

SERFF Tracking Number: UHLC-126489487 State: Arkansas  
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 44769  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AR Admin Guide  
Project Name/Number: /

## Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: AR Admin Guide

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-126489487 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num: 44769

For Informational Purposes

Co Tr Num:

State Status: Filed-Closed

Reviewer(s): Stephanie Fowler

Author: Ebony Terry

Disposition Date: 03/11/2010

Date Submitted: 02/04/2010

Disposition Status: Accepted For

Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/11/2010

Deemer Date:

Submitted By: Ebony Terry

Filing Description:

2009 AR Admin Guide

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/11/2010

Created By: Ebony Terry

Corresponding Filing Tracking Number:

## Company and Contact

### Filing Contact Information

Ebony Terry, Compliance Analyst

4 Taft Court

Rockville, MD 20850

Ebony\_N\_Terry@uhc.com

301-838-5611 [Phone]

301-838-5676 [FAX]

### Filing Company Information

<i>SERFF Tracking Number:</i>	<i>UHLC-126489487</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare of Arkansas, Inc.</i>	<i>State Tracking Number:</i>	<i>44769</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>AR Admin Guide</i>		
<i>Project Name/Number:</i>	<i>/</i>		
UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas	
Plaza West Building	Group Code:	Company Type: HMO	
415 North McKinley Street, Suite 300	Group Name:	State ID Number:	
Little Rock, AK 72205	FEIN Number: 63-1036819		
(952) 992-7428 ext. [Phone]			

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	02/04/2010	33995257

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Stephanie Fowler	03/11/2010	03/11/2010

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## Disposition

Disposition Date: 03/11/2010

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	AR Admin Guide Redlined Doc and Cover	Accepted for	Yes
	Letter	Informational Purposes	
Form	AR Admin Guide	Accepted for	Yes
		Informational Purposes	

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Product Name: AR Admin Guide

Project Name/Number: /

## Form Schedule

Lead Form Number: 100-6088 12/09

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Accepted for Information al Purposes 03/11/2010	100-6088 12/09	Other	AR Admin Guide	Initial			100-6088 UHC admin guide 2010_bookmarkedFINAL COPY.pdf

**Physician, Health Care Professional,  
Facility and Ancillary Provider**  
**2010 Administrative Guide**  
For Commercial and Medicare Products





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# Important information regarding the use of this guide

In the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this Guide, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix. Additionally, in the event of a conflict or inconsistency between your agreement and this Guide, the provisions of your agreement with us will control. This entire Guide is subject to change.

All items within this Guide that describe how you must do business with us are Protocols under the terms of your agreement.

This Guide applies to all covered services rendered to members covered under a benefit plan insured by or receiving administrative services from UnitedHealthcare and its affiliates, unless otherwise noted. Please note that, in the event your agreement indicates that additional protocols or guides are applicable to members covered under certain benefit plans, those other protocols and guides will control with respect to such members as described in your agreement.

This entire Guide applies to Medicare Advantage members. Unless otherwise noted, reference to Medicare Advantage members includes Erickson Advantage members. If a particular section does not apply to Medicare Advantage or Erickson Advantage members, that will be clearly indicated in this Guide. As used in this Guide, references to "Medicare members" only include those Medicare members enrolled in Medicare benefit plans offered through AARP® MedicareComplete, SecureHorizons, Evercare, and Erickson Advantage.

Unless otherwise specified herein, this Guide is effective on April 1, 2010 for physicians, health care professionals, facilities and ancillary providers currently participating in the UnitedHealthcare network and effective immediately for physicians, health care professionals, facilities and ancillary providers who join the UnitedHealthcare network on or after January 1, 2010.

**Note:** "Member" is used in this Guide to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "Commercial" as used in this Guide refers to all UnitedHealthcare medical products that are not Medicare, Medicaid or other governmental products. "Guide" refers to this 2010 Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. "You" or "your" refers to any provider subject to this Guide, including physicians, health care professionals, facilities and ancillary providers; unless otherwise specified in the specific item, all items are applicable to all types of providers subject to this Guide. "Us," "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Guide.

The codes and code ranges listed in this Guide were current at the time this Guide was published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes or visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) for further information.

# How to contact us

Commercial & Medicare products		
RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
UnitedHealthcare Online®	UnitedHealthcareOnline.com	<ul style="list-style-type: none"> <li>• Register for UnitedHealthcare Online</li> <li>• Review a member's eligibility or benefits and view their current HRA balances</li> <li>• Submit notifications</li> <li>• View claim pre-determination and bundling logic using Claim Estimator (not applicable to Medicare)</li> <li>• Submit claims with Real-Time Adjudication (for Commercial members only)</li> <li>• Check status of or update existing notifications</li> <li>• Check claims status</li> <li>• Request a claims adjustment or a reconsideration when attachments are not needed</li> <li>• Submit a claim research project for 20 or more claims using the Claim Research Project online form</li> <li>• Update facility/practice data (except TIN)</li> <li>• Review the physician, health care professional, and facility directory</li> <li>• Look up your fee schedule, ten (10) codes at a time</li> <li>• Review/print a current copy of this Guide</li> <li>• View UnitedHealthcare policies</li> <li>• View current and past issues of our Network Bulletin</li> <li>• Access and review clinical program information and patient safety resources</li> </ul>
	(866) UHC-FAST, Option 2 (866) 842-3278, Option 2	<ul style="list-style-type: none"> <li>• Get technical support for UnitedHealthcare Online</li> </ul>
<b>Electronic Claim Submission</b> (EDI Support Line)	(800) 842-1109  To obtain information on HIPAA Transactions & Code sets go to <a href="http://hipaa.uhc.com">hipaa.uhc.com</a> → Uniprise → CompanionDocument  Additional UnitedHealthcare and Affiliates' payer IDs can be found on UnitedHealthcare Online.com → Claims & Payments → Electronic Claims Submissions, under EDI Tools & Resources	<ul style="list-style-type: none"> <li>• Obtain information on submitting claims electronically</li> <li>• Use our payer ID 87726</li> </ul>
<b>United Voice Portal</b>	(877) UHC-3210 (877) 842-3210  To obtain a United Voice Portal Quick Reference Process Overview, go to UnitedHealthcareOnline.com → Contact Us, then reference the Service & Support Section. Click on the quick reference link under UnitedHealthcare for Health Care Professionals (United Voice Portal)	<ul style="list-style-type: none"> <li>• Inquire about a member's eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation</li> <li>• Check claim status, reason code explanation and claims pending and mailing addresses</li> <li>• Update facility/practice demographic data (except TIN)</li> <li>• Check credentialing status or request for participation inquiries</li> <li>• Check appeal or claim project submission process information</li> <li>• Check Care Notification process information</li> <li>• Check privacy practices information</li> </ul>

<b>Commercial &amp; Medicare products</b>		
<b>RESOURCE</b>	<b>WHERE TO GO</b>	<b>WHAT YOU CAN DO THERE</b>
<b>Advance &amp; Admission Notification</b>	UnitedHealthcareOnline.com or call United Voice Portal at (877) UHC-3210 (877) 842-3210 or See member's health care ID card for Customer Care contact information	<ul style="list-style-type: none"> <li>Notify us about the procedures and services outlined in the Notification Requirements section of this Guide</li> <li>Access Utilization Staff regarding utilization management issues</li> </ul>
<b>Erickson Advantage®</b> (A UnitedHealthcare Medicare Advantage network product for residents of Erickson Retirement Communities)	See member's health care ID card for Customer Care contact information	<ul style="list-style-type: none"> <li>Inquire about benefits and services as indicated in this Guide, including Notification Requirements</li> </ul>
<b>Pharmacy Services</b> (For Commercial members only)	UnitedHealthcareOnline.com	<ul style="list-style-type: none"> <li>View the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) by drug</li> </ul>
	Phone: (877) 842-1508	<ul style="list-style-type: none"> <li>Request a copy of the PDL</li> </ul>
	Fax: (877) 842-1435	<ul style="list-style-type: none"> <li>Call for medications requiring notification</li> </ul>
	Fax: (888) 327-9791	<ul style="list-style-type: none"> <li>Fax for easy Rx service</li> </ul>
<b>Pharmacy Services</b> (For Medicare Advantage members only)	Go to securehorizons.com/Search the drug list Fax: (877) MDRXFAX (877) 637-9329	<ul style="list-style-type: none"> <li>View the SecureHorizons Formulary or request a copy</li> </ul>
	Go to evercarehealthplans.com → prescription_drug_coverage	<ul style="list-style-type: none"> <li>View the Evercare Formulary</li> </ul>
	Phone: (800) 711-4555	<ul style="list-style-type: none"> <li>Request a prior authorization</li> </ul>
	Fax: (800) 527-0531	<ul style="list-style-type: none"> <li>Submit request for oral medications</li> </ul>
	Fax: (800) 853-3844	<ul style="list-style-type: none"> <li>Submit request for injectable medications</li> </ul>
	Phone: (866) 798-8780, Option 2	<ul style="list-style-type: none"> <li>Request information on the Medicare Medication Management Program</li> </ul>
<b>Behavioral Health Services</b>	See member's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> <li>Inquire about a member's behavioral health benefits</li> </ul>
<b>Vision Services</b>	See member's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> <li>Inquire about a member's vision benefits</li> </ul>
<b>Transplant Services</b>	See member's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> <li>Inquire about a member's transplant benefits</li> </ul>
<b>Customer Care</b>	See member's health care ID card for Customer Care contact information	<ul style="list-style-type: none"> <li>Obtain information for services as indicated in this Guide</li> </ul>
<b>Electronic Payments and Statements (EPS)</b>	UnitedHealthcareOnline.com (866) UHC-FAST, Option 5 (866) 842-3278, Option 5	<ul style="list-style-type: none"> <li>Sign up for EPS</li> <li>Call for questions or issues with EPS</li> </ul>
<b>Outpatient Radiology Notification Submission and Status</b> (For Commercial members only)	UnitedHealthcareOnline.com Phone: (866) 889-8054 Fax: (866) 889-8061	<ul style="list-style-type: none"> <li>Notify us of certain radiology procedures as described in the Outpatient Radiology Notification section of this Guide</li> </ul>
<b>Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers</b>	Myoptumhealthphysicalhealth.com (888) 329-5182	<ul style="list-style-type: none"> <li>Verify benefits and eligibility</li> <li>Check Notification process requirements</li> </ul>

# Our claims process

## Prompt claims processing

We know that you want your claims to be processed promptly for the covered services you provide to our members. We work hard to process your claims timely and accurately. Here's what you can do to help us:

### 1 Review the member's eligibility at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), using swipe card technology or keying in the member's information.

You can also check member eligibility by phone by calling the United Voice Portal at (877) 842-3210 or the Customer Care number on the back of the member's health care ID card.

Disclaimer: Eligibility & benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered and benefit plan terms and conditions.

### 2 Notify us in accordance with the Standard Notification Requirements list.

### 3 Prepare complete and accurate claims (see "Complete Claims" below).

### 4 Submit claims online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or use another electronic option.

a) **Connectivity Director is a free direct connection** for those who can create a claim file in the HIPAA 837 format. This Web-based application enables real-time and batch submissions direct to UnitedHealthcare. Connectivity Director provides immediate response back to all transaction submissions (claims, eligibility, and more). Additional information can be found at [UnitedHealthcareCD.com](http://UnitedHealthcareCD.com), including a comprehensive User Guide and information on how to get started.

b) **UnitedHealthcare Online All-Payer Gateway™** is a Web-based connectivity solution which links UnitedHealthcare Online users to a leading clearinghouse vendor (Ingenix) that offers multi-payer health transactions and services at preferred pricing. Using your current UnitedHealthcare Online User ID and password, you can register with Ingenix to submit batch claims to many of your governmental and commercial payers. For more information: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Claims and Payments → Electronic Claims Submission → EDI Options.

c) **EDI Gateway and Clearinghouse Connections** – UnitedHealthcare's preferred clearinghouse is Ingenix, but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare. Both participating and non-participating physician, health care professional, facility and ancillary provider claims are accepted electronically using UnitedHealthcare's **payer ID 87726**. Other UnitedHealthcare and affiliate payer IDs can be found on [UnitedHealthCareOnline.com](http://UnitedHealthCareOnline.com).

UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements.

While some claims may require supporting information for initial review, UnitedHealthcare has reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed.

### 5 Receive Electronic Payments and Statements (EPS)

If you are enrolled with us for EPS, payments are electronically deposited into one or more checking accounts which you designate. Take the next step by auto-posting the electronic 835/Electronic Remittance Advice (ERA) that you receive from your clearinghouse, or obtain one free of charge from our Web site at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com).

Explanations of Benefits (EOBs) that match each daily/weekly consolidated deposit are available on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), where you can review, store and print hard copies to use for manual posting.

EPS is UnitedHealthcare's preferred method for receiving payments and statements and results in faster and easier payment to you. If you have not yet enrolled in this standard operating process, start receiving electronic payments and statements now by enrolling online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or by contacting us at (866) 842-3278, Option 5. Please note EPS is not available in all markets for our Medicare Advantage plans.

## **Pass-through billing/CLIA requirements/reimbursement policy**

If you are a physician, practitioner or medical group, you must only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

For laboratory services, you will only be reimbursed for the services for which you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our members for any laboratory services for which you lack the applicable CLIA certification; however, this requirement does not apply to laboratory services rendered by physicians, practitioners or medical groups in office settings that have been granted "waived" status under CLIA.

Payment of a claim is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

## **Complete claims**

For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services (according to national coding guidelines). It is particularly important to accurately code because a member's level of coverage under his or her benefit plan may vary for different services. You must submit a claim for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the member at the time of service.

To assist you in understanding how your claims will be paid, UnitedHealthcare's Claim Estimator includes a feature called Professional Claim Bundling Logic which helps you determine allowable bundling logic and other claims processing edits for a variety of CPT (CPT is a registered trademark of the American Medical Association) and HCPCS procedure codes. Note: Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations are not included.

Allow enough time for your claims to process before sending second submissions or tracers, then check their status online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). If you do need to submit second submissions or tracers, be sure to submit them electronically no sooner than forty-five (45) days after original submission.

Complete claims include the information listed under the Complete Claims Requirements section of this Guide. We may require additional information for particular types of services, or based on particular circumstances or state requirements.

If you have questions about submitting claims to us, please contact Customer Care at the phone number listed on the member's health care ID card. For questions specific to electronic submission of claims, please review the information at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Claims and Payments → Electronic Claims Submission (EDI). If you need additional information on EDI, contact the EDI Support Line at (800) 842-1109, Option 3.

Learn about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) including: Claim Estimator with bundling logic and Real-Time Adjudication. Training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-by-Step Help and Tutorials are available by clicking "Help" at the top of any page.

**Note: At the time of publication of this Guide, the Claim Estimator is not available for Medicare products.**

To order 1500 HICF (CMS-1500) and UB-04 (CMS-1450) forms, contact the U.S. Government Printing Office, call (202) 512-0455, or visit their Web site at [cms.hhs.gov/CMSForms](http://cms.hhs.gov/CMSForms).

## Complete claims requirements

- Member's name
- Member's address
- Member's gender
- Member's date of birth (dd/mm/yyyy)
- Member's relationship to subscriber
- Subscriber's name (enter exactly as it appears on the member's health care ID card)
- Subscriber's ID number
- Subscriber's employer group name
- Subscriber's employer group number
- Rendering Physician, Health Care Professional, or Facility Name
- Rendering Physician, Health Care Professional, or Facility Representative's Signature
- Address where service was rendered
- Physician, Health Care Professional, or Facility "remit to" address
- Phone number of Physician, Health Care Professional, or Facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
- Physician's, Health Care Professional's, or Facility's National Provider Identifier (NPI) and federal Tax Identification Number (TIN)
- Referring physician's name and TIN (if applicable)
- Date of service(s)
- Place of service(s) (for more information see: [cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf](https://www.cms.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf))
- Number of services (day/units) rendered
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
- Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- Charges per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available
- Retail purchase cost or a cumulative retail rental cost for DME greater than \$1,000
- Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 Professional electronic form.

## Additional information needed for a complete UB-04 form

- Date and hour of admission
- Discharge date and hour of discharge
- Member status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current four-digit revenue code(s)
- Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current ICD-9-CM (or its successor) procedure codes for inpatient procedures
- Attending physician ID
- Bill all outpatient procedures with the appropriate revenue and CPT or HCPCS codes

- Provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount (\$.01 or \$1.00) must be reported on all other surgical revenue code lines to assure appropriate adjudication

## Claim correction/resubmit

If you need to correct and re-submit a claim, submit a new CMS-1500 or UB-04 indicating the correction being made. When correcting or submitting late charges on a CMS-1500, UB-04 or 837 Institutional claim, resubmit all original lines and charges as well as the corrected or additional information. When correcting UB-04 or 837 Institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. **Hand-corrected claim re-submissions will not be accepted.**

## Reporting requirements for anesthesia services

- One of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with an “MJ” qualifier in loop 2400 SV103. For CMS-1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.
- When medically directing residents for anesthesia services, the modifier GC must be reported in conjunction with the AA or QK modifier.
- When reporting obstetrical anesthesia services, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

## National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized National Provider Identifier (NPI) for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions. In addition, based on state specific regulations NPI may be required to be submitted on paper claims. HIPAA defines a covered health care provider as any provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the Implementation Guides.

