

FEBRUARY 2020

network bulletin

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

Updated Feb. 7, 2020

Enter



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

Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.



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Stay up to date with the latest news and information.

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Enhance the Way You Prescribe Medicine

PreCheck MyScript® (PCMS) is an integrated tool that allows you to check patient prescription cost and coverage at the time of care.

How it Works

Simple Integration with Current Workflow

PCMS integrates with popular electronic medical record (EMR) systems and runs a trial claim which displays accurate and up-to-date member benefit and medication information.

Quickly Request Prior Authorizations

You'll receive an alert for medications needing prior authorization and can check if medications are non-covered or non-preferred. Some EMRs even facilitate submission of a prior authorization directly from the workflow.

- Providers may save up to 50 minutes and \$41 per prescription per patient by using PCMS to understand which medications require prior authorizations — allowing them to either select an alternate which does not require one or completing the necessary documentation within the tool.¹

Know How Much Your Patients May Pay Before They Leave Your Office

PCMS lists alternative medications and price options, so your patients, who are our members, are not surprised at the pharmacy counter. Care providers will know when the patient is still in the office how much their medication will cost, based on their preferred pharmacy and benefit plan coverage during the office visit.

- Members may save \$135 per prescription fill.¹

Real Savings, Real Results

Care providers using PreCheck MyScript may see patient costs savings, medication adherence for chronic conditions and even reduced administrative time spent on prior authorizations.

- Pharmacies have seen 14% lower administrative cost per claim.³
- Member medication adherence increased by up to 4% for three common chronic conditions.²

Find Out More



Visit UHCprovider.com/pcms for more information. There, you'll find an interactive demo of PCMS, a FAQ document, overview document, videos and more!

¹Third party analysis of OptumRx claims data. September 2018 – August 2019 based on 4.6 million members, >188,000 providers, and 29.2 million transactions using PreCheck MyScript.

²Third party analysis of OptumRx claims data. July 2017–November 2018 based on 2.6 million members, >110,000 providers, and 13.3 million transactions using PreCheck MyScript.

³OptumRx data. Measurement of PreCheck MyScript impacted scripts within the diabetes therapeutic class, the statin therapeutic class, and the hypertension therapeutic class. Savings represents a pre/post methodology. Pre period is October 2016 – September 2017 and post period October 2017 – September 2018. Population included in the measurement was continuously enrolled.

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Prior Authorization Submission Enhancements

The following enhancements have been made to the Prior Authorization and Notification (PAAN) tool on Link:

- Outpatient facility case requests are changing from a single date of service to an automatic 90-day service period. You no longer have to call to change the date as long as it falls within the 90-day service period.
- Enhanced functionality is now available to support adding attachments in the new prior authorization experience.
- For standard medical prior authorizations, we have enabled an integrated screen experience which addresses any pop-up blocker issue.

In 2020, we'll continue to add additional prior authorization service categories. In the coming months we will also unveil a new look and feel of the prior authorization user interface tool to help simplify the initial authorization submission entry point. Please access the Interactive Guide for PAAN Tool found at UHCprovider.com/paan for the latest service category launch dates, system functionality and training.

How to Get Started With PAAN

You can learn more about the PAAN tool at UHCprovider.com/paan.

To access the PAAN tool, you'll need an Optum ID. Go to UHCprovider.com/newuser to get started.



If you need help, please call the Connectivity Help Desk at **866-842-3278**, option 1, from 7 a.m. – 9 p.m. Central Time, Monday – Friday.

Changes to Advance Notification and Prior Authorization Requirements

You can view the upcoming Changes to Advance Notification and Prior Authorization Requirements bulletin to get the latest updates to our advance notification and prior authorization requirements. The bulletin is available at UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > [2020 Summary of Changes](#).

We make these changes as part of our ongoing responsibility to evaluate medical policies, clinical programs and health benefits compared to the latest scientific evidence and medical 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, improved health outcomes and lower costs.

To see current prior authorization requirements for all plans, please visit UHCprovider.com/priorauth > [Advance Notification and Plan Requirement Resources](#) > Select a Plan Type.

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Updates to Requirements for Specialty Medical Injectable Drugs

Care providers should review the following table to determine changes to our specialty medical injectable drug programs:

Specialty Medical Injectable Drugs Added to Review at Launch

Drug Name	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses
Reblozyl® (Luspatercept-aamt)			X	For the treatment of anemia in adult patients with beta-thalassemia who require regular blood transfusions. <i>Added to Review at Launch for Commercial and Community Plans in November 2019.</i>
Vyondys 53 (golodirsen)	X	X		For the treatment of Duchenne muscular dystrophy (DMD) that is amenable to exon 53 skipping.

To view the **UnitedHealthcare Commercial Plan** Review at Launch Medication List, go to UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans > Review at Launch for New to Market Medications > [Review at Launch Medication List](#).

