing	Clinical	Oct. 1, 2018
Xolair® (Omalizumab)	Clinical	Oct. 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that Oxford 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.

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.

UnitedHealthcare Affiliates

Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

Effective Oct. 1, 2018, for Oxford Health Plan members, participating hospitals in Connecticut, New Jersey and New York will be required to purchase certain multiple sclerosis and anti-inflammatory specialty medications from the specialty pharmacy, BriovaRx.

The multiple sclerosis and anti-inflammatory specialty medications impacted by this change are:

JCODE	Brand Name
J2323	Tysabri
J0202	Lemtrada
J2350	Ocrevus
J1745	Remicade
Q5103	Inflectra
Q5104	Renflexis
J3380	Entyvio
J3357/J3358	Stelara
J0129	Orencia
J3262	Actemra
J1602	Simponi Aria
J0717	Cimzia

This list of specialty medications is subject to change upon 90 days written notice. This protocol applies to the drugs listed above when dispensed in the outpatient hospital setting of participating hospitals for Oxford Health Plan Members. We anticipate that all hospitals will be able to procure the specialty medications to be administered in an outpatient hospital setting from BriovaRx. Oxford may issue a denial of payment for failure to follow the protocol. Hospitals may not bill members for these medications. A payment policy will prohibit payment to hospitals for these medications unless the hospital has contracted all their separately reimbursable drugs at 165 percent of CMS or less. This protocol does not apply when Medicare or another health benefit plan is the primary payer and Oxford Health Plans is the secondary payer.

UnitedHealthcare Affiliates

Reminder for Your Patients in UnitedHealthcare Oxford Commercial Plans

In December 2017, we let care providers know that we would be taking steps to streamline the administrative experience for UnitedHealthcare Oxford commercial plans. These steps have begun and will continue over the next 24 to 36 months as employer groups renew health coverage for their employees.

If you have patients whose employers are renewing their health coverage with a UnitedHealthcare Oxford commercial plan, you'll see some differences in their new member identification (ID) card that we want to remind you about:

- The member's ID number will be **11** digits
- The Group Number will change to be **numeric-only**.
- The website listed on the back of the card is **myuhc.com**.

The ERA Payer ID number will not change and will remain **06111**.

When your patients see you for care, ask your staff to:

- Check their eligibility each time they visit your office.
- Include their new member ID number on claims or requests for services that require authorization.
- Use the provider website listed on the back of the member's ID card for secure transactions.

For more information about these changes, use this **Quick Reference Guide** and share it with your staff. For more information, please call Provider Services at **800-666-1353**. When you call, provide your National Provider Identifier (NPI) number.

Stay Organized with Safe and Paperless Payments from UnitedHealthcare Oxford

You can enroll for direct deposit of your claim payments with Optum's Electronic Payments and Statements (EPS). On day one, an organization will:

- Save money. Each paper check/paper remit costs a practice *$6.41 vs. $2.32 to process the same payment/remit electronically. The savings will add up quickly.
- Improve cash flow by eliminating five to seven days of mail time and check float
- Eliminate any bank fees for depositing paper checks or lockbox processing
- Access your organization's payment information on a secure, easy to use website.
- Post payments as you currently do today — either manually or take advantage of automated posting capabilities to streamline your administrative process

Go to **UHCprovider.com/eps** for more information and to enroll. Please call the EPS Help Desk at **877-620-6194** with questions. Sign up today at **Optum.com/Enroll**.

*CAQH 2017 Efficiency Index caqh.org/sites/default/files/explorations/index/report/2017-caqh-index-report.pdf

UnitedHealthcare Affiliates

SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Updates

For complete details on the policy updates listed in the following table, please refer to the **September 2018 SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > UnitedHealthcare SignatureValue/ UnitedHealthcare Benefits Plan of California Benefit Interpretation Policies > Benefit Interpretation Policy Update Bulletins**.

Policy Title
UPDATED/REVISED (Effective Oct. 1, 2018)
Inpatient Hospital Services
Outpatient Hospital Services

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UnitedHealthcare Affiliates

SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates

For complete details on the policy updates listed in the following table, please refer to the **September 2018 SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > UnitedHealthcare SignatureValue/ UnitedHealthcare Benefits Plan of California Medical Management Guidelines > Medical Management Guideline Update Bulletins**.

Policy Title	Effective Date
UPDATED/REVISED	
Bariatric Surgery	Nov. 1, 2018
Chromosome Microarray Testing (Non-Oncology Conditions)	Oct. 1, 2018
Computed Tomographic Colonography	Sept. 1, 2018
Core Decompression for Avascular Necrosis	Oct. 1, 2018
Functional Endoscopic Sinus Surgery (FESS)	Sept. 1, 2018
Hepatitis Screening	Oct. 1, 2018
High Frequency Chest Wall Compression Devices	Oct. 1, 2018
Lithotripsy for Salivary Stones	Sept. 1, 2018
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	Sept. 1, 2018
Neurophysiologic Testing and Monitoring	Sept. 1, 2018
Otoacoustic Emissions Testing	Oct. 1, 2018
Osteochondral Grafting	Sept. 1, 2018
Panniculectomy and Body Contouring Procedures	Sept. 1, 2018
Plagiocephaly and Craniosynostosis Treatment	Oct. 1, 2018
Preventive Care Services	Oct. 1, 2018
Sensory Integration Therapy and Auditory Integration Training	Sept. 1, 2018
Specialty Medication Administration – Site of Care Review Guidelines	Oct. 1, 2018

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UnitedHealthcare Affiliates

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SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates

Policy Title	Effective Date
UPDATED/REVISED	
Vagus Nerve Stimulation	Sept. 1, 2018
Virtual Upper Gastrointestinal Endoscopy	Oct. 1, 2018

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.

Doc#: PCA-1-012199-09072018_09142018