- To avoid payment delays or denials, UnitedHealthcare requires a valid Billing NPI and Taxonomy Code(s) be submitted on both paper and electronic claims. In addition, UnitedHealthcare strongly encourages the submission of all other NPIs as defined below.
- It is important that, in addition to the NPI, you continue to submit your Tax Identification Number (TIN).

The NPI information that you report to us now and on all future claims is essential in allowing us to efficiently process claims and to avoid delays or denials.

UnitedHealthcare will continue to accept NPIs submitted through any of the following methods:

1. UnitedHealthcare Online (UnitedHealthcareOnline.com)  
To update your NPI and related information online, login to UnitedHealthcareOnline.com. Go to Practice/Facility Profile and select your tax ID. Click continue, then select the View/Update NPI Information tab.
2. For members covered under benefit plans administered by AmeriChoice, please consult the applicable AmeriChoice state-specific physician section on americhoice.com for details on where and how to submit NPI.
3. For all UnitedHealthcare business, fax your NPI to the appropriate fax number based on your geographic location/state. The fax form can be found under “Most Visited” and “National Provider Identifier” at UnitedHealthcareOnline.com.
4. Call (877) 842-3210, the United Voice Portal. Select the “Health Care Professional Services” prompt. State “Demographic changes” and your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.
5. NPI and NUCC taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and recontracting efforts.

## How to submit NPI, TIN and taxonomy on a claim

The information below provides the location for NPI, TIN and Taxonomy on paper and electronic claims. See definitions in the UB-04 Data Specifications Manual.

<b>HIPAA 837P (Professional) Claim Transaction</b>	
Primary Identifier	Loop 2010AA, NM109
Pay-To Provider Federal Tax ID	Loop 2010AB, NM109
Referring Physician	Loop 2310A, NM109
Rendering Physician	Loop 2420A, NM109
<b>HIPAA 837I (Institutional) Claim Transaction</b>	
Billing Provider Primary ID	Loop 2010AA, NM109
Billing Provider Taxonomy	Loop 2000A, PRV03
Billing Provider Secondary ID (EIN)	Loop 2010AA, REF02
Attending Physician	Loop 2310A, NM109
Operating Physician	Loop 2310B, NM109
<b>HICF 1500 (08-05) Professional Claim Form</b>	
Referring Provider NPI	Field 17b
Rendering Provider NPI	Field 24j
Service Facility Location NPI	Field 32a
Billing Provider NPI	Field 33a
Billing Provider Legacy Identifier	Field 33b
Important: Make sure that your claim software supports the revised 1500 claim form (08-05). Reference the 1500 Reference Instruction Manual at nucc.org for specific details on completing this form.	
<b>UB-04 Paper Institutional Claim Form</b>	
Billing Provider NPI	Locator 56
Billing Provider Taxonomy Code	Locator 81
Attending Provider NPI	Locator 76
Operating Provider NPI	Locator 77
Other Provider NPI	Locator 78-79

## Laboratory claim submission requirement

Many UnitedHealthcare benefit plan designs exclude from coverage outpatient diagnostic services that were not ordered by a participating physician. UnitedHealthcare benefit plans may also cover diagnostic services differently when a portion of the service (e.g., the draw) occurs in the physician's office, but the analysis is performed by a laboratory provider. In addition, many state laws require that most, if not all, laboratory services are ordered by a licensed physician.

Therefore, all laboratory claims must include the NPI number of the referring physician, in addition to the other elements of a Complete Claim described in this Guide. Laboratory claims that do not include the identity of the referring physician will be rejected or denied.

This requirement applies to claims for laboratory services, both anatomic and clinical.

This requirement applies to claims received from both participating and non-participating laboratories, unless otherwise provided under applicable law. This requirement does not apply to claims for laboratory services provided by physicians in their offices. Please also refer to the Protocol on Use of Non-Participating Laboratory Services.

## Assistant surgeons or surgical assistants claim submission requirements

The practice of directing or using non-participating providers significantly increases the costs of services for our members. As such, UnitedHealthcare requires our participating providers to use reasonable commercial efforts to utilize the services of in network providers, including in-network surgical assistants or assistant surgeons to render services to our members. Health care professionals acting as assistant surgeons must report their health care services under the primary surgeon's TIN. Payment is subject to our payment policies (reimbursement policies).

## Submission of claims for services subject to medical claim review

In some instances, a claim may be pended for medical claim review under an applicable medical or drug policy, in order to determine whether the service rendered is a covered service, for example, Erythropoietin. To facilitate claim processing for such services, you are encouraged to include additional information or reports along with your original claim. For more information about UnitedHealthcare drug and medical policies, please see [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Most Visited → Policies, Protocols and Administrative Guides → Policies.

## Erythropoietin (For Commercial members)

For Erythropoietin (EPO) claims submitted via paper to UnitedHealthcare on a CMS-1500 Form, enter the Hematocrit (Hct) level in the shaded area of line 24A in the same row as the J-code. Enter Hct and the lab value (Hctxx). For electronic claims, the Hct level is required in the (837P) Standard Professional Claim Transaction, Loop 2400 – Service Line, segment MEA, Data Element MEA03. The MEA segment should be reported as follows:

- MEA01 = qualifier "TR", meaning test results
- MEA02 = qualifier "R2", meaning hematocrit
- MEA03 = hematocrit test result

Example: MEA\*TR\*R2\*33~

The following J codes require an Hct level on the claim:

- J0881 Darbepoetin alfa (non-ESRD use)
- J0882 Darbepoetin alfa (ESRD on dialysis)
- J0885 Epoetin alfa (non-ESRD use)
- J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)
- Q4081 Epoetin alfa (ESRD on dialysis)

For EPO claims submitted on a UB04 claim form, an Hct level is not required.

## **KRAS**

Effective April 1, 2009, UnitedHealthcare requires the submission of a pathology report documenting KRAS gene type in order to determine coverage for Erbitux® (cetuximab J9055) and Vectibix® (panitumumab J9303) for members with colorectal cancer.

Please fax the pathology reports to **(915) 231-1970** using the dedicated fax cover sheet that is located at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinician Resources → Cancer-Oncology → KRAS Testing.

## **Member financial responsibility**

Members are responsible for applicable copayments, deductibles and coinsurance associated with their plans. You should collect copayments at the time of service; however, to determine the exact member responsibility related to plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) when billing members.

If you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools are available on our Web site to help you determine member and health plan responsibility, including Claim Estimator and HRA Balance viewing through the Eligibility Inquiry function. (Note: Claim Estimator is not available for Medicare members.)

You can also use the claim submission feature on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) while the member is still in the office and receive a fully adjudicated claim value showing the plan's responsibility and the member's responsibility, based on contracted discounts and plan benefits. This will help promote accurate collections and avoid overpayment or underpayment situations. In the event the member pays more than the amount indicated on the medical claim EOB, you are responsible for promptly refunding the difference to the member.

For Medicare Advantage members, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage member who is eligible for both Medicare and Medicaid, or his or her representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance) when the state is responsible for paying such amounts. You will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

## **Overpayments**

If you identify a claim for which you were overpaid by us, or if we inform you in writing or electronically of an overpaid claim that you do not dispute, you must send us the overpayment within thirty (30) calendar days (or as required by law), from the date of your identification of the overpayment or our request. We may also apply the overpayment against future claim payments to the extent permitted by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from UnitedHealthcare, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter. Refunds of any credit balances existing on your records should be sent to:

UnitedHealth Group Recovery Services  
P.O. Box 740804  
Atlanta, GA 30374-0804

Please include appropriate documentation that outlines the overpayment, including member's name, health care ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from UnitedHealthcare. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician, health care professional, facility or ancillary provider. In the case of an overpayment, we will request a refund at least thirty (30) days prior to implementing a claim adjustment, or as provided by applicable law or contractual agreement. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination (see Claim Appeals section of this Guide).

## Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits (COB) rules.

- 1. Subrogation** – To the extent permitted under applicable law and the applicable benefit plan, we reserve the right to recover benefits paid for a member’s health care services when a third party causes the member’s injury or illness.
- 2. Coordination of Benefits (COB)** – COB is administered according to the member’s benefit plan and in accordance with applicable law. UnitedHealthcare can accept secondary claims electronically. To learn more, go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Claims & Payments → Electronic Claims Submission (EDI), contact your EDI vendor, or call EDI support at (800) 842-1109.

<b>Primary Plan</b>	Plan that pays benefits first.	Benefits under the primary plan will not be reduced due to benefits payable under other plans.
<b>Secondary Plan</b>	Plan will pay benefits after the primary plan.	Benefits under the secondary plan may be reduced due to benefits payable under other primary plans.
<b>Tertiary Plan</b>	Three or more group benefit plans may provide benefits for the same medical expense.	Tertiary plans would offset the incurred expenses with the benefits paid by the primary and secondary carriers, and provide benefits for any remaining unreimbursed expenses.

**Note:** When coordinating benefits with Medicare, all COB Types coordinate up to Medicare’s allowed amount when the provider accepts assignment. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary.

- 3. Workers’ Compensation** – In cases where an illness or injury is employment-related, workers’ compensation is primary. If notification is received that the workers’ compensation carrier has denied the claim, the provider should submit the claim to UnitedHealthcare, regardless of whether the case is being disputed. It is also helpful to send the other carrier’s denial statement with the claim.

## Retroactive eligibility changes

Eligibility under a benefit contract may change retroactively if:

1. We receive information that an individual is no longer a member;
2. The member’s policy/benefit contract has been terminated;
3. The member decides not to purchase continuation coverage; or
4. The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) that is affected by a retroactive eligibility change, a claim reconsideration may be necessary. The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA). If you are enrolled in EPS, you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us.

# Claim reconsideration and appeals processes

## Step 1: Claim reconsideration

If you believe you were underpaid by us, the first step in addressing your concern is to request a Claim Reconsideration.

- The quickest way to submit a Claim Reconsideration request is directly through UnitedHealthcareOnline.com. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration. Please identify the specific claims in “paid” or “denied” status which you believe should be adjusted and give a description of the requested adjustment.
- If written documentation, such as proof of timely filing is needed, you must use the Claim Reconsideration Request Form found on UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration → Claim Reconsideration Request Form. The form should be mailed to the claim address on the back of the member’s health care ID card.

If you are submitting a Claim Reconsideration Request Form for a claim which was denied because filing was not timely:

1. Electronic claims – include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
2. Paper claims – include a copy of a screen print from your accounting software to show the date you submitted the claim.

**Note:** All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.

- Alternatively, you can call the Customer Care number on the back of the health care ID card to request an adjustment for issues which do not require written documentation.
- If you have issues involving twenty (20) or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Research Project.

## Step 2: Claim appeal

If you believe you were underpaid by us, the first step in resolving your concern is to submit a Claim Reconsideration as described above.

If you still do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may submit a formal appeal request to:

UnitedHealthcare Provider Appeals  
P.O. Box 30559  
Salt Lake City, UT 84130-0575

Your appeal must be submitted to us within twelve (12) months from the date of the adjustment decision shown on the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as member-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review. Our decision will be rendered based on the materials available at the time of formal appeal review.

If you are appealing a claim that was denied because filing was not timely:

1. Electronic claims – include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
2. Paper claims – include a copy of a screen print from your accounting software to show the date you submitted the claim.

**Note:** All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.

If you are disputing a refund request, please send your letter of appeal to the address noted on the refund request letter. Your appeal must be received within thirty (30) calendar days of the date of the refund request letter, or as required by law or your participation agreement, in order to allow sufficient time for processing the appeal, and to avoid possible offset of the overpayment against future claim payments to you. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe we have made the refund request in error.

If you disagree with the outcome of any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution as described in the *Resolving disputes* section and in your agreement with us.

In the event that a member has authorized you to appeal a clinical or coverage determination on the member's behalf, such an appeal will follow the process governing member appeals as outlined in the member's benefit contract or handbook.

## **Resolving disputes**

### **Agreement concern or complaint**

If you have a concern or complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your agreement with us.

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, such as the credentialing, notification, or claim appeal processes described in this Guide, you and we will follow the dispute procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement.

If we have a concern or complaint about your agreement with us, we'll send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us.

Arbitration proceedings will be held at the location described in your agreement with us or if a location is not specified in your agreement, then at a location as described in the *Arbitration counties by location* section.

## Arbitration counties by location

Unless your agreement with us provides otherwise, the following list contains locations where arbitration proceedings will be held. Locations listed under the state in which you provide care are the locations applicable to you.

### Alabama

Jefferson County, AL

### Alaska

Anchorage, AK

### Arizona

Maricopa County, AZ

### Arkansas

Pulaski County, AR

### California

Los Angeles County, CA  
San Diego County, CA  
San Francisco County, CA

### Colorado

Arapahoe County, CO

### Connecticut

Hartford County, CT  
New Haven County, CT

### Delaware

Montgomery County, MD

### District of Columbia

Montgomery County, MD

### Florida

Broward County, FL  
Hillsborough County, FL  
Orange County, FL

### Georgia

Gwinnett County, GA

### Hawaii

Honolulu County, HI

### Idaho

Boise, ID  
Salt Lake County, UT

### Illinois

Cook County, IL

### Indiana

Marion County, IN

### Iowa

Polk County, IA

### Kansas

Johnson County, KS

### Kentucky

Fayette County, KY

### Louisiana

Jefferson Parish, LA

### Maine

Cumberland County, ME

### Maryland

Montgomery County, MD

### Massachusetts

Hampden County, MA  
Suffolk County, MA

### Michigan

Kalamazoo County, MI  
Oakland County, MI

### Minnesota

Hennepin County, MN

### Mississippi

Hinds County, MS

### Missouri

St. Louis County, MO  
Jackson County, MO

### Montana

Yellowstone County, MT

### Nebraska

Douglas County, NE

### Nevada

Clark County, NV  
Washoe County, NV  
Carson City County, NV

### New Hampshire

Merrimack County, NH  
Hillsboro County, NH

### New Jersey

Essex County, NJ

### New Mexico

Bernalillo County, NM

### New York

New York County, NY  
Onondaga County, NY

### North Carolina

Guilford County, NC

### North Dakota

Hennepin County, MN

### Ohio

Butler County, OH  
Cuyahoga County, OH  
Franklin County, OH

### Oklahoma

Tulsa County, OK

### Oregon

Multnomah County, OR

### Pennsylvania

Allegheny County, PA  
Philadelphia County, PA

### Rhode Island

Kent County, RI

### South Carolina

Richland County, SC

### Tennessee

Davidson County, TN

### Texas

Dallas County, TX  
Harris County, TX  
Travis County, TX

### Utah

Salt Lake County, UT

### Vermont

Chittenden County, VT  
Washington County, VT  
Windham County, VT

### Virginia

Montgomery County, VA

### Washington

King County, WA

### West Virginia

Montgomery County, MD

### Wisconsin

Milwaukee County, WI  
Waukesha County, WI

### Wyoming

Laramie County, WY

# Health care identification cards

## Health care ID cards

UnitedHealthcare members receive a health care ID card containing information needed for you to submit claims.

**Information may vary in appearance or location on the card due to payer or other unique requirements.**

However, cards display essentially the same information (e.g., claims address, copayment information, telephone numbers such as those for Customer Care and Notification) and are viewable on UnitedHealthcareOnline.com in the Patient Eligibility section. Click on the "View Patient's ID card" link located in the Patient Search results section of the Eligibility Detail page.

Please check the member's health care ID card at each visit and keep a copy of both sides of the card for your records.

## Checking health care benefit eligibility and copayment using the UnitedHealthcare health care ID swipe card at the time of service

UnitedHealthcare uses a 3-track card reader for checking health care eligibility and copayment information. The 3-track card reader can be used in conjunction with UnitedHealthcareOnline.com. Swipe the member's health care ID card to access the member's Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions. UnitedHealthcare uses the national WEDI (Workgroup for Electronic Data Interchange) card standards for our member ID cards.

UnitedHealthcare has arranged a discounted 3-track card reader purchase price for physicians and health care professionals in our network, through a preferred distributor – Bayscan Technologies. To order your reader(s), contact **BayScan** directly at **(877) 229-7226** or at **bayscan.com**. Indicate that you are part of the UnitedHealthcare Network and supply your TIN to receive the discounted price when ordering.

As an additional resource, we have created a Swipe Health Care ID Cards Quick Reference, which can be found at UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Health Care ID Card Swipe Technology. This resource will enable you to learn more about how the UnitedHealthcare Medical - Rx ID Card and Integrated Financial & Medical - Rx ID Card can simplify your transaction entry and accelerate payments.

## Sample health care ID card



## Medicare Advantage health care ID cards

In order to help identify those members associated with our Medicare Advantage products offered through AARP® MedicareComplete, SecureHorizons, Evercare, and Erickson Advantage, please go to the following provider Web site for ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → 2010 UnitedHealthcare Medicare Solutions Physician/Provider Information → Scroll to the "Member ID Card Information" section at the bottom of the page.

# Our products

## Our Commercial products

This table provides information about some of the most common UnitedHealthcare products (your agreement with us may use “benefit contract types” or “Benefit Plan types” or a similar term to refer to our products). Visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) for more information about our products in your area. Medicare and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in these products. If a member presents an identification card with a product name with which you are not familiar, please contact Customer Care at the number on the back of the member’s health care ID card. This product list is provided for your convenience and is subject to change over time.