To view the **UnitedHealthcare Community Plan** Review at Launch Drug List Plan, go to UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Review at Launch for New to Market Medications > [Review at Launch Medication List](#).

The **UnitedHealthcare Medicare Advantage** Review at Launch drugs are added as Review at Launch Part B Medications in the Medications/Drugs (Outpatient/Part B) Coverage Summary. To view the summary, go to UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans > [Medications/Drugs \(Outpatient/Part B\) – Medicare Advantage Coverage Summary](#) > Attachment A: Guideline 5 – Other Examples of Specific Drugs/Medications.

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Updates to Requirements for Specialty Medical Injectable Drugs

Updates to Step Therapy Prior Authorization Requirements for Medicare Advantage Plans – May 1, 2020

For dates of service on or after May 1, 2020, there will be two changes to the Medicare Part B Step Therapy Programs.

1. Colony Stimulating Factors will be a new step therapy prior authorization category. Colony Stimulating Factors Category will be added to the existing step therapy categories required for Part B medications and other Part B covered items that are non-preferred products. For Colony Stimulating Factors, the preferred drugs require Prior Authorization under the existing Cancer Supportive Care Program, and this will still be required after step therapy is implemented.
2. For the immunomodulator category, the non-preferred drug Avsola will be added to the existing step therapy drugs for that prior authorization category. Preferred drugs (marked with an * and bolded) do not require prior authorization.

Step Therapy Category	Preferred	Drug/Medical Device Name	HCPCS Code
Colony Stimulating Factors			
Short-Acting	Yes	Zarxio (filgrastim-sndz)	Q5101
	No	Neupogen (filgrastim)	J1442
	No	Nivestym (filgrastim-aafi)	Q5110
	No	Granix (tbo-filgrastim)	J1447
Long-Acting	Yes	Neulasta (pegfilgrastim)	J2505
	Yes	Udenyca (pegfilgrastim-cbqv)	Q5111
	No	Fulphila (pegfilgrastim-jmdb)	Q5108
	No	Ziextenzo (pegfilgrastim-bmez)	J3490/J3590/C9399
Immunomodulators			
	Yes	*Inflixtra (infliximab-dyyb)	Q5103
	Yes	*Renflexis (infliximab-abda)	Q5104
	No	Remicade (infliximab)	J1745
	No	Avsola (infliximab-axxq)	J3490/J3590/C9399

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Updates to Requirements for Specialty Medical Injectable Drugs

Step therapy prior authorization requirements do not apply for members who are currently and actively receiving non-preferred medications/medical devices on the list and with a paid claim for one of those non-preferred medications/medical devices on the list within the past 365 days.

Step therapy prior authorizations apply to UnitedHealthcare Medicare Advantage plans, including UnitedHealthcare Dual Complete plans, UnitedHealthcare Connected plans and Medica HealthCare and Preferred Care Partners plans of Florida.

Plans excluded from Colony Stimulating Factors Step Therapy and Immunomodulators Step Therapy prior authorizations include Medicare Advantage plans offered in Arizona, California, Colorado, Hawaii, Nevada and Washington; Peoples Health in Louisiana; PFFS, Erickson Advantage Plans and UnitedHealthcare Group Medicare Advantage plans.

To Submit a Prior Authorization/Step Therapy Request, follow the chart below:

Plan	Diagnosis Type	Who will Manage the Request	How to Submit a Request
UnitedHealthcare Medicare Advantage plans, including UnitedHealthcare Dual Complete plans	Cancer	Optum, an affiliate company of UnitedHealthcare	Go to UHCprovider.com and sign in to Link to access the Prior Authorization and Notification tool. <ul style="list-style-type: none"> • Select the “Radiology, Cardiology + Oncology” box. • After selecting Medicare as the product type, you will be directed to another website to process the authorization requests.
	Non-cancer	UnitedHealthcare	<ul style="list-style-type: none"> • Go to UHCprovider.com/priorauth OR • Call the Provider Services phone number on the back of the member’s health care identification card.
UnitedHealthcare Connected plans, and Medica HealthCare and Preferred Care Partners plans of Florida	Cancer or Non-cancer	UnitedHealthcare	<ul style="list-style-type: none"> • Go to UHCprovider.com/priorauth OR • Call the Provider Services phone number on the back of the member’s health care identification card.

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Updates to Requirements for Specialty Medical Injectable Drugs

The process of requesting authorization for coverage of a Part B medication covered by the UnitedHealthcare Medicare Advantage Medications/Drugs (Outpatient/Part B) – Medicare Advantage Coverage Summary is called an organization determination. An organization determination will evaluate whether the drug is appropriate for the individual member, taking into account several factors, including, but not limited to:

- 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 organization determination request has been made. This will take no more than 72 hours (24 hours for expedited requests). This notification will include appeal rights if the decision is unfavorable.