<b>Product Name</b>	<i>How do members access physicians and health care professionals?</i>	<i>Is the treating physician and/or facility required to give notice when providing certain services?</i>
<b>UnitedHealthcare Choice and Choice Plus and CORE Choice Plus</b>	Members can choose any network physician or health care professional without a referral and without designating a primary physician.* Choice Plus provides out-of-network coverage,** Choice does not (except for emergency).	Yes, on selected procedures. See guidelines in Notification Requirements section.
<b>UnitedHealthcare Select and Select Plus</b>	Members choose a primary physician from the network of physicians for each family member. The primary physician coordinates their care.* Select Plus provides out-of-network coverage,** Select does not (except for emergency).	Yes, on selected procedures. See guidelines in Notification Requirements section.
<b>UnitedHealthcare Options PPO</b>	Members can choose any network physician or health care professional without a referral and without designating a primary physician.* Options PPO provides out-of-network coverage.**	No. Members are responsible for notifying us at the phone number on their health care ID card, as described under the member’s benefit plan. Please refer members to Customer Care for questions about their responsibilities.
<b>UnitedHealthcare Indemnity</b>	Members can choose any physician or health care professional.*	No. Members are responsible for notifying us at the phone number on their health care ID card. Please refer members to Customer Care for questions about their responsibilities.

\* Physicians and health care professionals must be licensed for the health services provided and the health care services provided must be covered under the member’s benefit contract.

\*\* The benefit level for non-emergency services from non-network physicians and health care professionals will generally be less than for services from network physicians and health care professionals.

# Definity<sup>SM</sup>

## Consumer-Driven Health Plans

UnitedHealthcare offers consumer-driven health plans to our members under the Definity<sup>SM</sup> name. These products may be identified via the health care ID card or by looking up your patient's eligibility information at UnitedHealthcareOnline.com. The Definity products each include three major components:

1. Traditional medical insurance that includes preventive care not charged against the deductible;
2. A Health Reimbursement Account (HRA) or Health Savings Account (HSA) for routine health care expenses; and
3. Educational tools and other support resources designed to positively impact consumer behavior and health care choices.

### Definity HRA fast facts

- The Definity HRA plan's medical benefit includes a deductible, but enrollees typically use their HRA to pay for out-of-pocket expenses before they meet the deductible. The HRA is a type of medical savings account that is most often funded by the employer.
- The Definity HRA plan includes an enrollee out-of-pocket maximum. Once the maximum is met, the plan provides 100% reimbursement for covered services, including pharmacy benefits.
- Definity HRA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not subject to the deductible.

### Definity HSA fast facts

- The Definity HSA plan's medical benefit includes a deductible, but enrollees can use their HSA to pay for out-of-pocket expenses before they meet the deductible. The HSA is a type of medical savings account that is most often funded by the employee.
- If Definity enrollees do not have sufficient funds in their HSA, or choose to save those funds for a later date, they pay any remaining plan deductible and coinsurance out-of-pocket. The HSA belongs to the account holder even if he or she changes employers, and the Internal Revenue Service allows annual deposits that can equal the plan's deductible.
- The Definity HSA plan includes an enrollee out-of-pocket maximum. Once the maximum is met, the plan provides 100% reimbursement for covered services, including pharmacy benefits.
- Definity HSA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not subject to the deductible.

### Estimating treatment costs for Definity

To help facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of UnitedHealthcare's free online Claim Estimator. The Claim Estimator tool provides a fast and simple way to obtain your professional claim predeterminations through UnitedHealthcareOnline.com. With Claim Estimator, you can receive an estimate on whether a procedure will be covered, at what amount and what the claim payment will be. Claim Estimator allows you to share this information with your patient before treatment.

### Claims submission

To promote timely claims turnaround and accurate reimbursement for services you render to patients with Definity HRAs or HSAs, please verify patient eligibility and benefits coverage online at UnitedHealthcareOnline.com → Patient Eligibility, or you can call the Member Service number on the back of your patient's health care ID card.

Special note regarding Definity HRA enrollees: Once logged into the Patient Eligibility section of UnitedHealthcareOnline.com, the "HRA Balance" field will be displayed if the patient is enrolled in any Definity consumer-driven health plan. When there are funds available in an HRA account, the current balance will be displayed. This amount is based on the most recent information available and is subject to change. The actual balance may differ

from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed.

Balances for Definity HSA enrollees are not available through the Patient Eligibility application.

Most Definity plans do not require copayments; therefore, please do not ask your Definity-enrolled patients to make a copayment at the time of service unless it is expressly indicated on their health care ID card.

Submit claims electronically through [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or through your clearinghouse relationship to payer ID 87726. Alternatively, you may submit claims to the address on the back of your patient's health care ID card.

Please wait until after a claim is processed and you receive your EOB before collecting funds from your patient because the patient responsibility may be reimbursable through their HRA account and paid directly to you. The EOB will indicate any remaining patient balance. UnitedHealthcare will not automatically transfer the HSA balance for payment; however, the patient can pay with their HSA debit card or convenience checks linked directly to their account balance.

## **Consumer account cards and qualified medical expenses**

Providers may charge UnitedHealthcare HRA or FSA consumer account cards only for expenses that are "qualified medical expenses" (as defined in Section 213(d) of the Internal Revenue Code) incurred by the cardholder or the cardholder's spouse or dependent. "Qualified medical expenses" are expenses for medical care which provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for the purpose of affecting any structure or function of the body. An expense can be defined as a "qualified medical expense", but may not be covered under an enrollee's benefit plan. Providers may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses, including, but not limited to:

- Cosmetic surgery/procedures (which include procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), including the following:
  - Face lifts
  - Liposuction
  - Hair transplants
  - Hair removal (electrolysis)
  - Breast augmentation or reduction

**Note:** Surgery or procedures that are necessary to ameliorate a deformity arising from a congenital abnormality, and reconstructive surgery following a mastectomy for cancer, may be qualified medical expenses.

- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight loss programs (note, however, that disease-specific nutritional counseling may be covered)
- Illegal operations or procedures

For updated information regarding qualified medical expenses, please consult the Internal Revenue Service (IRS) Web site at: [irs.gov](http://irs.gov) or call the IRS toll-free telephone number at (800) TAX-FORM; (800) 829-3676.

# Our Medicare Advantage products

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for individuals and employer group retirees. Visit [securehorizons.com](http://securehorizons.com), [evercarehealthplans.com](http://evercarehealthplans.com), or [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) for more information about our Medicare Advantage products in your area. If a member presents a health care ID card with a product name with which you are not familiar, please contact the United Voice Portal at (877) 842-3210, or the phone number on the back of the member's health care ID card. This product list is provided for your convenience and is subject to change over time.

<b>Product Name</b>	<b>HMO and HMO-POS plans under the SecureHorizons or AARP® brands: MedicareComplete MedicareComplete Essential MedicareComplete Plus MedicareComplete Plus Essential</b>	<b>PPO and RPPO plans under the SecureHorizons or AARP® brands: MedicareComplete Choice MedicareComplete Choice Essential</b>	<b>Evercare Plan DH Evercare Plan DH-POS Evercare Plan DH-U Evercare Plan DP Evercare Plan RDP</b>
<i>Member Eligibility</i>	Members who are Medicare eligible.	Members who are Medicare eligible.	Members who are Medicare and Medicaid eligible.
<i>How do members access physicians and health care professionals?</i>	Members choose a primary physician from the network of physicians. The primary physician coordinates their care.  MedicareComplete Plus HMO-POS plans provide out-of-network coverage for some covered benefits.**  MedicareComplete and MedicareComplete Essential HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	In most plans, members choose a primary physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care.  MedicareComplete Choice PPO plans provide out-of-network coverage for all benefits also covered in-network.**	Members choose a primary physician from the network of physicians. The primary physician coordinates their care.  Evercare Plan DP, RDP and DH-POS provide out-of-network coverage.*** Evercare Plan DH does not except for emergency services
<i>Does a primary physician have to make a referral to a specialist?</i>	A referral may or may not be required to see a specialist depending on the plan.**  For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.	No. A referral is not needed.	A referral may or may not be required to see a specialist depending on the plan.** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.
<i>Is the treating physician and/or facility required to give notice when providing certain services?</i>	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.

\*\* Physicians in both the St. Louis, MO market and the Miami-Dade County, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

\*\*\* The benefit level for non-emergency services from non-network physicians and health care professionals will generally be less than that for services from network physicians and health care professionals.

<b>Product Name</b>	<b>Evercare Plan IH Evercare Plan IH-POS Evercare Plan IP</b>	<b>Erickson Advantage</b>	<b>Evercare Plan MP Evercare Plan MH Evercare Plan MH-POS Evercare Plan RMP</b>
<i>Member Eligibility</i>	Members who are Medicare eligible and reside in a contracted institutional setting.	Members who are Medicare eligible and reside in an Erickson Retirement Community.	Members who are Medicare eligible and have one or more specific long term illness.
<i>How do members access physicians and health care professionals?</i>	Members choose a primary physician from the network of physicians. The primary physician coordinates their care.  Evercare Plan IP and IH-POS provides out-of-network coverage.*** Evercare Plan IH does not except for emergency services.	Members are assigned a primary physician from the Erickson Health <sup>SM</sup> network of physicians. The primary physician coordinates their care.  Erickson Advantage provides out-of-network coverage.***	Members choose a primary physician from the network of physicians. The primary physician coordinates their care.  Evercare Plans MP, MH-POS and RMP provide out-of-network coverage.***
<i>Does a primary physician have to make a referral to a specialist?</i>	No. A referral is not needed.	No. A referral is not needed.	A referral may or may not be required to see a specialist depending on the plan** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.
<i>Is the treating physician and/or facility required to provide notice when providing certain services?</i>	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.

\*\* Physicians in both the St. Louis, MO market and the Miami-Dade County, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

\*\*\* The benefit level for non-emergency services from non-network physicians and health care professionals will generally be less than that for services from network physicians and health care professionals.

<b>Product Name</b>	<b>MedicareComplete Group Retiree (HMO and HMO-POS) plans under the SecureHorizons or AARP® brands</b>	<b>MedicareComplete Group Retiree (PPO and RPPO) plans under the SecureHorizons or AARP® brands</b>	<b>UnitedHealthcare Group Medicare Advantage (PPO)</b>
<i>Member Eligibility</i>	Members who are Medicare eligible and meet employer's requirements	Members who are Medicare eligible and meet employer's requirements	Members who are Medicare eligible and meet employer's requirements
<i>How do members access physicians and health care professionals?</i>	Members choose a primary physician from the network of physicians. The primary physician coordinates their care. MedicareComplete (POS) provides out-of-network coverage for some covered benefits.*** MedicareComplete HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	Members may choose a primary physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care. MedicareComplete (PPO and RPPO) provide out-of-network coverage.***	Members are not required to choose a primary physician from the network of physicians.
<i>Does a primary physician have to make a referral to a specialist?</i>	A referral may or may not be required to see a specialist based on service area.** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.	No. A referral is not needed.	No. A referral is not needed.
<i>Is the treating physician and/or facility required to notify?</i>	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.	In-network providers are required to follow the policies, protocols and provisions of their contract and this Guide.

\*\* Physicians in both the St. Louis, MO market and the Miami-Dade County, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

\*\*\* The benefit level for non-emergency services from non-network physicians and health care professionals will generally be less than that for services from network physicians and health care professionals.

# Medicare Select (AARP® Health)

## What Is Medicare Select?

Medicare Select is a Medicare Supplement product available only to AARP® members who reside within the service area of a hospital which participates in our Medicare Select network. It is a lower cost alternative to Standardized Medicare Supplement coverage.

## Responsibilities of Medicare Select members

To offer the plan at a lower premium, we require that Medicare Select members utilize a participating hospital for all inpatient and outpatient hospital services (except emergency care and services provided when members are outside of their service area).

## Hospital responsibilities

Participating hospitals agree to a reduced/waived reimbursement of Medicare's Part A In-Hospital deductible. Cost savings associated with hospitals' reduction/waiver of Medicare's Part A In-Hospital deductible are passed on to Medicare Select members in the form of lower premium cost.

To submit a Medicare Part A or Part B Intermediary claim for a Medicare Select insured, mail a copy of the standard CMS billing form along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

**AARP® Medicare Select**  
UnitedHealthcare Claim Division  
P.O. Box 740819  
Atlanta, GA 30374-0819

Note: Medicare Part B claims billed to a Medicare carrier are, in most cases, received electronically from the Medicare carrier.

To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the 11-digit AARP® Medicare Select member's health care ID number on the standard CMS billing form.

## What does Medicare Select cover in addition to Part A In-Hospital deductible?

- In-Hospital Part A coinsurance for days 61 through 90 in a Medicare Benefit Period.
- In-Hospital Part A coinsurance for days in which Lifetime Reserve days are used.
- Medicare Part A eligible expenses for a Lifetime Maximum of 365 days after all Medicare Part A benefits are exhausted.
- Medicare Part B coinsurance (generally 20% of Medicare's approved amount).
- Medicare Part B deductible amount applied each calendar year.
- Skilled Nursing Facility stays - the daily coinsurance amount for days 21 to 100 for stays eligible under Medicare.
- Medicare Parts A and B Blood deductible: Charge incurred for the first three pints of unreplaced blood furnished in a calendar year.
- Foreign Travel Emergency.

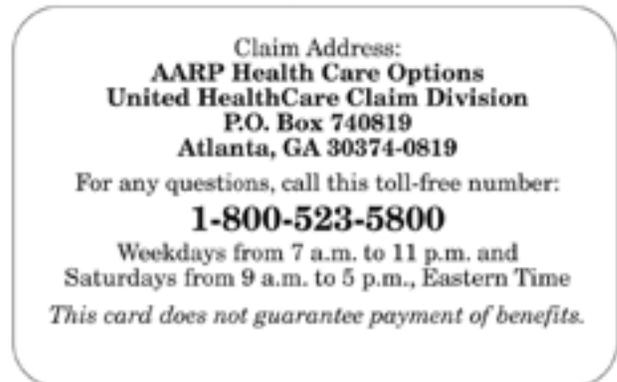
## What advantages does Medicare Select give to participating hospitals?

- Medicare Select will increase the hospital's access to AARP® members. The hospital will be included in AARP® Medicare Select marketing materials within their service area.
- By participating in Medicare Select, the hospital will be limiting its financial exposure. The hospital agrees to a reduced reimbursement of Medicare's Part A deductible. UnitedHealthcare reimburses all other Medicare Part A eligible expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare.
- Hospitals can expect to receive claim payment in a timely fashion as more than 90% of all claims are processed within 10 business days. This may reduce hospital collection efforts.
- This product meets "Safe Harbor" requirements under Federal Anti-Kickback legislation.

## For more information

For more information on Medicare Select and other AARP® Medicare Supplement product offerings, contact our Member Service Center at (800) 523-5800.

## Sample AARP® Health Medicare Select ID Card



# Notification requirements

## Standard notification requirements (for most states\*)

Information gathered about planned member care supports the care coordination process. UnitedHealthcare's notification requirements are designed to effectively gather the pertinent information in a timely manner.

- Physicians, Health Care Professionals and Ancillary Providers are responsible for Advance Notification for certain planned services.
- Facilities are responsible for Admission Notification for inpatient admissions described in this Guide.
- Notify us at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) → Notifications → Notification Submission. We will accept daily composite census logs for inpatient admissions, with complete and relevant information, via fax. If you do not have electronic access, please call us at the number on the back of the member's health care ID card.

\* For information showing each state's status, please refer to [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) → Tools and Resources → Policies and Protocols → Advance and Admission Notification. If additional states are added, you will receive a written notice if you participate in that state. This Protocol was previously communicated to providers, so the effective date of this Protocol supersedes the overall effective date of this Guide. Please refer to [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) for state-specific variations of this Protocol.

## Advance notification

(applies to Physicians, Health Care Professionals and Ancillary Providers only)

- Notification is required only for those planned services on the *Advance Notification List*.
- Certain services may not be covered within an individual member's plan. Notification should be submitted as far in advance of the planned service as possible to allow for coverage review. Notification is required at least five (5) business days prior to the planned serviced date (unless otherwise specified within the *Advance Notification List*). Note that notification for home health services is required within forty-eight (48) hours after the physician's order.
- Advance Notifications must contain the following information associated with the planned service:
  - Member/enrollee name and member/enrollee ID
  - Ordering physician or health care professional name and TIN or NPI
  - Rendering physician or health care professional name and TIN or NPI
  - ICD-9-CM (or its successor) diagnosis code for primary diagnosis
  - Anticipated date(s) of service
  - Type of service (procedure code(s)) and volume of service (when applicable)
  - Facility name and TIN or NPI where service will be performed (when applicable)
  - Original start date of dialysis (ESRD only)
  - Please refer to the individual services listed in the *Advance Notification List* below for specific, additional required information.