You may view the Medications/Drugs (Outpatient/Part B) – Medicare Advantage Coverage Summary for affected classes of drugs on [UHCprovider.com](#) > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans.

Pharmacy Update

You can review our pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial and UnitedHealth Oxford commercial plans. To view it, go to [UHCprovider.com/pharmacy](#).

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Medical Policy Updates

You can access a **Policy Update Bulletin** from the following list for complete details on the latest updates:

UnitedHealthcare Commercial & Affiliates

[UnitedHealthcare Commercial Medical Policy Update Bulletin: February 2020](#)

[Oxford Policy Update Bulletin: February 2020](#)

[UnitedHealthcare West Benefit Interpretation Policy Update Bulletin: February 2020](#)

[UnitedHealthcare West Medical Management Guideline Update Bulletin: February 2020](#)

UnitedHealthcare Community Plan

[Community Plan Medical Policy Update Bulletin: February 2020](#)

UnitedHealthcare Medicare Advantage

[Medicare Advantage Coverage Summary Update Bulletin: February 2020](#)

[Medicare Advantage Policy Guideline Update Bulletin: February 2020](#)

UnitedHealthcare Dental

[Dental Policy Update Bulletin: February 2020](#)



UnitedHealthcare Commercial

Learn about program revisions
and requirement updates.

[New Requirements for Percutaneous PFO Closure](#)

Effective May 1, 2020, we're introducing a required notification/prior authorization process for Percutaneous Patent Foramen Ovale (PFO) Closure for UnitedHealthcare commercial members. >

[Prior Authorization and Site of Service Reviews for Surgical Codes](#)

In the last several editions of the Network Bulletin, we've put out several notices regarding our newly expanded prior authorization requirements. >

[New Inhaled Nitric Oxide Medical Policy](#)

We have a new medical policy for UnitedHealthcare commercial plan members for the usage of Inhaled Nitric Oxide (iNO). >

[Levemir Exclusion Delayed](#)

Coverage is still available for your patients' Levemir prescriptions. >

[Hospital Reference Lab Protocol](#)

Starting with claims paid on May 1, 2020, hospitals acting as a Reference Laboratory must be contracted as a Reference Laboratory. >

[Reimbursement Policy Updates](#) >

[UnitedHealthcare Commercial](#)

New Requirements for Percutaneous PFO Closure

Effective **May 1, 2020**, we're introducing a required notification/prior authorization process for Percutaneous Patent Foramen Ovale (PFO) Closure for UnitedHealthcare commercial members. In Iowa, this change will be effective Aug. 1, 2020.

You'll need to complete the notification/prior authorization process when requesting a PFO Closure for new and existing UnitedHealthcare commercial members for the following CPT® procedure code:

- **93580:** Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant

If a notification/prior authorization isn't completed before performing the procedure, the claim will be denied. Members can't be billed for services denied due to lack of prior authorization.

Why We're Making this Change

We're making this change as part of an ongoing effort to improve health care quality and affordability for members while managing the appropriate use of certain services. Based on available clinical evidence, percutaneous PFO closure, for the prevention of recurrent ischemic stroke, will be covered for certain clinical indications.

How to Request Notification/Prior Authorization

You can complete the notification/prior authorization process:

- **Online:** Go to UHCprovider.com/paan. This preferred option gives you the option of attaching clinical information and may help give you and your patient the fastest results.
- **By Phone:** Call the Provider Services number on your patient's member health plan ID card.

After we receive your request and the required clinical records, we'll review the request and contact both the requesting care provider and member by mail and phone with our coverage decision within 15 calendar days from the date of submission or sooner based on regulations. If coverage is denied, details on how to appeal will be provided in the letter.

Additional Information



For more information about this notification/prior authorization requirement, please review these [frequently asked questions](#). If you have questions, please call Provider Services at the number on the back of the member's ID card.

[UnitedHealthcare Commercial](#)

Prior Authorization and Site of Service Reviews for Surgical Codes

In the last several editions of the Network Bulletin, we’ve put out notices regarding our newly expanded notification/prior authorization requirements around site of service medical necessity reviews for certain surgical procedures.

We want to make you aware of changes to code lists we’ve previously announced. We included the following table in the detailed article we ran in the [January Network Bulletin](#) to help provide you with a synopsis of the various expansions and their effective dates. Please note, we’ve removed all CPT® codes included in [Code Group 4](#) from the list of surgical codes that are subject to site of service medical necessity review.

Expanded Surgical Code Effective Dates					
These CPT codes will be subject to notification/prior authorization requirements for dates of services starting on or after the dates listed in the table. Note that the information in this table only pertains to UnitedHealthcare commercial plans.					
States	Original Codes	Expanded Codes			
		Code Group 1	Code Group 2	Code Group 3	Removed Code Group 4
Most States	Oct. 1 2015	Nov. 1, 2019	Jan. 1, 2020	Feb. 1, 2020	March 1, 2020
California, Connecticut, New Jersey, New York	Oct. 1 2015	Dec. 1, 2019	Feb. 1, 2020	March 1, 2020	March 1, 2020
Maryland, Rhode Island	Oct. 1 2015	Jan. 1, 2020	Jan. 1, 2020	Feb. 1, 2020	March 1, 2020
Colorado	Oct. 1 2015	Jan. 1, 2020	April 1, 2020	April 1, 2020	April 1, 2020
Georgia, *Iowa , Kansas, Maine, Nebraska, New Hampshire, North Carolina, South Carolina, Vermont	Oct. 1 2015	March 1, 2020	March 1, 2020	March 1, 2020	March 1, 2020
Currently Excluded States	*Iowa and **Utah	**Alaska, Kentucky, Massachusetts, Texas, Utah and Wisconsin			

* As of March 1, 2020, Iowa will be included in the Original Codes list.

** As of Nov. 1, 2019, Alaska, Kentucky, Massachusetts, Texas, Utah and Wisconsin are excluded from the Original Codes list until further notice.

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[UnitedHealthcare Commercial](#)

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Prior Authorization and Site of Service Reviews for Surgical Codes

Important Changes

- **UnitedHealthcare Oxford Site of Service Expansion *April 6, 2020 Effective Date – Change to Code List**
The Cardiology codes referenced in Code Group 4 have also been removed from the Oxford list of surgical codes that are subject to site of service medical necessity reviews.
 - You can find the clinical policy, including an updated list of the codes, in the [Oxford Policy Update Bulletin: February 2020](#)

Helpful Resource



As always, the best way to check whether a service requires prior authorization is to go online and search the Prior Authorization and Notification tool on Link. To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification tile on your Link dashboard. Learn more at UHCprovider.com/paan.

[UnitedHealthcare Commercial](#)

New Inhaled Nitric Oxide Medical Policy

As we continue to work toward the triple aim of better care, better health, and lower costs for our members, we have developed a new medical policy for UnitedHealthcare commercial plan members that outlines appropriate usage of Inhaled Nitric Oxide (iNO). This policy is replacing the Optum Clinical Performance Guideline Neonatal Resource Services Inhaled Nitric Oxide Clinical Guideline.

The new medical policy will be used for post-service reviews of iNO as of April 1, 2020. Until then, the Optum Clinical Guideline will continue to be used for reviews.



On April 1, 2020 you can find the policy at UHCprovider.com/policies > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans](#).

Until then, you can find the policy in the [UnitedHealthcare Commercial Medical Policy Update Bulletin: February 2020](#).

Levemir Exclusion Delayed

Previously, we announced we would be moving Levemir from Tier 3 coverage to exclusion starting on Jan. 1, 2020, where allowed by law. This exclusion has been delayed.

What You Need to Know

- The exclusion of Levemir has been delayed while the basal insulin category long-term strategy is being reevaluated.
- Commercial members may continue to receive coverage for Levemir under their benefit plan until further notice.
- Additional communication will be provided if and when timing for the exclusion of Levemir has been determined.

[UnitedHealthcare Commercial](#)

Updated Feb. 7, 2020

Hospital Reference Lab Protocol

For claims paid on or after May 1, 2020, hospitals acting as a Reference Laboratory or conducting diagnostic testing for non-patients cannot bill for such non-patient diagnostic laboratory tests under that hospital's Facility Participation Agreement. Hospitals wishing to participate in UnitedHealthcare's commercial network as a Reference Laboratory may apply with UnitedHealthcare to be credentialed and contracted as a Reference Laboratory.

Definitions

- **Reference Laboratory:** A laboratory that performs diagnostic testing on specimens it receives from other referring laboratories or care providers.
- **Non-patient:** Is a member that is neither an inpatient nor an outpatient of a hospital, but for whom a specimen is submitted for laboratory testing to a hospital.

What Hospitals Need to Do

To contract your hospital as a Reference Laboratory, please contact your network representative to begin the credentialing and contracting process.

Claims submitted for non-patient diagnostic laboratory tests, or claims where a hospital is acting as a Reference Laboratory, will be denied for failure to comply with this protocol in the event a hospital is billing under its Facility Participation Agreement.

Questions



If you have questions, please contact your network representative.