## Clinical coverage review: clinical information

- You must cooperate with all requests for information, documents or discussions from UnitedHealthcare for purposes of a clinical coverage review including, but not limited to, pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment. Please refer to the individual services listed in the *Advance Notification List* for specific, additional required information.
- You must return/respond to calls from the care management team and/or medical director. You must provide complete clinical information as required within four (4) hours if request is received before 1:00 p.m. local time, or make best efforts to provide within the same business day if request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

- You can obtain copies of the Coverage Determination Guidelines (CDG) and Medical Policies which UnitedHealthcare uses to determine whether a particular medical procedure or treatment is covered online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies and Protocols.
- In addition to CDGs and Medical Policy, UnitedHealthcare uses Milliman® Care Guidelines®, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

## **Admission Notification (applies to Facilities only)**

- Admission Notification is required for the following admission types:
  - All planned/elective admissions for acute care
  - All unplanned admissions for acute care
  - All SNF admissions
  - All admissions following outpatient surgery
  - All admissions following observation
  - All newborns admitted to NICU
  - All newborns who remain hospitalized after the mother is discharged (within twenty-four (24) hours of the mother's discharge)
- Admission Notification must be received within twenty-four (24) hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if twenty-four (24) hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.
- Admission Notification is required by the hospital even if Advance Notification was supplied by the physician.
- Admission Notifications must contain the following details regarding the admission:
  - Member/enrollee name and member/enrollee ID
  - Facility name and TIN or NPI
  - Admitting/attending physician name and TIN or NPI
  - Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code
  - Actual admission date
- For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances. We will flag the case for payment without any notification-related reimbursement adjustments.
- For all admissions: If admission notification is provided after twenty-four (24) hours, but within seventy-two (72) hours after admission, the reimbursement will be 50% of the average daily payment rate for each day preceding notification and 100% thereafter (not applicable to DRG/case rate contracts without outlier provisions). The average daily payment rate will be calculated by dividing the contracted rate for the admission by the admission length of stay.
- For all admissions: If admission notification is provided after seventy-two (72) hours or not at all, the reimbursement will be 50% of the contracted rate for the entire admission (applicable to all contracts, regardless of payment methodology).
- Reimbursement reductions will not be applied when notification is received by 5:00 p.m. local time on the next business day: (a) for weekend and federal holiday admissions; or (b) if twenty-four (24) hour notification would require notification on a weekend or federal holiday.

## **Concurrent review: clinical information**

- You must cooperate with all requests for information, documents or discussions from UnitedHealthcare for purposes of concurrent review and discharge planning including, but not limited to, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).
- You must return/respond to inquiries from the inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within four (4) hours if request is received before 1:00 p.m. local time, or make best efforts to provide within the same business day if request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).
- UnitedHealthcare uses Milliman® Care Guidelines®, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. A copy of the clinical criteria may be obtained upon request.

## **Provide access to your facility**

In support of UnitedHealthcare's clinical and quality initiatives, including Healthcare Effectiveness Data and Information Set (HEDIS) notification and concurrent review activities, you will provide us access to: (1) your facilities, including the emergency room; (2) our members and their medical records; and (3) your hospital and medical staff for purposes of obtaining necessary clinical information regarding our member's condition or treatment plan. In addition, you will participate in discharge planning activities. This Protocol also applies when providing continued care to our members following termination of your agreement.

## Advance Notification List

The following list does not indicate or imply coverage. Coverage is determined in accordance with the member's benefit plan.

Notification Requirements for Physician Services*	
Procedures and Services	Explanation
<b>Bariatric Surgery</b> (Does not apply to Erickson Advantage members)	<p>Bariatric Surgery and specific obesity-related services (as defined by the ICD-9-CM and CPT codes below, or their successor codes) whether scheduled as inpatient or outpatient.</p> <p><b>ICD-9-CM (or its successor)</b> 44.31, 44.38, 44.39, 44.68, 44.95, 44.96, 44.98</p> <p>CPT 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999</p> <p><b>As a reminder, bariatric surgery and other obesity services are not covered in some benefit plans.</b> In some situations, there is a Center of Excellence (COE) requirement for coverage of bariatric surgery/services.</p> <p>Medicare coverage is based on the guidelines outlined by the Centers for Medicare and Medicaid Services (CMS). For additional information, consult the CMS National Coverage Determination Database.</p>
<b>BRCA Genetic Testing Program</b> (Does not apply to Medicare Advantage members)	<p>BRCA 1 and BRCA 2 (Breast Cancer Susceptibility) are genetic tests performing DNA sequencing to look for known gene mutations that are associated with the development of breast and ovarian cancer.</p> <p>BRCA testing requires an advance notification prior to performing the DNA sequencing.</p> <p><b>HCPCS:</b> S3818-S3820; S3822-S3823</p> <p>Genetic Counseling is a service that members may elect to receive if they would like a board-certified genetic counselor to explain the BRCA testing, and help them make decisions about the clinical indications for such testing. Once we receive notification for BRCA testing from the provider, members will receive a letter outlining the available genetic counseling service, and how to access that service if they wish. <b>As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans.</b></p> <p>Please note: Medicare coverage for genetic testing is based on the guidelines outlined by the Centers for Medicare and Medicaid Services (CMS). For additional information, consult the CMS National Coverage Determination Database.</p> <p>For services listed in this section, fax to (866) 756-9733.</p>
<b>Cancer Treatment Initiation</b> (For Commercial members only)	<p>Initiation of Cancer Treatment for a diagnosis other than skin cancer or cervical cancer. Notification is requested to assist UnitedHealthcare in identifying members that may be eligible for additional UnitedHealthcare programs and services.</p> <p>For services listed in this section, call OptumHealth directly at (866) 936-6002.</p>
<b>Congenital Heart Disease</b>	<p>Congenital Heart Disease-related services, including the following codes:</p> <p>ICD-9-CM (or its successor) 745.0 through 747.81</p> <p>CPT 33250-33252, 33254-33259, 33261, 33404, 33414-33417, 33476-33478, 33500-33506, 33600-33619, 33641-33647, 33660, 33665, 33670, 33675-33688, 33690-33697, 33702-33853, 33917, 33920-33922, 33924, 33945 and 93580-93581</p> <p>For services listed in this section, call OptumHealth directly at (888) 936-7246 or the number on the back of the health care ID card.</p>

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for Congenital Heart Disease without CPT code, Cancer Treatment Initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

This notification list may change from time to time. If there is such a change, we will provide you with information about the change before it takes effect.

This list does not indicate or imply coverage for benefits. Coverage decisions are determined by the member's benefit plan and the physician/provider participation agreement. If you have questions about a member's coverage, visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or call the United Voice Portal at (877) 842-3210.

<b>Notification Requirements for Physician Services*</b>	
<b>Procedures and Services</b>	<b>Explanation</b>
<b>Intensity Modulated Radiation Therapy (IMRT)</b> (For Commercial members only)	UnitedHealthcare requires advance notification for the following IMRT codes: 77301 – Intensity modulated radiotherapy plan 77418 - Intensity modulated treatment delivery, single or multiple fields / arcs, per treatment session 0073T – Compensator-based beam modulation treatment delivery  Fax the completed UnitedHealthcare IMRT Data Collect form and all supporting information to (866) 756-9733. The UnitedHealthcare IMRT Data Collection form can be found at UnitedHealthcareOnline.com.
<b>MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroids</b>	MR-guided focused ultrasound procedures and treatments, as defined by but not limited to the CPT codes listed below. 0071T and 0072T  MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those plans:  The physician and/or facility must confirm coverage of the service for the member. The hospital and or/facility must be contracted with UnitedHealthcare. UnitedHealthcare enrollees have no out-of-network benefits for MRgFUS.  The enrollee must consent in writing to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective. The enrollee must agree in writing to hold UnitedHealthcare harmless if the enrollee is dissatisfied with the results of treatment. The consent form can be found at: UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Medical & Drug Policies and Coverage Determination Guidelines.  The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare.  The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.
<b>Orthopaedic and Spine Surgeries</b>	Inpatient admissions for spinal surgeries, total knee replacements and total hip replacements.
<b>Part B Occupational Therapy, Speech Therapy or Physical Therapy</b> (For Medicare Advantage members only)	Part B occupational therapy, speech therapy or physical therapy provided in a skilled nursing facility.
<b>Pregnancy, Healthy Pregnancy Notification</b> (Does not apply to Erickson Advantage members)	Upon confirmation of pregnancy, a notification is required by physicians or other health care professionals who provide obstetrical care to a pregnant member for: ICD-9-CM (or its successor) V72.42 or any other diagnosis code related to pregnancy. Notification is required only once per pregnancy. Notification is not required for ancillary services such as ultrasound and lab work. If, after you have notified us of a pregnancy, you obtain information that would cause you to conclude that the member is no longer appropriate for a Healthy Pregnancy Program, e.g., termination of pregnancy, we ask that you notify us of that fact.

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for Congenital Heart Disease without CPT code, Cancer Treatment Initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

This notification list may change from time to time. If there is such a change, we will provide you with information about the change before it takes effect.

This list does not indicate or imply coverage for benefits. Coverage decisions are determined by the member's benefit plan and the physician/provider participation agreement. If you have questions about a member's coverage, visit UnitedHealthcareOnline.com or call the United Voice Portal at (877) 842-3210.

<b>Notification Requirements for Physician Services*</b>	
<b>Procedures and Services</b>	<b>Explanation</b>
<b>Radiology</b> (For Commercial members only)	<p>For Commercial programs, UnitedHealthcare requires prior notification for the following defined set of outpatient imaging procedures: CT, MRI, MRA, PET, Nuclear Medicine, and Nuclear Cardiology. The Physician/Health Care Professional ordering the imaging service is responsible for obtaining a notification number prior to scheduling the outpatient imaging procedures. Ordering Physicians/Health Care Professionals can obtain the required notification number by contacting UnitedHealthcare through any of the following:</p> <p>Online: UnitedHealthcareOnline.com → Notifications → Radiology Notification Submission and Status</p> <p>Phone: (866) 889-8054 (Direct Line), or using the United Voice Portal line at (877) 842-3210 and selecting the Radiology Option</p> <p>Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline.com → Notifications → Radiology Notification Submission and Status)</p> <p>Additional details regarding this notification requirement, including a list of the CPT codes for which notification is required are available online at: UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification, and in the Outpatient Radiology Notification section of this Guide.</p>
<b>Reconstructive/Potentially Cosmetic Procedures</b>	<p>Cosmetic Procedures are procedures or services that change or improve physical appearance, without significantly improving or restoring physiological function, as determined by us.</p> <p>Reconstructive Procedures are procedures or services that either treat a medical condition or improve or restore physiologic function.</p> <p>To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Ablation, Ligation, Vein Stripping – removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins</li> <li>• Blepharoplasty, upper lid – reconstructive procedures including repair of brow ptosis, includes Canthoplasty and unlisted procedure, eyelids</li> <li>• Breast Reconstruction – reconstruction of the breast other than following mastectomy</li> <li>• Breast Reduction – removal of breast tissue in men or women other than mastectomy for cancer</li> <li>• Cranial remolding helmet – for treatment of congenital musculoskeletal deformities</li> <li>• Genioplasty - sliding, augmentation with interpositional bone grafts</li> <li>• Mastectomy for gynecomastia</li> <li>• Orthognathic Surgery – treatment of maxillofacial functional impairment</li> <li>• Palatopharyngoplasty – oral pharyngeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup)</li> <li>• Panniculectomy or Abdominoplasty– Excision, excessive skin and subcutaneous tissue (includes lipectomy)</li> <li>• Septoplasty – treatment of nasal functional impairment and septal deviation</li> <li>• Thoracoscopy – sympathectomy for treatment of hyperhidrosis</li> </ul>

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for Congenital Heart Disease without CPT code, Cancer Treatment Initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

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<b>Notification Requirements for Physician Services*</b>	
<b>Procedures and Services</b>	<b>Explanation</b>
<b>Referral for Non-Network Services</b> (Does not apply to Erickson Advantage members)	Please note that your agreement with UnitedHealthcare may include restrictions on directing members outside the UnitedHealthcare network. Your patients who utilize non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses. Notification is required when a network physician or health care professional directs a member to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a member's benefit plan has benefits for out-of-network services.
<b>Transplant Services</b> For services listed in this section, call OptumHealth directly at (888) 936-7246 or the notification number on the back of the health care ID card.	Request for transplant or transplant-related services prior to pre-treatment or evaluation, including the following CPT Procedure Codes for Specifically Requested Transplantations: <b>BONE MARROW - Peripheral Stem Cell</b> 38230 Bone marrow harvesting for transplantation 38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic 38241 Bone marrow or blood-derived peripheral stem cell transplantation; autologous 38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions <b>HEART / LUNG</b> 33930 Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft 33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy <b>HEART</b> 33940 Donor cardiectomy, with preparation and maintenance of allograft 33945 Heart transplant, with or without recipient cardiectomy 0051T Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy 0052T Replacement or repair of thoracic unit of a total replacement heart system (artificial heart) 0053T Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for Congenital Heart Disease without CPT code, Cancer Treatment Initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

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<b>Notification Requirements for Physician Services*</b>	
<b>Procedures and Services</b>	<b>Explanation</b>
<b>Transplant Services</b> (Continued)	<b>LUNG</b>
	32850 Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)
	32851 Lung transplant, single; without cardiopulmonary bypass
	32852 with cardiopulmonary bypass
	32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
	32854 with cardiopulmonary bypass
	<b>KIDNEY</b>
	50300 Donor nephrectomy, with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral
	50320 Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)
	50340 Recipient nephrectomy
	50360 Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
	50365 with recipient nephrectomy
	50370 Removal of transplanted renal allograft
	50380 Renal autotransplantation, reimplantation of kidney
	50547 Laparoscopic donor nephrectomy from living donor (excluding preparation and maintenance of allograft)
	<b>PANCREAS</b>
	48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
	48550 Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation
	48554 Transplantation of pancreatic allograft
	48556 Removal of transplanted pancreatic allograft
	<b>LIVER</b>
	47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
	47136 heterotopic, partial or whole, from cadaver or living donor, any age
	<b>INTESTINE</b>
	44132 Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor
	44133 partial, from living donor
	44135 Intestinal allotransplantation; from cadaver donor
	44136 from living donor

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<b>Ancillary Provider and Other Health Care Professional notification requirements</b>	
<b>Procedures and Services</b>	<b>Explanation</b>
<b>Accidental Dental Services</b> (Does not apply to Erickson Advantage members)	Dental services that meet the following criteria may be eligible for medical coverage depending on the member's benefit contract: <ul style="list-style-type: none"> <li>• Date of initial contact for dental evaluation is within plan limits following the accident.</li> <li>• Initiation of definitive treatment services within guidelines.</li> <li>• Estimated completion date of treatment services is known.</li> <li>• Certification that the injured tooth was a sound natural tooth.</li> </ul> This does not apply to dental services that are excluded under the member's benefit plan. Dental implants are not covered under most plans.
<b>Ambulance Transportation</b> (Non-Urgent)	Non-urgent ambulance transportation between specified locations for members who cannot travel by other forms of transportation.
<b>Durable Medical Equipment</b> (DME) Greater than \$1,000	In general, we require notification for DME with a retail purchase cost or a cumulative retail rental cost over \$1,000. Prosthetics are not DME (see separate Prosthetics and Orthotics notification requirement). Some payer groups may have different DME notification requirements imposed upon members through their benefit plans. For further information, please call Member Care at the number on the back of the member's health care ID card.
<b>End Stage Renal Disease/ Dialysis Services</b> (Does not apply to Erickson Advantage members)	Services for the treatment of End Stage Renal Disease (ESRD), including outpatient dialysis services (as defined by, but not limited to, the revenue and CPT codes below), require notification. No notification is required for end stage renal disease when a Medicare member travels outside of the service area. Dialysis: 90935, 90937, 4052F, 4054F – hemodialysis 90945, 90947, 4055F – peritoneal 90963 – 90970 – ESRD 90989 – patient training, completed course 90993 – patient training, per session 90999 – unlisted dialysis procedure, inpatient or outpatient Revenue Codes: 304 – Nonroutine Dialysis 800 – 804, 809 – Renal Dialysis 820 – 825, 829 – Hemo/op or home 830 – 835, 839 – Other outpatient/peritoneal dialysis 840 – 845, 849 – Capd/op or home 850 – 855, 859 – Ccpd/op or home 880 – 882, 889 – Dialysis / misc For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to our online provider directory at <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> or call us at (877) 842-3210. In an effort to maximize member benefit coverage and lifetime maximum limits, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible. Note that your agreement with us may include restrictions on referring members outside the UnitedHealthcare network.
<b>Home Health Care Services</b> (Does not apply to Erickson Advantage members)	All services which are based in the home including, but not limited to, Enteral Formula, Home Infusion Therapy, Home Health Aid (HHA), Occupational Therapy (OT), Physical Therapy (PT), Private Duty Nursing (T1000), Respiratory Therapy (RT), Skilled Nursing (SNV), Social Worker (MSW) and Speech Therapy (ST).
<b>Hospice</b>	Inpatient Hospice services only.

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## Ancillary Provider and Other Health Care Professional notification requirements

Procedures and Services	Explanation
<b>Prosthetic and Orthotic Services Greater than \$1,000</b> (Applies to Medicare Advantage members only)	Prosthetic and orthotic services with a retail purchase cost or cumulative retail rental cost exceeding \$1,000.

## Other notification requirements

Procedures and Services	Explanation
<b>Specific Medications as Indicated on the PDL</b> (Applies to Commercial members only)	Call (877) 842-1435 when prescribing medications that require notification. These medications are so designated on the Prescription Drug List (PDL). To view the Prescription Drug List (PDL), visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> → Tools & Resources → Pharmacy Resources, or call (877) 842-1508 to request a copy of our PDL.
<b>Behavioral Health Services</b> (Does not apply to Erickson Advantage members)	Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network. Therefore, it is important for you to call the number on the member's health care ID card when referring for any mental health or substance abuse services.
<b>Chiropractic Services</b> (Does not apply to Erickson Advantage members)	Many of our benefit plans only provide coverage for chiropractic services through a designated arrangement subject to a benefit review. Therefore, it is important for you to call the number on the member's health care ID card when referring for any chiropractic services.
<b>Physical Therapy/ Occupational Therapy (PT/OT)</b> (Does not apply to Erickson Advantage members)	Many of our benefit plans only provide coverage for PT/OT through a designated arrangement subject to a benefit review. Therefore, it is important for you to call the number on the member's health care ID card when referring for any PT/OT services.

## Arizona - Additional Notification Requirements for Physician Services, Ancillary Provider and other Health Care Professional Services Rendered in Arizona

<b>Capsule Endoscopy</b> (Does not apply to Medicare Advantage members)	Non-invasive procedure in which an ingested capsule containing a miniature video camera takes a video recording of the mucosal lining of the esophagus or small bowel as it moves through the gastrointestinal tract.
<b>Cochlear Implants</b> (Does not apply to Medicare Advantage members)	Surgically-placed devices used to improve sound recognition.
<b>Hyperbaric Oxygen Treatment</b> (Does not apply to Medicare Advantage members)	Non-emergent hyperbaric oxygen treatments require advanced notification and benefit review.
<b>Joint Replacement</b> (Does not apply to Medicare Advantage members)	Joint replacement procedures in addition to total hip and knee.
<b>Sleep Apnea Procedures and Surgeries</b> (Does not apply to Medicare Advantage members)	Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea.
<b>Outpatient Spine Surgeries</b> (Does not apply to Medicare Advantage members)	Outpatient Spinal Surgeries (in addition to Inpatient Spinal Surgeries).

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## **Outpatient Radiology Notification (for Commerical Members only)**

The outpatient radiology notification requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers (“Physicians/Providers”) for Advanced Outpatient Imaging Procedures.

This Protocol is a prior notification requirement, and we do not consider the Protocol to be a precertification, preauthorization or medical necessity determination. Notification under this Protocol is required for outpatient services only. Imaging services ordered during emergency room visits, in the observation unit or during an inpatient stay do not require notification.

- Compliance with this Protocol is required. Incomplete notification and/or non-notification rates will be tracked through physician data sharing reports.
  - Without completion of the entire notification process described below, a notification number will not be issued. If the imaging study requested for a member is performed and the claim is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur.
  - This Protocol is effective on the date noted in your notification letter.

### **Ordering Physician/Provider**

- The Physician/Provider ordering the imaging service is responsible for obtaining a notification number prior to scheduling Advanced Outpatient Imaging Procedures. The process required by this Protocol for ordering Physicians/Providers is as follows:
  - Obtain the required notification number by contacting us via:
    - Online: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Notifications → Radiology Notification Submission & Status
    - Fax: (866) 889-8061
    - Phone: (866) 889-8054

The information listed below may be requested at the time of the notification request.

#### *Member/procedure information*

- Member’s/enrollee’s name and member’s/enrollee’s UnitedHealthcare ID number
- Member’s/enrollee’s address and telephone number
- Member’s/enrollee’s group number
- Member’s/enrollee’s date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The primary diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s)

#### *Physician/Provider information*

- Ordering Physician’s or health care professional’s name, TIN/NPI, specialty, address, and telephone number
- Physician/Provider to whom the member is being referred, if specified, and the address
- Rendering physician’s or health care professional name and TIN/NPI

#### *Clinical information*

- The member’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Physician/Provider believes would be useful in evaluating whether the service ordered meets current evidence-based guidelines, such as prior diagnostic tests and consultation reports.
  - If the requested imaging study is consistent with evidence-based clinical guidelines, a notification number will be communicated to the ordering Physician/Provider at the time of the request.

OR

- If the imaging study requested for the member is not consistent with evidence-based clinical guidelines, or if further information is needed to assess the request, the ordering Physician/Provider participates in a physician-to-physician discussion to understand the request, provide additional clinical information and to consider alternative approaches. Upon completion of the discussion, the ordering Physician/Provider will confirm the procedure ordered and a notification number will be issued. The ordering physician maintains final decision authority.

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on clinical guidelines. This discussion is not a preauthorization, precertification or medical necessity determination.

- Notification numbers will be communicated to the ordering Physician/Provider when the notification process is completed. They will be communicated by telephone, fax and/or online, consistent with how the request was initiated. To help promote proper payment, this number should be communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to perform the Advanced Outpatient Imaging Procedures. Please note that the receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was made. Medical coverage/payment authorization is a separate process determined by the member's benefit contract and your agreement with us.

### **Urgent requests**

- Physician/Provider may request a notification number on an urgent basis if the Physician/Provider determines it to be medically required. A notification number will be issued for urgent requests within three (3) hours of UnitedHealthcare receiving all required information. If the Physician/Provider determines that care must be provided before a notification number can be issued on an urgent basis, the services should be performed and the notification requested retrospectively following the Retrospective Notification process described below.

### **Retrospective notification**

- If an Advanced Outpatient Imaging Procedure is required on an urgent basis, or notification cannot be obtained because it is outside of UnitedHealthcare's normal business hours, the service may be performed and notification can be requested retrospectively.
- Retrospective notification requests must be made within two (2) business days of the service.
- Ordering Physicians/Providers should follow the same notification process outlined above for a standard request.
- Documentation must include an explanation as to why the procedure was required on an urgent basis or why notification could not be obtained during UnitedHealthcare's normal business hours.

### **Rendering Physician/Provider**

To receive payment for services rendered, prior to performing the stated Advanced Outpatient Imaging Procedures, the rendering Physician/Provider must validate with us that a notification is on file by contacting us as follows:

- Online: [UnitedHealthcareOnline.com](https://UnitedHealthcareOnline.com) → Notifications → Radiology Notification Submission & Status
- Phone: (866) 889-8054 (select prompt 2 to check status of a notification request)

If the rendering Physician/Provider determines there is no notification on file, the rendering Physician/Provider may contact UnitedHealthcare to obtain notification via the channels noted above. UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to obtain the notification from the ordering Physician/Provider prior to the rendering of services.

### **Provision of additional advanced outpatient imaging procedures**

If, during the provision of an Advanced Outpatient Imaging Procedure, the rendering Physician/Provider determines that additional services should be delivered above and beyond the service(s) for which notification has been obtained, the rendering Physician/Provider should render those service(s) and obtain retrospective notification following the Retrospective Notification process described above.

## **If the ordering physician is non-participating**

The rendering Physician/Provider may call (866) 889-8054 and select option 5 to speak with a Customer Care professional. The Customer Care professional will assist with obtaining a notification number on behalf of the non-participating ordering physician.

### **Products included**

Commercial benefit plans issued and administered by UnitedHealthcare or one of its affiliates, which are subject to this Guide, and for which the physician is required to provide prior notification, are subject to the Radiology Notification Program. In-scope products include such products as Choice, Choice Plus, Definity<sup>SM</sup> HRA/HSA, Select and Select Plus.

### **Products/members excluded**

Benefit plans issued or administered by Oxford Health Plans, LLC; Oxford Health Insurance, by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC, MD-Individual Practice Association, Inc. (M.D. IPA), Optimum Choice, Inc. (Optimum Choice), MAMSI Life and Health Insurance Company (MLH), Neighborhood Health Partnership, UnitedHealthcare Services Company of the River Valley, Inc.\*, UnitedHealthcare Plan of the River Valley\*, Inc. or UnitedHealthcare Insurance Company of the River Valley\*, which are subject to the administrative guide or manual of that affiliate, are excluded. Also excluded are governmental benefit plans for Medicare and Medicaid members, and benefit plans for which the member (rather than the physician) is required to provide notification, such as Options PPO and UnitedHealthcare Indemnity.

These excluded benefit plans may have separate Radiology notification or pre-authorization requirements.

Refer to UnitedHealthcareOnline.com for the most current listing of CPT codes that require notification.

*\*Except Medicare Advantage benefit plans are subject to this notification requirement.*

# Compensation

## Additional fees for covered services

You may not charge our members fees for covered services beyond copayments, coinsurance or deductible as described in their benefit plans. You may not charge our members retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies. This does not prevent you from charging our Commercial members nominal fees for missed appointments or completion of camp/school forms. Please note, however, that for Medicare Advantage members, CMS does not allow the provider to charge for “missed appointments” unless the provider has previously disclosed that policy to the member.

## Charging members for non-covered services

For Commercial members, you may seek and collect payment from our member for services not covered under the applicable benefit plan, provided you first obtain the member’s written consent. Such consent must be signed and dated by the member prior to rendering the specific service(s) in question. Retain a copy of this consent in the member’s medical record. In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must: (a) include an estimate of the charges for that service; (b) include a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, include a statement that UnitedHealthcare has determined that the service is not covered and that the member, with knowledge of UnitedHealthcare’s determination, agrees to be responsible for those charges.

For Medicare Advantage members, a Notice of Denial of Medical Coverage must be provided to the member advising them when a service is not covered.

You should know or have reason to know that a service may not be covered if:

- We have provided general notice through an article in a newsletter or bulletin, or information provided on our Web site (UnitedHealthcareOnline.com), including clinical protocols, medical and drug policies, either that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the member; or
- We have made a determination that planned services are not covered services and have communicated that determination to you on this or a previous occasion.

You must not bill our member for non-covered services if you do not comply with this Protocol.

If you do not obtain written consent as specified above, the rendering provider must accept full financial liability for the cost of care. General agreements to pay, such as those signed by the member at any time (including at admission or upon the initial office visit), are not considered written consent under this Protocol.

## Financial incentives

UnitedHealthcare notifies our members that the treatment decisions are made between physicians and members, and coverage decisions on health care services are based on the member’s benefit contract.

- Coverage decisions are made based on the existence of coverage as defined within the member’s benefit contract.
- The staff of UnitedHealthcare, its delegates, and the physicians and other health care professionals making these decisions are not rewarded for issuing non-coverage decisions.
- UnitedHealthcare and its delegates do not offer incentives to physicians or other health care professionals to encourage underutilization of care or services.

## Medicare Advantage risk adjustment data

The risk adjustment data you submit to UnitedHealthcare must be accurate and complete.

- Remember that risk adjustment is based on ICD-9-CM (or its successor) diagnosis codes, not CPT codes. Therefore, it is critical for your office to refer to an ICD-9-CM (or its successor) coding manual and code accurately, specifically and completely when submitting claims to UnitedHealthcare.
- Diagnosis codes must be supported by the medical record. If it is not documented in the medical record, then UnitedHealthcare will not recognize it as occurring. Therefore, medical records must be clear and complete.
- Never use a diagnosis code for a “probable” or “questionable” diagnosis. Instead, code only to the highest degree of certainty.
- Be sure to distinguish between acute vs. chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member’s condition and pertinent history at the time of the visit.
- Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5-digit code more accurately describes the member’s condition.
- Be sure that the diagnosis code is appropriate for the member’s gender.

## Reimbursement policies

UnitedHealthcare reimbursement policies are available online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools and Resources → Policies and Protocols. Reimbursement policies may be referred to in your agreement with UnitedHealthcare as “payment policies.”

## Receiving reimbursement

UnitedHealthcare contracts generally contain the requirement to conduct business with us electronically.

UnitedHealthcare has made Electronic Payments and Statements (EPS) the preferred method for issuing claim payments and Explanation of Benefits (EOBs). To learn about EPS and how to enroll, go to [WelcometoEPS.com](http://WelcometoEPS.com).

# Quality Management

## Health management program information: Case and Disease Management programs

Our approach to Case and Disease Management goes beyond traditional medical coverage and preventive services. We use integrated systems and proprietary software for Case and Disease Management that allows us to identify, stratify, assess, and intervene in order to identify gaps in care, and educate and coordinate access to services. Using medical, pharmacy and behavioral health claims data, our proprietary predictive model system helps us to identify people who are at high risk and direct them to our programs for outreach to facilitate the management of their care. Individuals can also be identified at time of hospital discharge, using results from our Health Risk Assessment, referred from our Nurse Triage line, through self-referral and through direct referrals by physicians or other practitioners.

Our outbound call programs assess members with high-risk conditions for gaps in care. We then apply structured interventions to facilitate access to care. Our programs are built using evidence-based guidelines. At the core of these programs are health education and a focus on self-care and medication management. We give our members easy access to information and resources that focus on education, prevention and reminders. The programs also include medical director peer-to-peer conversations to alert practitioners to gaps in care, discuss best practices and encourage the use of evidence-based medicine in the treatment of the member.

We manage over twenty-three (23) high-risk conditions in our Case and Disease Management programs, where appropriate members can be referred to our transplant, kidney, cancer, neonatology and maternity resource services programs and engage with clinical specialists in these complex areas. In addition to the medical support we provide, we also screen for depression so that those with behavioral health needs are directed to the appropriate behavioral health resource. For support with lifestyle-oriented risks, we actively refer members to our online self-directed behavior modification programs for weight management, nutrition, smoking cessation, exercise, diabetes care, stress management and others. Physicians may refer members to any of the Case Management or Disease Management programs by calling the physician toll-free service number (877) 842-3210, then selecting the care notification prompt to speak with a representative to initiate a referral to the appropriate program. The member will be assessed to determine the appropriate level of intervention.

Members with chronic diseases who are at high-risk can benefit from the following programs.

## High-Risk Case Management

At the core of High-Risk Case Management is the philosophy of identifying at-risk members with complex, high-cost conditions who can benefit from case management services. We partner with members and their physicians or other health care professionals to facilitate health care access and decisions that can have a dramatic impact on the quality and affordability of their health care. Specifically, our programs are designed to assist members to:

- Receive evidenced-based care
- Have necessary self-care skills
- Have the right equipment and supplies to perform self-care
- Have requisite access to health care delivery system
- Be compliant with medications

Our case managers are registered nurses who engage the appropriate resources needed to address the health care needs, whether the resources are internal, external or community-based. When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, behavioral health, employee assistance and disability.

Case managers engage the member's physician, whether primary care or specialist, to help our members receive the right care, and the right medication, at the right time. Our medical directors are engaged in the process of case review and support the provision of evidence-based care. Our case managers utilize community-based resources to

meet the needs of members such as home health care agencies, equipment vendors, schools, churches or referrals to financial resources.

Depending on a member's needs, member engagement in the High-Risk Case Management program can range from a few weeks to an indefinite period of time.

## **Disease Management programs**

UnitedHealthcare offers population-based longitudinal Disease Management programs that are designed to use multiple sources of information, including, but not limited to, the Ingenix predictive model to identify and stratify members with these conditions into the appropriate level of intervention. The programs are voluntary and at no cost to the participant. Physicians are notified when their patients participate in the high-risk program, and members participating in the moderate intensity program are provided with a letter to give to their physician about their participation.

The Disease Management programs use evidence-based medicine to identify gaps in care and prevent avoidable admissions or slow the progression of the chronic condition. The outbound call program provides a series of structured calls as needed to address a member's particular gaps in care. The focus is on providing education about self-management, medication management, access to care and coordination of appropriate tests and physician visits. The participant may also call a Disease Management nurse at any time during normal business hours. Programs offered may include:

- Coronary Artery Disease
- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

The goal of the Disease Management programs is to assist members in managing their condition. Each program aims to deliver optimal clinical and financial outcomes by targeting the areas with the greatest potential for impact: the right health care provider, the right medications, the right care and the right lifestyle.

Our programs provide information and resources that members need to understand their condition and its implications, how to reduce risk factors, maintain a healthy lifestyle, adhere to physician treatment plans and medication regimens, effectively manage their condition and co-morbidities including depression, and receive the most clinically appropriate, cost-effective and timely diagnostic testing.

For some programs, members may receive comprehensive assessments by specialty-trained registered nurses to determine the appropriate level and frequency of interventions required. For many of our programs members also receive educational mailings, newsletters and tools such as the HealthLog to assist them in tracking their physician visits, health status and recommended targets or other screenings. For members in employer-based plans, Disease Management programs available to members may vary.

## **Clinical performance assessment**

The UnitedHealth Premium<sup>®</sup> physician designation program uses clinical practice information to assist physicians in their continuous practice improvement and to assist consumers in making more informed and personally appropriate choices for their medical care. The program uses national industry, evidence-based and medical society standards with a transparent methodology and robust data sources to evaluate physicians across twenty (20) specialties to advance safe, timely, effective, efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific standards for quality and local cost efficiency benchmarks.

In general, the evaluation of physicians for quality of care compares observed practice to expected practice, using measurements based on published scientific evidence and national standards applied to administrative data. The evaluation of physicians for cost efficiency compares observed cost for episodes of care to expected cost for episodes of care, with adjustments for the patient's severity of illness and the physician's case mix.

UnitedHealthcare strongly supports transparency in its performance assessment criteria and methods. The criteria supporting our clinical performance assessment programs may be viewed at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), or you may request a copy by contacting UnitedHealth Premium program advisors at (866) 270-5588. For more information regarding the UnitedHealth Premium physician designation program, go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinician Resources → UnitedHealth Premium, or call our toll-free number at (866) 270-5588. Please note the UnitedHealth Premium physician designation program does not apply to Medicare Advantage benefit plans.