[UnitedHealthcare Commercial](#)

Reimbursement Policy Updates

We regularly make changes to policies as part of an ongoing effort to improve health care quality and affordability for members while managing the appropriate use of certain services. The following chart shows new policy changes and their effective dates:

Policy	Effective Date	Summary of Change
Intraoperative Neuromonitoring Policy, Professional	5/1/2020	<p>Effective with dates of service on or after May 1, 2020, the following changes will be made to the IONM Policy:</p> <ul style="list-style-type: none"> • The technical component (modifier TC) of study codes reported with IONM services (95940, 95941 and G0453) in a non-facility POS on the same DOS, will be denied. • The professional component (modifier 26) of study codes reported with IONM services (95940, 95941 and G0453) in a non-facility POS, on the same DOS, will be denied. • Study codes without a TC or 26 modifier, reported with IONM services (95940, 95941 and G0453) in any POS, on the same DOS, will be denied. • The following change was previously communicated with an effective date of Oct. 1, 2019. The technical component (modifier TC) of study codes reported with IONM services (95940, 95941 and G0453) in POS 24, on the same DOS, will be denied. • To view the applicable codes, please refer to the Intraoperative Neurophysiology section in the American Medical Association CPT manual, beginning with code 95940, and the HCPCS Level II manual, code G0453. • As a reminder, per UnitedHealthcare’s Replacement Codes policy, IONM code 95941 is not reimbursable.

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Reimbursement Policy Updates

Policy	Effective Date	Summary of Change
Outpatient Hospital CCI Editing Policy, Facility	5/1/2020	<ul style="list-style-type: none"> Effective with dates of service on or after May 1, 2020, UnitedHealthcare will align with the CMS National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits for outpatient claims submitted on the CMS UB04 claim form or its electronic equivalent. The purpose of this new policy is to provide coding guidance for outpatient hospitals billing HCPCS/CPT codes that should not be reported together. Claims submitted with Type of Bill 13X and where the facility is reimbursed at a percent of charge rate and/or by the fee schedule, including non-par providers, will be subject to the policy.
Reminder: Outpatient Hospital Maximum Frequency Per Day (MFD) Policy, Facility	2/1/2020	<ul style="list-style-type: none"> In alignment with the CMS National Correct Coding Initiative (NCCI) Facility Outpatient Hospital Services Medically Unlikely Edits (MUE), UnitedHealthcare will apply unit value maximums for outpatient hospital claims submitted with Type of Bill 13X. CMS MUE Zero values will not be applied; however, providers should continue to bill the appropriate number of units for a service. The reimbursement policy will contain the applicable code list that includes the max number of units allowed. This reimbursement policy will apply to claims billed on a UB04 claim form or its electronic equivalent.
Observation and Discharge Policy, Professional	2/1/2020	<ul style="list-style-type: none"> In alignment with the February 2019 CMS Observation Services Fact Sheet, UnitedHealthcare will be providing clarifying verbiage within the Observation and Discharge Reimbursement Policy. The verbiage provides more detail on the use of initial and subsequent observation codes. The intent of the policy is not changing. The February 2019 Observation Services Fact Sheet is found at the following website: CGSmedicare.com.

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



UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

[New Prescription Safety Edits](#)

Learn what new Concurrent Drug Utilization Review (cDUR) edits are rolling out to pharmacies across the country. >

[Site of Service Reviews for Surgical Procedures – Code List Change](#)

Important Changes to UnitedHealthcare Community Plan Notification/Prior Authorization Requirements and Site of Service Reviews for Certain Surgical Procedures – effective March 1, 2020. >

[Medical Policy Updates](#) >

[Reimbursement Policy Updates](#) >

[UnitedHealthcare Community Plan](#)

New Prescription Safety Edits

To help increase patient safety and prevent abuse and fraudulent activity, UnitedHealthcare Community Plan is continuing to implement Concurrent Drug Utilization Review (cDUR) safety edits.

How it works

1. At the point of sale, the pharmacist will be alerted of a drug-drug interaction, therapeutic duplication or high dose.
2. The pharmacist will then look at the member’s profile and contact the prescriber or member to determine if the member should receive both prescriptions.
3. If the pharmacist determines the prescription should be processed, they can override the alert by entering the appropriate reason codes.
4. Pharmacies will receive a fax explaining these safety edits and what action needs to be taken to override them.

Safety edits will be implemented on **Feb. 1, 2020**, in the pharmacy systems to review the member’s current medications for the following:

- **Therapeutic Duplication:** Identifies potential duplications to prevent members from taking more than one drug in the same drug class.
- **Therdose (High Dose):** Identifies potential instances where a member could be exceeding the Food and Drug Administration’s approved maximum dose.
- **Drug-Drug Interaction:** Identifies potential instances where a member could be utilizing two drugs with an identified drug-interaction flag in Medispan.