## Cancer status forms

UnitedHealthcare is collecting patient-specific clinical data from oncology/hematology providers on members with breast, colon, lung, prostate or rectal cancers as well as lymphomas, as part of a new Cancer Status Collection initiative.

The clinical data will be collected every six (6) months for these cancer patients who are UnitedHealthcare members. This data will allow us to combine patients into clinically similar groups - a sorting task we cannot do using only claims data. By combining patients into clinically similar groups, we can assess treatment approaches and make comparisons between like cases. We will then use these clinically similar groups to identify gaps in care. In the future, we will be sharing our aggregate results with participating oncology/hematology providers. Participating providers with sufficient volume will be able to receive results for UnitedHealthcare members in their practices.

Forms will be faxed directly to your office to request data. For more information regarding this program, go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinician Resources → Cancer – Oncology → Cancer Status Forms or send an email to [unitedoncology@uhc.com](mailto:unitedoncology@uhc.com).

## Clinical guidelines

UnitedHealthcare utilizes evidence-based clinical guidelines to develop our quality and health management programs. The following chart lists the clinical guidelines and the Web sites where the most current version of the guideline can be found.

Topic	Name of guideline	Web address
<b>Acute MI</b>	ACC/AHA Guideline for the Management of Patients with ST Elevation Myocardial Infarction	American College of Cardiology/American Heart Association <a href="http://acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm">acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm</a>
	2007 Focused Update	American College of Cardiology/American Heart Association <a href="http://content.onlinejacc.org/cgi/content/full/jacc.2007.10.001">content.onlinejacc.org/cgi/content/full/jacc.2007.10.001</a>
	ACC/AHA 2007 Guideline for the Management of Patients with Unstable Angina and Non-ST Elevation Myocardial Infarction	American College of Cardiology/American Heart Association <a href="http://content.onlinejacc.org/cgi/content/full/50/7/e1">content.onlinejacc.org/cgi/content/full/50/7/e1</a>
<b>Asthma</b>	National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma	National Heart, Lung and Blood Institute <a href="http://nhlbi.nih.gov/guidelines/asthma/index.htm">nhlbi.nih.gov/guidelines/asthma/index.htm</a>
<b>Attention Deficit Hyperactivity Disorder (ADHD)</b>	Practice Parameter for the Assessment and Treatment of Children, Adolescents and Adults with Attention Deficit Hyperactivity Disorder	American Academy of Child and Adolescent Psychiatry <a href="http://aacap.org/galleries/practiceparameters/JAACAP_ADAH_2007">aacap.org/galleries/practiceparameters/JAACAP_ADAH_2007</a>
<b>Bipolar Disorder – Adults</b>	Treatment of Patients With Bipolar Disorder, Second Edition	American Psychiatric Association <a href="http://psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx">psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx</a>

<b>Topic</b>	<b>Name of guideline</b>	<b>Web address</b>
<b>Bipolar Disorder – Children &amp; Adolescents</b>	Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder	American Academy of Child and Adolescent Psychiatry aacap.org/page.wv?section=Practice+Parameters&name=Practice+Parameters
<b>Cardio-vascular Disease</b>	AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2006 Update	American College of Cardiology/American Heart Association content.onlinejacc.org/cgi/content/full/47/10/2130
<b>Cardio-vascular Disease - Women</b>	Evidenced-based Guidelines for Cardiovascular Disease Prevention in Women; 2007 update	American College of Cardiology/American Health Association acc.org/qualityandscience/clinical/pdfs/cvdinwomen.pdf
<b>Cholesterol Management</b>	The Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)	National Heart, Lung and Blood Institute nhlbi.nih.gov/guidelines/cholesterol/index.htm
<b>Chronic Heart Failure</b>	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult	American College of Cardiology content.onlinejacc.org/cgi/reprint/j.jacc.2008.11.013v1.pdf
<b>Chronic Obstructive Pulmonary Disease</b>	Global Initiative for Chronic Obstructive Lung Disease	goldcopd.com
<b>Chronic Stable Angina</b>	2007 Chronic Angina Focused Update of the ACC/AHA 2002 Guidelines for the Management of Patients with Chronic Stable Angina	American College of Cardiology/American Heart Association content.onlinejacc.org/cgi/content/full/j.jacc.2007.08.002
<b>Depression</b>	Treatment of Patients with Major Depressive Disorder (Second Edition)	American Psychiatric Association psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx
<b>Diabetes</b>	Standards of Medical Care for Patients with Diabetes 2009	American Diabetes Association care.diabetesjournals.org/content/vol32/Supplement_1
<b>Hemophilia and von Willebrand Disease</b>	Guidelines for the Management of Hemophilia National Heart Lung and Blood Institute - von Willebrand Disease	wfh.org/2/docs/Publications/Diagnosis_and_Treatment/Gudelines_Mng_Hemophilia.pdf nhlbi.nih.gov/guidelines/vwd/index.htm
<b>Human Immunodeficiency Virus Guideline</b>	A guide to care of patients with HIV/AIDS	Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America, 2004 guideline.gov/summary/summary.aspx?ss=15&doc_id=5625&nbr=3793  A Guide to Primary Care for People with HIV/AIDS, 2005. U.S Department of Health and Human Services, Health Resources and Service Administration. ftp://ftp.hrsa.gov/hab/PCARE04.pdf  Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents U.S. Department of Health and Human Services, January 29, 2008 aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf

Topic	Name of guideline	Web address
<b>Hyperbilirubinemia in the Newborn</b>	Management of Hyperbilirubinemia in the Newborn Infant 35 or more weeks in gestation	American Academy of Pediatrics aappolicy.aappublications.org/cgi/reprint/pediatrics;114/1/297.pdf Information for families can be accessed at <a href="http://aap.org/family/jaundicefaq.htm">aap.org/family/jaundicefaq.htm</a>
<b>Hypertension</b>	The Seventh Report on the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure	National Heart, Lung and Blood Institute <a href="http://nhlbi.nih.gov/guidelines/hypertension/index.htm">nhlbi.nih.gov/guidelines/hypertension/index.htm</a>
<b>Preventive Services Guidelines</b>	Guide to Clinical Preventive Services - US Preventive Services Task Force (USPSTF)	Agency for Health care Research and Quality <a href="http://ahcpr.gov/clinic/pocketgd08">ahcpr.gov/clinic/pocketgd08</a>
<b>Seizure Disorders (Epilepsy) with Antiepileptic Medications</b>	Multiple names now for use in initial diagnosis, recurring seizures, etc.	Multiple guidelines exist at <a href="https://aan.com/practice/guideline">https://aan.com/practice/guideline</a> And Initial monotherapy guideline at <a href="http://ilae-epilepsy.org/Visitors/Documents/Guidelines.pdf">ilae-epilepsy.org/Visitors/Documents/Guidelines.pdf</a>
<b>Schizophrenia Guideline</b>	Practice guideline for the treatment of patients with schizophrenia (Second Edition)	<a href="http://guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=5217&amp;nbr=3572">guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=5217&amp;nbr=3572</a>
<b>Spinal Stenosis</b>	Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care	North American Spine Society <a href="http://spine.org/Pages/PracticePolicy/ClinicalCare/ClinicalGuidelines/Default.aspx">spine.org/Pages/PracticePolicy/ClinicalCare/ClinicalGuidelines/Default.aspx</a>

If you do not have internet access and would like a copy of any of the guidelines, please call our National Clinical Excellence Manager at (954) 447-8818 or our Medicare National Manager of Accreditation and Clinical Quality at (866) 934-5717.

This information is provided to you for general reference and is not intended to address every aspect of a clinical situation that may exist now, or in the future. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it, when it is appropriate for eligible members.

## Important behavioral health information

*(References to United Behavioral Health also include our affiliates PacifiCare Behavioral Health and PacifiCare Behavioral Health California.)*

### Screening for depression

United Behavioral Health (UBH) is responsible for managing the behavioral health care benefits for most UnitedHealthcare members. UBH is committed to supporting primary care physicians in identifying and treating mental health disorders. The U.S. Preventive Services Task Force (USPSTF) recommends screening patients for depression in primary care. If left untreated, depression can adversely affect patient quality of life and clinical outcomes. For more information on depression, you and your patients may access the [liveandworkwell.com](http://liveandworkwell.com) Web site of UBH. To refer a patient to a participating UBH clinician for assessment and/or treatment, call UBH at the toll-free number on the back of the patient's health care ID card.

### Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

UBH has developed an online Preventive Health Program which offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse/dependence and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes: a dedicated section

for physicians and other health care professionals with articles addressing aspects of each condition; information about co-morbid conditions; links to nationally recognized practice guidelines from the American Psychiatric Association; a self-appraisal that you can print, use or refer your patients to; and a listing of support resources for you, your patients and their families. Physicians and other health care professionals may access the program via [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinician Resources → Patient Safety Resources → Behavioral Health or at [liveandworkwell.com/prevention](http://liveandworkwell.com/prevention).

## **The importance of collaboration between primary physicians and behavioral health clinicians**

A substantial number of patients who have serious illnesses also have behavioral health conditions. Approximately 20% of patients who have had a heart attack are likely to develop depression within twelve (12) months of the event; likewise greater than 20% of patients with diabetes also have depression.

It is important to determine if a behavioral health clinician is treating a patient with these and other illnesses. If so, it is helpful to coordinate care with the behavioral health clinician. Coordination of care takes on greater importance for enrollees with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when patients have been hospitalized for a medical or psychiatric condition.

Communication between clinicians can also maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions for patients being prescribed psychotropic medication. It can also help reduce the risk of relapse for patients with substance abuse disorders or psychiatric conditions.

Please discuss with your patients the benefits of sharing essential clinical information. We encourage you to obtain a signed release from each UnitedHealthcare patient that allows you to share appropriate treatment information with the patient's behavioral health clinician.

## **Psychiatric consults for medical patients**

Please contact UBH if you would like to arrange a psychiatric consultation for a patient in a medical bed, are unclear whether a consultation is warranted, or need assistance with any needed authorization. We can be reached by calling the telephone number on the back of the patient's medical ID card.

## **Cooperation with quality improvement activities**

All participating physicians and providers must cooperate with all quality improvement activities. These include, but are not limited to, the following:

- Timely provision of medical records upon request by UnitedHealthcare or its contracted business associates;
- Cooperation with quality of care investigations;
- Participation in quality audits, including site visits and medical record standards review, and annual Health care Effectiveness Data and Information Set (HEDIS) record review;
- If medical records are requested by UnitedHealthcare, provision of copies of such records free of charge during site visits or via mail, secure email, or secure fax.

## **Hospital audit services**

The agreement between UnitedHealthcare and the hospital establishes UnitedHealthcare's right to audit submitted claims. In order to assure that audits performed by UnitedHealthcare's Hospital Audit Services unit are conducted in a fair and reasonable manner, UnitedHealthcare utilizes appropriate nationally recognized billing or coding guidelines, such as those set forth by CMS Billing Guidelines, as stated in the Medicare Provider Reimbursement Manual, or the National Uniform Billing Commission, as the criteria for audit.

UnitedHealthcare may have other claim audit programs, and claim audits under such programs will be conducted in accordance with the provisions of such programs. Audits may occur on a pre-payment or post-payment basis,

depending on the circumstances and the terms of the agreement.

The following provisions, *Hospital Requirements and Access*, *Audit Findings & Exit Conference* and *Post Audit Procedures* are specific to the Standard Hospital Bill Audit, in accordance with the National Hospital Billing Audit Guidelines. UnitedHealthcare may conduct other audits, or make other records requests, in addition to Standard Hospital Bill Audits.

The scope of audit for UnitedHealthcare's Standard Hospital Bill Audit is to review the medical record to substantiate charges billed. As more fully described below, when, during the course of audit, a UnitedHealthcare Nurse Reviewer identifies a charge billed to UnitedHealthcare that appears to have been unbundled from the more general charge in which it is commonly included or that is not supported by the medical record, the UnitedHealthcare Nurse Reviewer is expected to report his/her findings to the hospital representative and disallow the charges. Written notification of disallowed charges will be provided at the conclusion of the audit. Post-audit claim reconsideration will reconcile any overpayments or underpayments identified as a result of the audit process, in accordance with applicable law and the agreement with us.

### **Hospital requirements and access**

- UnitedHealthcare's Hospital Audit Services Department will notify the hospital of the intent to audit a claim. This notification will be provided utilizing a Communication Form, and will be addressed to the hospital CFO, his/her designee or the hospital auditing representative.
- The hospital will provide one of the following:
  - A copy of the itemized bill to UnitedHealthcare's Hospital Audit Services Department within thirty (30) calendar days of the date requested.
  - A copy of the bill breakdown to UnitedHealthcare's Nurse Reviewer at the time of the audit. (The hospital will notify the UnitedHealthcare Hospital Audit Services Department within thirty (30) calendar days of notification of intent to audit if bill breakdown will be provided.)
- The hospital will cooperate in a timely manner, so the UnitedHealthcare Nurse Reviewer can complete the audit scheduling process within thirty (30) calendar days of the scheduling request.
- If there is a hospital requirement for a member release of medical information, it is the hospital's responsibility to obtain this release, or to waive the requirement if permitted by applicable law. Most standard hospital release forms, signed by the member at the time of admission, authorize release of UnitedHealthcare member information to UnitedHealthcare for purposes of claims review. Additionally, per HIPAA, protected health information may be disclosed to UnitedHealthcare for "...treatment, payment, or health care operations...".
- If there is a hospital-imposed fee to audit the medical record, or a copy fee, said fee will be waived unless specified in the hospital's network participation agreement.
- Standard Hospital Bill Audits will be conducted at the hospital in cooperation with the hospital representative.
- At the time of the audit, the hospital will provide the UnitedHealthcare Nurse Reviewer with access to the medical record, all applicable department charge sheets and, if requested, any applicable hospital policy and procedure.
- The hospital will give UnitedHealthcare's audit vendors the same level of access as UnitedHealthcare employee auditors, when those vendors are acting at the direction and on behalf of UnitedHealthcare. Any vendor authorized by UnitedHealthcare to conduct an audit on UnitedHealthcare's behalf will be bound by UnitedHealthcare's obligations under the agreement, including any confidentiality requirements regarding the hospital audit and HIPAA requirements with regard to protected health information.
- The hospital will not impose any time limitation on UnitedHealthcare's right or ability to audit, except to the extent such a limit is imposed by the agreement or by applicable state law.

## Audit findings and exit conference

- After completing the review, the UnitedHealthcare Nurse Reviewer will provide the facility representative with a copy of the findings of the review. This document will list all discrepancies noted during the course of the audit, including item, unit cost, number charged, number documented, discrepancy, overcharge, undercharge, unbilled charge or disallowed/unbundled charge. If the audit occurs at the hospital, a copy of the documented audit findings will be provided to the hospital at the time of the exit conference. If the audit occurs at a location other than the hospital, a copy of the findings will be supplied promptly.
- At the completion of each audit, the UnitedHealthcare Nurse Reviewer will participate in an exit conference with the hospital representative. The purpose of the exit conference is to notify the hospital of UnitedHealthcare's audit findings, including overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed. UnitedHealthcare's Nurse Reviewer will provide the hospital representative with a copy of the document findings.
- During this conference, the hospital representative will have the opportunity to present any conflicting audit findings. When additionally required by the agreement or by applicable state regulation, hospital representative sign-off will be obtained.

## Post-audit procedures

- **Refund Remittance** – In the event there is an undisputed overpayment, the hospital will remit the amount of the overpayment within thirty (30) calendar days of receipt of the refund request, or as required by law.
- **Disputed Audit Findings** – In the event the hospital wishes to dispute any audit findings, the hospital will submit notification of its intent to dispute the audit findings to UnitedHealthcare's Hospital Audit Services Department within thirty (30) calendar days of receipt of the audit findings. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.
- **Dispute Resolution** – UnitedHealthcare's Hospital Audit Services Department will respond to notification of disputed audit findings in writing within sixty (60) calendar days of receipt.
- **Escalated Dispute Resolution** – In the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare's Hospital Audit Services Department as well as Network Management. Escalated dispute resolution will cause suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties.
- **Unresolved Dispute** – Either party may further pursue dispute resolution as outlined in the agreement between us.
- **Offsets** – When a refund request has been issued, UnitedHealthcare will recoup or offset the identified overpayment, underpayment, and/or disallowed charge amounts after the expiration of thirty-five (35) calendar days from the date of the refund request provided by UnitedHealthcare's Hospital Audit Services Department, except under the following circumstances: (1) the hospital has remitted the amount due within the thirty-five (35) calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the thirty-five (35) calendar day repayment period.

## Imaging accreditation

If you perform outpatient imaging studies and bill on a CMS/HICF-1500 or the electronic equivalent, you must obtain accreditation for the following procedures: CT, MRI, Nuclear Medicine/Cardiology, PET and Echocardiography. This accreditation requirement applies to global and technical service claims. The accreditation process takes approximately six (6) to nine (9) months to complete. This accreditation Protocol promotes compliance with nationally recognized quality and safety standards.

Upon notice from UnitedHealthcare, failure to obtain accreditation will affect your right to be reimbursed for procedures rendered using these modalities. As a result, an administrative claim reimbursement reduction, in part or in whole, will occur.

Upon completion and submission of an accreditation application if you are:

1. an existing participating provider adding any of the above modalities and/or expanding to a new site, or
2. a newly participating provider with UnitedHealthcare, you will be placed in a pending accreditation status for the modalities in the application. The pending status will continue for twelve (12) months from the date of submission, or until you have received a decision on your accreditation application, whichever occurs first. During this pending status, your claims will not be denied under this Protocol solely for the reason of your pending status.

Accreditation is obtained by submitting an application and fulfilling accreditation standards with one of the following accreditation agencies:

- American College of Radiology (ACR) at [acr.org](http://acr.org)
- Intersocietal Commission Accreditation of CT Labs (ICACTL) at [icactl.org](http://icactl.org)
- Intersocietal Accreditation Commission (IAC) at [intersocietal.org](http://intersocietal.org)
- Intersocietal Commission Accreditation of Magnetic Resonance Labs (ICAMRL) at [icamrl.org](http://icamrl.org)
- Intersocietal Commission Accreditation of Echocardiography Labs (ICAEL) at [icael.org](http://icael.org)
- Intersocietal Commission Accreditation of Nuclear Medicine Labs (ICANL) at [icanl.org](http://icanl.org)

Additional details regarding this accreditation requirement, including a list of the CPT codes for which accreditation is required, are available on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinician Resources → Radiology → Imaging Accreditation.

# **Additional requirements**

## **Access to records**

UnitedHealthcare may request copies of medical records from you in connection with UnitedHealthcare's utilization management/care management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of the network participation agreement and appropriate billing practice. If medical records are requested by UnitedHealthcare, you will provide copies of such records free of charge.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to UnitedHealthcare members within fourteen (14) calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Such records must be maintained for six (6) years, or longer if required by applicable statutes or regulations. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

## **After-hours care**

The emergency department is an appropriate venue for emergencies, but in non-emergent circumstances, use of the emergency department needlessly overwhelms hospital resources and contributes to the delivery of more fragmented and costly care. Overuse of emergency department services may result from a variety of factors, including perceived difficulty in accessing the primary care physician's office, limited availability of urgent appointment times, member preferences and other factors. We ask that you and your practice have a mechanism in place for after-hours access, and influence some of these factors by implementing advanced or open access scheduling, establishing relationships with local urgent care and emergency rooms, and providing members with information such as:

- Alternative resources the member may access if care by you is not available or not appropriate. This may include a listing of local urgent care centers, convenience care centers, or after hour triage services.
- Directions regarding after hours follow-up with you or another care setting if they experience certain changes in their condition.

## **Arrange substitute coverage**

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with UnitedHealthcare so that services may be covered under the member's in-network benefit. We encourage you to go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) to find the most current directory of our network physicians and health care professionals.

## **Comply with protocols**

Your agreement with us states that you will cooperate with, and be bound by, UnitedHealthcare's and Payer's Protocols, including those Protocols contained in this Guide. Failure to comply with such Protocols will be reviewed by UnitedHealthcare and may result in appropriate action under your agreement with us, which may include, but is not limited to, change to or reduction in payment, financial offsets, ineligibility to participate in designation and/or recognition programs, other measures as identified in connection with a specific Protocol, or termination of your agreement with us. You must not bill our members for any amounts not paid due to your failure to comply with the Protocols. A complete list of UnitedHealthcare Protocols can be viewed at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols.

## Credentialing and recredentialing

We are dedicated to providing our members with access to effective health care and, as such, we periodically review the credentials of participating physicians and other health care professionals in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee on Quality Assurance (NCQA) requirements.

We are a member of the Council for Affordable Quality Health care (CAQH), and we utilize the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for recredentialing are instructed on the proper method for accessing the CAQH UPD.

## Rights related to the credentialing process

Physicians and other health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at (877) 842-3210.

While current board certification is not a requirement for network participation, it is a requirement for the UnitedHealth Premium<sup>®</sup> designation program. Providing updated board certification is part of the credentialing application.

## Delay in Service

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to provide covered services to our members in a timely manner. A Delay in Service is defined as a failure to execute a physician order in a timely manner that results in a longer length of stay.

A Delay in Service may result for any of the following reasons:

- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- A facility resource needed to execute a physician's order is not available
- Facility does not discharge the member on the day the physician's discharge order is written

## Inform members of Advance Directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to members on state law about advance treatment directives, about members' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform members of state laws on advance directives through our member handbooks and other communications. We encourage these discussions with our members.

## Important news and updates

Our preferred method to communicate with you is electronically, and any news or updates regarding policy, product or reimbursement changes are posted in the news section of UnitedHealthcareOnline.com. We also use multiple channels (mail, Internet, email, telephone, facsimile) to communicate with you. In the event a Protocol changes or is modified, we will notify you prior to implementation in accordance with your agreement with us. To the extent that some Protocols are applicable only in certain states at the time of printing, we have indicated that in this Guide. If your agreement with us is effective after the date of printing, please reference UnitedHealthcareOnline.com to view a complete list of states to which such Protocols are applicable. To register on UnitedHealthcareOnline.com, simply select the 'New User' link in the upper right corner of the UnitedHealthcareOnline.com home page, and follow the prompts.

## Continuity of member care following termination of your participation

If your network participation terminates for any reason, you are required to assist in the transition of your patient's care to another physician or health care professional who participates in the UnitedHealthcare network to the extent provided in your agreement. This may include providing service(s) for a reasonable time, at our contracted rate during the continuation period. Customer Care is available to help you and our members with the transition. At least thirty (30) calendar days prior to the effective date of your departure from the network, UnitedHealthcare will send, via regular mail, notification to affected members. If applicable state law requires earlier notification, the state law will prevail.

## Medical record standards

Medical records will contain all information necessary and appropriate for quality improvement activities and to support claims for services submitted by you.

In providing care for UnitedHealthcare members, we expect that you have **signed, written** policies to address the following (critical elements appear in bold text in this section):

1. Maintain a single, permanent medical record that is current, detailed, organized and comprehensive for each member and is available at each visit.
2. **Protect member records, whether in paper or electronic form, against loss, destruction, tampering or unauthorized use.** For electronic medical records, you must establish security safeguards in order to prevent unauthorized access or alteration of records without leaving an audit trail to identify the breach. Such safeguards must be programmed so that they cannot be overridden or turned off.
3. **Maintain medical records in a confidential manner and provide periodic training to office staff regarding confidentiality processes. Records storage must allow for easy retrieval, be secure and allow access only by authorized personnel.**
4. Maintain a mechanism for monitoring and handling missed appointments.
5. Demonstrate the office does not discriminate in the delivery of health care.

## General documentation guidelines

We also expect you to follow these commonly accepted guidelines for medical record information and documentation:

- Date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and their credentials. It should be apparent from the documentation which individual performed a given service.
- Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.
- Generate documentation at the time of service or shortly thereafter.
- Make entries legible.

- **Cite medical conditions and significant illnesses on a problem list and document clinical findings and evaluation for each visit.**
- Documentation that is not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the function of a malformed body member (over documentation) should not be considered when selecting the appropriate level of an E&M service. Only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate E&M level.
- **Give prominence to notes on medication allergies and adverse reactions. Also, note if the member has no known allergies or adverse reactions.**
- **Make it easy to identify the medical history, and include chronic illnesses, accidents and operations.**
- **For medication records, include name of medication and dosages. Also, list over the counter drugs taken by the member.**
- Records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the physician/health care professional.
- Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.

Document these important items:

- Tobacco habits, including advice to quit, alcohol use and substance abuse for members age eleven (11) and older
- **Immunization record**
- Family and social history
- Preventive screenings/services and risk screenings
- Screening for depression and evidence of coordination with behavioral health providers
- Blood pressure, height and weight, body mass index

## Goals

- 90% of medical records will contain documentation of critical elements. Critical elements appear in bold text in this section.
- 80% of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record audits.
- Documentation of allergies and adverse reactions must be documented in 100% of the records.

## Demographic information

The medical record for each member should include:

- Member name and date of birth, or member name and health care ID number, on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and/or work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

## Member encounters

When you see one of our members, document the visit by noting:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric members
- Developmental assessment for pediatric members
- Member education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary physician (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- Consultation and abnormal studies are initialed and include follow-up plans

## Clinical decision and safety support tools

Examples of evidence-based care tools include the following:

- Immunization tracking sheet
- Flow sheet for chronic diseases (e.g., diabetes, asthma)
- Member reminder system
- Electronic medical records
- Eprescribing
- Epocrates®

## Additional Medicare Advantage requirements

**If you participate in the network for UnitedHealthcare's Medicare Advantage products, you are required to comply with the following additional requirements.**

- You may not discriminate against members in any way based on health status.
- You must allow members to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for influenza vaccine or pneumococcal vaccine.
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services.
- You must ensure that members have adequate access to covered health services.
- You must ensure that your hours of operation are convenient to members and do not discriminate against members and that medically necessary services are available to members twenty-four (24) hours a day, seven (7) days a week. Primary Care Physicians must have backup for absences.
- You may not distribute marketing materials or forms to members without CMS approval of the materials or forms.
- You must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether the member has executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.

- You must ensure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying members of provider agreement terminations.
- You must comply with our medical policies, quality improvement programs and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators, as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals.
- You must provide full disclosure to members before providing a health service, if you feel that such service will not be covered by the member's benefit plan. The member may assume additional responsibility in accordance with the member's benefit plan and the contract language. A document similar to the Medicare Advanced Beneficiary Notice (ABN) must be signed by the member before liability for payment can be passed to the member. If the service is performed and there is not signed advance notice on record, the claim will be denied with provider liability.

## Fraud, waste and abuse prevention & training

If you identify potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately. Please see the *How to Contact Us* section of this guide for contact information. Please note UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

- **Fraud** Is a false statement, made or submitted by an individual or entity, who knows that the statement is false, and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity. These false statements could be verbal or written.
- **Waste** Generally means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.
- **Abuse** Generally refers to provider, contractor or member practices that are inconsistent with sound business, financial or medical practices; and that cause unnecessary costs to the health care system.

Effective January 1, 2009, the Centers for Medicare & Medicaid Services ("CMS") modified certain rules and regulations of the Medicare Advantage and the Part D programs. The rules state that a compliance plan must include training, education, and effective lines of communication between the compliance officer and the organization's employees, managers, directors, as well as first tier, downstream and related entities. This change clarified that plan sponsors, such as UnitedHealthcare, need to apply these training and communication requirements to all entities they are partnering with to provide services in Medicare Advantage or Part D programs.

As a contracted provider for UnitedHealthcare's Medicare Advantage programs, you are considered a first tier or downstream entity and are subject to this CMS requirement. It is our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we will be providing your organization with training materials, which will be made available on UnitedHealthcareOnline.com.

Annually, your organization must administer the training materials to your employees and applicable subcontractors. This annual training can be done using our materials or you may use your existing training program and/or materials provided by another health plan as long as that training meets the CMS requirements. Please maintain records of the training (i.e. sign-in sheets, materials, etc). Documentation of the training may be requested by UnitedHealthcare, CMS, or an agent of CMS to verify the training was completed.

## Protocol for Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to members at least two (2) calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than two (2) calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between service exceeds two (2) calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or member's authorized representative. The notice must be written in CMS required language and is entitled, "Notice of Medicare Non-Coverage" (NOMNC). The text may be found on the CMS Web site or you may contact your Quality Improvement Organization (QIO) for information.

Any appeals of such service terminations are called "fast track" appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of business of the day that you are notified by the plan or the QIO if the member has requested a fast track appeal.

## Medicare hospital discharge appeal rights protocol

Medicare Advantage members have the statutory right to appeal their hospital discharge to a Quality Improvement Organization (QIO) for immediate review.

The QIO notifies the facility and UnitedHealthcare of an appeal.

- When UnitedHealthcare completes the Detailed Notice of Discharge (DNOD), UnitedHealthcare will deliver it to the facility. The facility will deliver the DNOD to the Medicare Advantage member, or his or her representative, as soon as possible but no later than 12:00 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO.
- When the facility completes the DNOD, the facility will deliver the DNOD to the Medicare Advantage member, or his or her representative, as soon as possible but no later than 12:00 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO and UnitedHealthcare.

## Medicare Advantage protocol for Evercare Institutional Plan

**Applicability** – This Protocol is only applicable to Primary Care Physicians, Nurse Practitioners and Physicians Assistants who participate in the network for Evercare Institutional Customers.

**Definitions** – Capitalized terms used herein but not otherwise defined will have the meanings ascribed to them in the applicable participation agreement.

**Evercare Institutional Customer:** A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and who is enrolled in a Medicare Advantage institutional special needs benefit contract that: (a) exclusively enrolls special needs individuals who are institutionalized (as such term is defined in 42 CFR 422.2); (b) is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's Affiliates; and (c) is administered by UnitedHealthcare's business unit Evercare, as indicated by a reference to Evercare or Erickson Advantage on the face of the valid identification card of any Evercare Institutional Customer eligible for and enrolled in such Benefit Plan.

**Nurse Practitioner:** A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

**Physician Assistant:** A health care professional licensed to practice medicine with physician supervision.

Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

**Primary Care Physician:** Defined as (a) a Doctor of Medicine or a Doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable Benefit Plan to admit or refer patients to Skilled Nursing Facility for covered services; (b) who has been selected by or assigned to an Evercare Institutional Customer to provide and/or coordinate the Evercare Institutional Customer's covered services; (c) whose practice predominantly includes internal medicine, family or general practice; and (d) who participates in UnitedHealthcare's network.

**Primary Care Team:** A team comprised of a care manager, a Primary Care Physician, and a Nurse Practitioner or Physician Assistant.

**Skilled Nursing Facility:** A Medicare-certified nursing facility that (a) provides Skilled Nursing Services and (b) is licensed and operated as required by applicable law.

## Primary Care Physician Protocols

If these Primary Care Physician Protocols differ from or conflict with other Protocols in connection with any matter pertaining to Evercare Institutional Customers, these Primary Care Physician Protocols will govern unless statutes and regulations dictate otherwise.

The Primary Care Physician will cooperate with and be bound by these additional protocols:

1. Attend Primary Care Physician orientation session and annual Primary Care Physician meetings thereafter.
2. Conduct face-to-face initial and ongoing assessments of the medical needs of Evercare Institutional Customers, including all assessments mandated by regulatory requirements.
3. Deliver health care to Evercare Institutional Customers at their place of residence in collaboration with the Primary Care Team.
4. Family Care Conferences - Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare Institutional Customer to discuss the Evercare Institutional Customer's condition, care needs, overall plan of care and goals of care, including advance care planning.
5. Primary Care Team Collaboration and Coordination - Collaborate with other members of the Primary Care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services to Evercare Institutional Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to Evercare Institutional Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled Evercare Institutional Customer reassessment, significant change in plan of care and/or condition.
6. Collaborate with Evercare when a change in the Primary Care Team is necessary.
7. Provide Evercare a minimum of forty-five (45) calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare Institutional Customers reside.
8. When admitting an Evercare Institutional Customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.

## **Nurse Practitioner and Physician Assistant Protocols**

If these Nurse Practitioner and Physician Assistant Protocols differ from or conflict with other Protocols in connection with any matter pertaining to Evercare Institutional Customers, these Nurse Practitioner and Physician Assistant Protocols will govern unless statutes and regulations dictate otherwise.

The Nurse Practitioner and Physician Assistant will cooperate with and be bound by these additional protocols:

1. Attend training and orientation meetings as scheduled by Evercare.
2. Deliver health care to Evercare Institutional Customers at their place of residence in collaboration with a Primary Care Physician, including making joint visits to Evercare Institutional Customers in the facility on a regular basis.
3. Family Care Conferences - Communicate with the Evercare Institutional Customer's responsible parties, family and/or legal guardian on a regular basis. Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare Institutional Customer to discuss the Evercare Institutional Customer's condition, care needs, overall plan of care and goals of care, including advance care planning.
4. Primary Care Team Collaboration and Coordination - Collaborate with other members of the Primary Care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services for Evercare Institutional Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to Evercare Institutional Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled Evercare Institutional Customer reassessment, significant change in plan of care and/or condition.
5. Collaborate and communicate with Evercare's designated Director of Health Services to coordinate all inpatient, outpatient and facility care delivered to Evercare Institutional Customers. Forward copies of required documentation to Evercare's office. Work with the Director to develop a network of providers cognizant of the special needs of the frail elderly.
6. Initial Assessment - Conduct a comprehensive initial assessment for all Evercare Institutional Customers within thirty (30) calendar days of enrollment that includes:
  - a) History and physical examination, including mini-mental status (MMS) and functional assessment.
  - b) Review previous medical records.
  - c) Prepare problem list.
  - d) Review medications and treatments.
  - e) Review lab and x-ray procedures.
  - f) Review current therapies (PT, OT, ST).
  - g) Update treatment plan.
  - h) Review advance directive documentation including DNR/DNI and use of other life-sustaining techniques.
  - i) Contact the family/responsible party within thirty (30) calendar days of enrollment to:
    - schedule a meeting at the facility, if possible;
    - obtain further history;
    - agree on type and frequency of future contacts; and
    - discuss advance directives.
  - j) Perform clinical and quality initiative documentation as directed.

7. Provide care management services to coordinate the full range of covered services outlined in the Evercare Institutional Customer's benefit contract including, but not limited to:
  - a) All medically necessary and appropriate facility services.
  - b) Outpatient procedures and consultations.
  - c) Inpatient care management.
  - d) Podiatry, audiology, vision care and mental health care provided in the facility.
8. When admitting an Evercare Institutional Customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.
9. Provide Evercare a minimum of forty-five (45) calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare Institutional Customers reside.