The following drug classes and cDUR edits will be added to the UnitedHealthcare Community Plan:

cDUR Edit	Drug Class	States in Scope
Drug-Drug Interaction	Varenicline + Bupropion	AZ, CA, FL, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, PA, RI, TX, VA, WA
Drug-Drug Interaction	Apomorphine + 5-HT3 antagonists	AZ, CA, FL, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, PA, RI, TX, VA, WA
Therdose	Atomoxetine	AZ, CA, FL, HI, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, PA, RI, TX, VA, WA (ages 18 and older)
Therdose	Clonidine IR Clonidine ER	AZ, CA, FL, HI, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, PA, RI, TX, VA, WA (ages 18 and older)
Therdose	Guanfacine IR Guanfacine ER	AZ, CA, FL, HI, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, PA, RI, TX, VA, WA (ages 18 and older)
Therapeutic Duplication	Statins	AZ, CA, FL, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, RI, TX, VA, WA
Therapeutic Duplication	Beta Blockers	AZ, CA, FL, HI, KS, MD, MI, MS, NE, NJ, NV, NY, NY EPP, OH, RI, TX, VA, WA

[UnitedHealthcare Community Plan](#)

Site of Service Reviews for Surgical Procedures — Code List Change

As part of our efforts towards achieving better health outcomes, improving patient experience and lowering the cost of care, in the October 2019 edition of the Network Bulletin, we announced that we'd be expanding our notification/prior authorization requirements and site of service medical necessity reviews to include certain surgical codes, effective Nov. 1, 2019 for Maryland, Rhode Island and Washington.

We also announced these updates effective for dates of service on or after Jan. 1, 2020 for Michigan, Missouri and Ohio. You can find the original announcement at [UHCprovider.com/news > Network Bulletin Archive > October 2019 Network Bulletin > Page 33](#).

In the December 2019 edition of the Network Bulletin, we announced the expansion of our notification/prior authorization requirements and site of service medical necessity reviews to include certain surgical codes effective for dates of service on or after March 1, 2020 in Arizona, Florida and New York. You can find the original announcement at [UHCprovider.com/news > Network Bulletin Archive > December 2019 Network Bulletin > Page 30](#).

We'd like to make you aware of some changes we've made to the original October and December announcements, effective **March 1, 2020**.

Please note the following updates to the original announcement:

We've **removed** a number of surgical codes from the code list. Notification/prior authorization will not be required for these surgical codes. You can find the list of surgical codes we removed [here](#). You can find the list of surgical codes that still require notification/prior authorization [here](#).

Medical Policy Updates

Access the [Community Plan Medical Policy Update Bulletin: February 2020](#) for complete details on the latest updates.

Reimbursement Policy Updates

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 Medicare Advantage

Learn about Medicare policy
and guideline changes.

[MA Benefit Plans Expanding in 2020](#)

This year our Medicare Advantage plans are expanding across 43 states, potentially boosting the impact you can have on patients near you. >

[Get Ready for the CAHPS/HOS Season](#)

Your patients may be participating in a survey initiative that may impact your care and interactions with them. >

[Enhancements to Procedure to Modifier Policy](#)

CT, FX and FY Modifiers will be included in plans consistent with Medicare & Medicaid Services (CMS) to enhance the Procedures to Modifier Policy. >

[Enhancement to Laboratory Services Policy](#)

Instead of individual claims, the requirement is now to submit the proper CPT/HCPC code for the entire laboratory panel. >

[Enhance Editing PC/TC Indicator 4 Codes](#)

Policy update for codes assigned to Professional/ Technical Component (PC/TC) status indicator 4 in the National Physician Fee Schedule (NPFS). >

[Post-Acute Prior Authorization Changes](#)

Facilities providing post-acute inpatient services are required to request prior authorization. >

[New ED Professional E/M Coding Policy](#)

We have a new ED Professional E/M coding policy – effective May 1, 2020. >

[UnitedHealthcare Medicare Advantage](#)

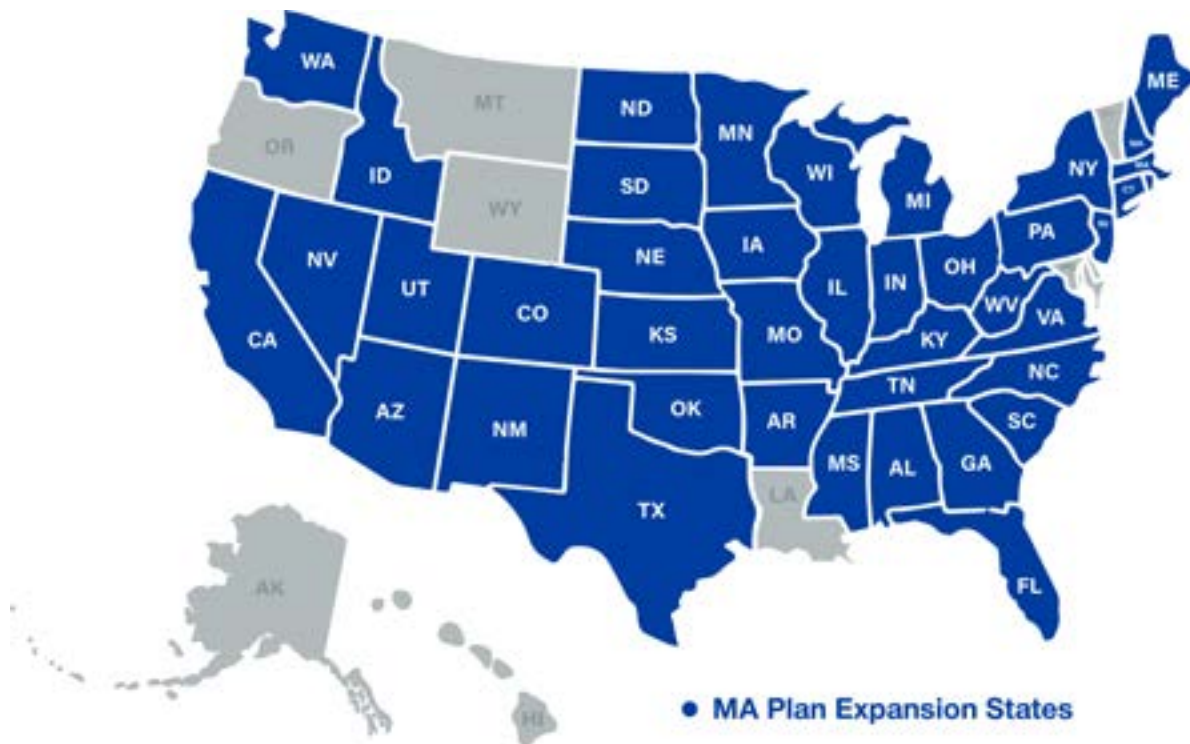
MA Benefit Plans Expanding in 2020

Beginning Jan. 1, 2020, we expanded our MA benefit plan offerings into more than 850 counties, across 43 states. Our plans are supported by the UnitedHealthcare Medicare Advantage provider network.

In addition to the benefit plan expansions, in 2020, many but not all UnitedHealthcare and AARP® branded PPO plans rolled out a new feature — access to a broader national network of contracted care providers. That means these PPO members will have nationwide access to care at in-network costs.

Visit [Link](#) to use the My Practice Profile tool to review the plans you are contacted to accept and explore the Provider Products section within the Provider Demographic. [Link > Provider Demographics > Details > Provider Products.](#)

To learn more about all the Medicare Advantage plans in your state, please visit UHCprovider.com > Health Plans by State > *Choose your state* > Medicare Advantage Health Plans.



The following states have Medicare Advantage plan expansions:

AL, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IL, IN, KS, KY, MA, ME, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV

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Get Ready for the CAHPS/HOS Season

The Medicare **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** program is an annual survey initiative to support and promote the assessment of patients' experiences with health care providers and access to health care services. The **Health Outcomes Survey (HOS)** is a survey to assess the ability of a Medicare Advantage (MA) organization to maintain or improve the physical and mental health of its members over time. The survey takes place March through July 2020.

Why is it Important?

Insights from the surveys are used to learn more about opportunities to better serve your patients and improve their health, quality of life and experience with you. It is also the opportunity for us, the health plan, to improve our interaction with our members.

Who participates?

A random sample of members is selected to participate to gather feedback about their experience with you and with us. Participation is voluntary.

Who administers the surveys?

Vendors certified by the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS).

How do you impact CAHPS/HOS?

Your interaction with patients plays a key role in impacting their experience and overall health. Improving your interactions with your patients enhances patient perception, access to care and overall experience.

[Click here](#) to see our article on best practices to help improve patient experiences in your offices.



If you have any questions or need further information, contact your Network Provider Advocate or Practice Performance manager.

[UnitedHealthcare Medicare Advantage](#)

Enhancements to Procedure to Modifier Policy

Consistent with the Centers for Medicare & Medicaid Services (CMS), we will enhance the Procedure to Modifier Policy for Medicare Advantage plans to include modifiers CT, FX and FY.

- Modifier CT:
 - CAT scans furnished on non-NEMA Standard XR-29-2013-compliant equipment
 - Payment reduction of 15% will be applied to the technical component (TC) payment portion
- Modifier FX:
 - Imaging services that are X-rays taken using film
 - Payment reduction of 20% will be applied to the TC payment portion
- Modifier FY:
 - Imaging services that involve cassette-based imaging which utilizes an imaging plate to create the image
 - Payment reduction of 7% will be applied to the TC payment portion

Effective for claims with dates of service on or after April 1, 2020; we will implement reductions to the TC payment (and the TC portion of the global fee) portion of radiological services when appended with the CT, FX or FY modifiers.



You can see more information online at [cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3820CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3820CP.pdf).

This announcement pertains to Medicare Advantage Plan reimbursement policies for services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.

Enhancement to Laboratory Services Policy

Effective April 1, 2020, you will be required to submit the appropriate CPT/HCPCS code for the AMCC panel test and not report separately the individual tests. We will deny CPT/HCPCS codes for separately billed tests where an AMCC panel test is appropriate.

This announcement pertains to reimbursement policies for services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.



These changes are to better align with the Centers for Medicare & Medicaid Services (CMS). You can see more information online at [cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4299CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4299CP.pdf).

[UnitedHealthcare Medicare Advantage](#)

Enhance Editing PC/TC Indicator 4 Codes

Effective for claims with a date of service on or after March 1, 2020, we will enhance the Professional/Technical Component (PC/TC) Policy for Medicare Advantage plans to deny procedure codes assigned a PC/TC status indicator 4 in the National Physician Fee Schedule (NPFSS) when reported with a facility place of service (POS) (19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 55, 56, 57 and 61).

According to Centers for Medicare & Medicaid Services (CMS), a code assigned a PC/TC indicator 4 identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only.

This announcement pertains to Medicare Advantage Plan reimbursement policies for services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.

[UnitedHealthcare Medicare Advantage](#)

Post-Acute Prior Authorization Changes

Facilities providing post-acute inpatient services are required to request prior authorization. Authorization must be received before members can be admitted to a post-acute bed in one of the following facility types:

- Acute inpatient rehabilitation
- Long-term acute care hospitals
- Skilled nursing facilities
- Critical access hospitals that provide post-acute services
- Acute care hospitals that provide post-acute services

Starting March 11, 2020, United Healthcare is making enhancements to the current prior authorization process in place today across select states. This enhancement will leverage both innovative technology and clinical expertise to assess the appropriate level of care.

What This Means for You

As part of this process, effective March 11, 2020, we will be enhancing the prior authorization questionnaire to ensure the appropriate level of care is approved for optimal post-acute recovery. If applicable, you should be prepared to provide the following documentation to support your prior authorization request.

- Initial Physical Therapy evaluation and last treatment note
- Initial Occupational Therapy evaluation and last treatment note
- Initial Speech Therapy evaluation and last treatment note
- Initial Respiratory Therapy evaluation and last treatment note (if vented include vent settings)
- Emergency Room note
- Last progress note from referring provider/attending
- Discharge plan from care manager (if available)
- Any orders for special needs at next level of care (i.e., wound care, IV therapy, ancillary medical treatments)
- Last History and Physical

Please complete the questionnaire thoroughly. Submitting all supporting clinical information electronically via the Prior Authorization and Notification (PAAN) will reduce turnaround time for a determination.

Additional communication and training on these changes are forthcoming.

What You Need to Know

The preferred method of submission will continue to be the PAAN tool on Link. Sign in to Link by going to UHCprovider.com and clicking on the Link button in the top right corner, or go to UHCprovider.com/paan. By submitting online, it may expedite the processing of the prior authorization request. If you're unable to use the Prior Authorization and Notification tool on Link, you can call **877-842-3210**. Requests for prior authorization will be reviewed for medical necessity. This change does not affect admission notification requirements.



If you have questions, please call your Network Provider Advocate or call Provider Services at **877-842-3210** and ask to speak to a Network contact.

[UnitedHealthcare Medicare Advantage](#)

New ED Professional E/M Coding Policy

Effective for dates of service on or after May 1, 2020, UnitedHealthcare will implement a new Emergency Department (ED) Professional Evaluation and Management (E/M) reimbursement policy that will focus on professional ED claims submitted with level 5 (99285) E/M code for Medicare Advantage plans.

In accordance with American Medical Association guidelines that are further supported by CMS, ED E/M codes must meet or exceed all three key components of History, Exam and Medical Decision Making (MDM) to qualify for a specific level of E/M service. Therefore, when only two of the three key components meet or exceed the requirement to qualify for a particular level of E/M service, the third key component is utilized to select the appropriate level of E/M service.

In an effort to reduce the administrative burden of requesting and submitting medical records for review, we will begin using the Optum Evaluation and Management Professional (E/M Pro) tool, which determines appropriate E/M coding levels based on data, such as patient's age and conditions, for the MDM key component. We will presume the provider meets the requirements of the E/M code level they have submitted related to the History and Exam key components for the initial adjudication of the claim.

The E/M Pro tool accounts for diagnosis codes submitted on the claim and determines the appropriate level of complexity that correlates with the E/M service reimbursement. Since MDM and problem complexity is the primary driver, the E/M Pro tool calculates the appropriate E/M level based on submitted diagnosis codes. This will result in fair and appropriate reimbursement for ED services rendered.

Once implemented, your claims for ED Level 5 E/M code (99285) may experience adjustments to reflect the appropriate level E/M code, based on the reimbursement structure within your agreements with us.



If you need further information, please contact your Network Representative or call Provider Services at **877-842-3210**.

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