## **Non-Discrimination**

You will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a member of UnitedHealthcare or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any members in need of the services you provide.

## **Physical Medicine and Rehabilitation Services**

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy provider.

## **Provide official notice**

Notification should be sent to the address noted in your participation agreement and delivered via the method required, within ten (10) calendar days of your knowledge of the occurrence of any of the following:

1. Material changes to, cancellation or termination of, liability insurance;
2. Bankruptcy or insolvency;
3. Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
4. Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
5. Loss or suspension of your license to practice; or
6. Transfer of member records to another physician/facility due to relocation or closing of your practice.

## **Provide timely notice of demographic changes**

### **Physician/health care professional verification outreach**

UnitedHealthcare is committed to providing our members with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO). Your office may receive a call from a member of our staff asking to verify your data that is currently on file in our provider database. Please be assured that this information is confidential and will be immediately updated in our database.

## Proactive notification of changes

You must notify us of changes to the demographic information that you reported with the executed agreement within ten (10) calendar days prior to the effective date of the change. Changes which must be reported include, but are not limited to, TIN changes, address changes, additions or departures of health care providers from your practice and new service locations.

### To change an existing TIN or to add a physician or health care provider

You must include the physician's or health care provider's W-9 form to make a TIN change or to add a physician or health care provider to your practice. To submit the change, please complete and fax the Physician/provider demographic update fax form and the W-9 form to the appropriate fax number listed on the bottom of the fax form.

The W-9 form and the Physician/provider demographic update fax form are available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com)  
→ Contact Us → Service & Support → Forms.

### To update your practice or facility information

You can make all other updates to your practice information by submitting the change directly through [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) by using the Practice/Facility profile function found on the global navigation at the top of any [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) page. You can also submit your change by: (a) completing the Physician/provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our United Voice Portal at (877) 842-3210.

## Use of non-participating laboratory services

- This Protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals.
- This Protocol does not apply where the physician bears financial risk for laboratory services.
- This Protocol does not apply to laboratory services provided by physicians in their offices.

## Requirement to use participating laboratories

UnitedHealthcare maintains a robust network of more than 1,500 national, regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the UnitedHealthcare network. Participating laboratories also provide clinical data and related information to support the UnitedHealth Premium® Designation program and other clinical quality improvement activities. It is important to note that in many benefit plans, members receiving services in non-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

**You are required to refer laboratory services to a participating provider in our network, except as otherwise authorized by UnitedHealthcare or a Payer.** Participating laboratory providers can be found in the UnitedHealthcare directory online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). If you need assistance in locating or using a participating laboratory provider, please contact UnitedHealthcare Network Management. We are here to support your efforts to direct laboratory services to participating laboratories.

We are aware of the vital importance of laboratory services to our members, and we are committed to maintaining a laboratory network that is both reliable and affordable. Given the size of this network, we are confident that you will have no difficulty locating and using a participating laboratory.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UnitedHealthcare Network Management to confirm that the specific laboratory test is covered. We will work with you to assure that those covered proven tests are performed, even if that means the use of a non-participating laboratory.

## **Administrative actions for non-network laboratory services referrals**

UnitedHealthcare network physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that virtually all participating physicians will be able to easily find a participating laboratory that will meet their needs.

If UnitedHealthcare determines an ongoing and material practice of referrals to non-network laboratory service providers, UnitedHealthcare will inform the responsible physicians of the issue and remind them of their contractual requirements. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with Protocols:

- a change in eligibility for the Practice Rewards programs;
- a decreased fee schedule; or
- termination of network participation, as provided in your agreement with us.

Please refer to [UnitedHealthcareOnline.com](https://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols for state-specific variations of this Protocol.

## **Use of specialty pharmacies for certain drugs (for commercial members)**

### **Synagis® (palivizumab)**

#### **Acquisition for administration in the health care setting by physicians and other health care professionals**

- This Protocol applies to the acquisition, including prescription ordering, clinical coverage review, and purchase of Synagis by physicians and other health care professionals.
- This Protocol applies to Commercial members only.

#### **Requirement to use a participating specialty pharmacy provider for Synagis procurement**

UnitedHealthcare has contracted for the national distribution of Synagis. Our participating specialty pharmacy provider(s) provide(s) Synagis fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) also provide(s) reviews consistent with UnitedHealthcare's Drug Policy for Synagis and work(s) directly with the Clinical Coverage Review unit in UnitedHealthcare's Care Management Center which determines whether Synagis treatment is covered. The UnitedHealthcare Drug Policy for Synagis is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities.

#### **You must acquire Synagis from a participating network specialty pharmacy provider, except as otherwise authorized by UnitedHealthcare.**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services. Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for our members meeting the criteria for coverage. Requests for prescriptions of Synagis should be submitted to our participating specialty pharmacy using the Synagis enrollment request form that is available at [UnitedHealthcareOnline.com](https://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols. The specialty pharmacy will dispense Synagis in compliance with the UnitedHealthcare Synagis Drug Policy and the member's benefit plan. The specialty pharmacy will bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare the appropriate code for administration of the medication and should not bill UnitedHealthcare for the Synagis medication itself. The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Synagis to the physician office.

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2010 UnitedHealthcare Administrative Guide Protocols.

### **Administrative actions for non-network acquisition of Synagis**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies. For the member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Synagis from a participating specialty pharmacy.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of Synagis, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part.

It is the intent of UnitedHealthcare to work with participating physicians and other health care professionals to promote the specialty pharmacy network and to maximize the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

### **Xolair® (omalizumab)**

#### **Acquisition for administration in the health care setting by physicians and other health care professionals**

- This Protocol applies to the acquisition including prescription ordering, clinical coverage review, and purchase of Xolair by physicians and other health care providers.
- This Protocol applies to Commercial members only.

#### **Requirement to use a participating specialty pharmacy provider for Xolair procurement**

UnitedHealthcare has contracted for the national distribution of Xolair. Our participating specialty pharmacy provider(s) provide(s) Xolair fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) also provide(s) reviews consistent with UnitedHealthcare's Drug Policy for Xolair and work(s) directly with the Clinical Coverage Review unit in UnitedHealthcare's Care Management Center to determine whether Xolair treatment is covered. The UnitedHealthcare Drug Policy for Xolair is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities.

#### **You must acquire Xolair from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare.**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services. Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for United members that meet the criteria for coverage. Requests for prescriptions of Xolair should be submitted to our participating specialty pharmacy using the Xolair enrollment request form that is available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols. The specialty pharmacy will dispense Xolair in compliance with the UnitedHealthcare Xolair Drug Policy, and the member's benefit and eligibility and bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for the administration code for Xolair when the injection is given and will not bill UnitedHealthcare for the Xolair medication.

The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Xolair to the physician office.

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2010 UnitedHealthcare Administrative Guide Protocols.

### **Administrative actions for non-network acquisition of Xolair**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies. For member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Xolair from a participating specialty pharmacy.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of Xolair, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part.

### **Administration in a health care setting**

Effective July 2007, the prescribing information for Xolair was updated to include a black box warning on the risk of anaphylaxis that has been reported to occur after as early as the first dose of Xolair but also has occurred beyond one (1) year of regularly administered Xolair treatment. The labeling advises that patients should be closely observed for an appropriate period of time after Xolair administration and Xolair should only be administered in a health care setting by physicians or other health care professionals. Physicians and other health care professionals administering Xolair should be prepared to manage anaphylaxis and members should be informed of the signs and symptoms of anaphylaxis and instructed to seek immediate medical care should symptoms occur.

UnitedHealthcare's Drug Policy on Xolair includes this updated warning and administration information. The participating specialty pharmacy provider(s) will assist in dissemination of this information as part of the clinical review of Xolair utilization.

It is the intent of UnitedHealthcare to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

### **Botox<sup>®</sup> (botulinum toxin type A), Dysport<sup>®</sup> (botulinum toxin type A), and Myobloc<sup>®</sup> (botulinum toxin type B)**

#### **Acquisition for administration in the health care setting by physicians and other health care professionals**

- This protocol applies to the acquisition (including prescription ordering, clinical coverage review, and purchase), of Botox, Dysport, and Myobloc by participating physicians and other health care professionals.
- This protocol applies to Commercial members only.

#### **Requirement to use a participating specialty pharmacy provider for Botox, Dysport, and Myobloc procurement**

UnitedHealthcare has contracted for the national distribution of Botox, Dysport, and Myobloc. Our participating specialty pharmacy provider(s) provide(s) Botox, Dysport, and Myobloc fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) also provides reviews consistent with UnitedHealthcare's Drug Policy for Botox, Dysport, and Myobloc and work(s) directly with the Clinical Coverage Review unit in UnitedHealthcare's Care Management Center to determine whether Botox, Dysport, and Myobloc

treatment is covered. The UnitedHealthcare Drug Policy for Botox, Dysport, and Myobloc is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities.

**You must acquire Botox, Dysport, and Myobloc from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare.**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services. Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for our member enrollee(s) meeting the criteria for coverage.

Requests for prescriptions of Botox, Dysport, and Myobloc should be submitted to our participating specialty pharmacy using the applicable enrollment request forms that are available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols. The specialty pharmacy will dispense Botox, Dysport, and Myobloc in compliance with the UnitedHealthcare Botox, Dysport, and Myobloc Drug Policy and the member's benefit and eligibility and bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for the administration code for Botox, Dysport, and Myobloc when the injection is administered, and should not bill UnitedHealthcare for the Botox, Dysport, or Myobloc medication itself. The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Botox, Dysport, or Myobloc to the physician office.

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2010 UnitedHealthcare Administrative Guide.

**Administrative Actions for Non-Network Acquisition of Botox, Dysport, and Myobloc**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and compliance with medication policies. For member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Botox, Dysport, and Myobloc from a participating specialty pharmacy provider.

Continued use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part.

It is our intent to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

**Use of designated specialty pharmacy or home infusion providers for specialty medications**

- This Protocol applies to the provision and billing of specific specialty pharmacy medications covered under the medical benefit.
- This Protocol prohibits specialty pharmacy or home infusion providers from providing non-contracted services, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, for a therapeutic category and billing UnitedHealthcare as a non-participating or non-contracted specialty pharmacy or home infusion provider.

- This Protocol does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional, who then procures and bills directly to UnitedHealthcare for the specific specialty medications.
- This Protocol applies to Commercial members only.

### **Requirement of specialty pharmacy and home infusion provider(s) to be a network provider**

UnitedHealthcare has contracted with a network of specialty pharmacy and home infusion providers by therapeutic category to distribute specialty medications covered under the medical benefit. The contracted specialty pharmacy and home infusion providers have been selected by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and member services. This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our members and the UnitedHealthcare network. Full program participation requirements are identified in the contracted specialty pharmacy or home infusion provider's participation agreement. Specialty pharmacy and home infusion providers are prohibited, even if they are contracted for other medical benefit medications and services, from providing non-contracted services in a therapeutic category, and billing UnitedHealthcare as a non-participating or non-contracted provider.

We are aware of the importance of drug procurement for our members, and we are committed to maintaining specialty pharmacy and home infusion distribution channels that are reliable and also offer low, contracted rates and superior clinical and member services.

### **Coverage of self-infused/injectable medications under the pharmacy benefit**

- This Protocol applies to the provision and billing of self-infused/injectable medications, such as Hemophilia Factor products, under the pharmacy benefit.

Under most UnitedHealthcare products, self-infused/injectable medications are generally excluded from coverage under the medical benefit, and coverage for a self-infused/injectable medication is provided through the pharmacy rider. This exclusion from the medical benefit does not apply to self-infused/injectable medications necessary to treat diabetes or to medications, which due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified physician or licensed/certified health care professional in an outpatient setting.

Participating physicians, health care professionals, home infusion providers, hemophilia treatment centers or pharmacies fulfilling, distributing, and billing for the provision of self-infused/injectable medications to members and subject to the exclusion described above are required to submit claims for reimbursement under the member's pharmacy benefit.

### **Use of specialty pharmacies for certain drugs (for commercial members)**

#### **Sodium Hyaluronate Preparations (Hyalgan<sup>®</sup> and Supartz<sup>®</sup>) (Effective on and after April 1, 2010)**

##### **Acquisition for Administration in the Health Care Setting by Physicians and other Health Care Professionals.**

- This Protocol applies to the acquisition, including prescription ordering and purchase of sodium hyaluronate and hyaluronan cross-linked preparations (Hyalgan and Supartz) by physicians and other health care professionals. For consistency in this document, these preparations will be referred to as sodium hyaluronate preparations.
- Euflexxa<sup>®</sup>, Orthovisc<sup>®</sup>, Synvisc<sup>®</sup> and Synvisc-One<sup>®</sup> may continue to be purchased and directly billed to UnitedHealthcare. Health care providers may continue to "buy and bill" Euflexxa, Orthovisc, Synvisc and Synvisc-One.
- This Protocol applies to Commercial members only.

## **Requirement to Use a Participating Specialty Pharmacy Provider for the Procurement of Sodium Hyaluronate Preparations (Hyalgan and Supartz)**

UnitedHealthcare has contracted for the national distribution of sodium hyaluronate preparations (Hyalgan and Supartz). Our participating specialty pharmacy provider(s) provide(s) sodium hyaluronate preparations (Hyalgan and Supartz) fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities.

### **You must acquire the sodium hyaluronate preparations (Hyalgan and Supartz) from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare.**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable, cost effective, and also superior clinical and member services. Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring these drugs for our members meeting the criteria for coverage.

Requests for impacted sodium hyaluronate preparations (Hyalgan and Supartz) are submitted to the specialty pharmacy using the applicable request form available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols. The specialty pharmacy will dispense the requested medication in compliance with the UnitedHealthcare Medical Policy Sodium Hyaluronate for the Treatment of Arthritis, and the member's benefit and eligibility and bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for the administration of the sodium hyaluronate preparation. The specialty pharmacy will advise the member of any cost share responsibility for the medication and advise of any amount due prior to dispensing product to the physician office.

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2010 UnitedHealthcare Administrative Guide.

### **Administrative actions for non-network acquisition of the sodium hyaluronate preparations (Hyalgan and Supartz)**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of sodium hyaluronate preparations (Hyalgan and Supartz) without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part.

It is the intent of UnitedHealthcare to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize effectiveness of the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

# Other information

## Member rights and responsibilities

We tell our members they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

### Your patient's rights as a UnitedHealthcare member

- Be treated with respect and dignity by UnitedHealthcare personnel, network physicians and other health care professionals.
- Be assured of privacy and confidentiality for treatments, tests and procedures you receive.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Participate in a candid discussion with your physician about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be provided with access to health care, physicians, health care professionals and other health care facilities.
- Participate with your physician and other health care professionals in decisions about your care.
- Receive and make recommendations regarding UnitedHealthcare's members' rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services, network physicians and other health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an advance directive to designate the kind of care you wish to receive should you be unable to express your wishes.

### Your patient's responsibilities as a UnitedHealthcare member

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your health care ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of physicians and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer's human resource department of changes in your address or family status.
- Visit our Web site [myuhc.com](http://myuhc.com)<sup>®</sup> or call the phone number on the back of your health care ID card when you have a question about your eligibility, benefits, claims and more.
- Access our Web site [myuhc.com](http://myuhc.com) or call the phone number on the back of your health care ID card to verify that your physician or health care professional is participating in the UnitedHealthcare network before receiving services.

## **Member Rights and Responsibilities – Medicare Advantage**

We tell our members they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

### **Medicare Advantage members have the right**

- To be treated with respect and in a manner that recognizes their need for privacy and dignity.
- To receive assistance in a prompt, courteous, responsible and culturally competent manner.
- To be provided with information about their health care benefits and any limitations and exclusions associated with their coverage.
- To be informed by their physician or other health care professional of their diagnosis, prognosis and plan of treatment in terms they understand.
- To participate in decisions with their physician regarding their care.
- To expect UnitedHealthcare not to interfere with any contracted physician or health care professional's discussion with them about their treatment options whether covered or not.
- To have UnitedHealthcare refer them to another contracted physician or health care professional if their physician or health care professional objects to a treatment based on moral or religious grounds.
- To be provided with information about the network of contracted physicians and health care professionals in their service area.
- To be informed by their physician or other health care professional about any treatment they may receive.
- To have their physician or health care professional request their consent for all treatment, unless there is an emergency and they are unable to sign a consent form and their health is in serious danger.
- To refuse treatment, including any experimental treatment, and be advised of the probable consequences of their decision.
- To choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes.
- To select, without interference, a primary care physician of their choice from within UnitedHealthcare's network of contracted physicians.
- To express a complaint about UnitedHealthcare.
- To make recommendations regarding the organization's member's rights and responsibilities policies.
- To express a complaint about the care they have received and to receive a response in a timely manner.
- To initiate the grievance procedure if they are not satisfied with UnitedHealthcare's decision regarding their complaint.
- To receive "timely access" to the records and information that pertains to them.

## **Medicare Advantage members have the responsibility**

- To know and confirm your benefits prior to receiving treatment.
- To show your Medicare Advantage ID card before receiving services and to protect against the wrongful use of your ID card by another person.
- To verify that the physician or health care professional you receive services from is participating in the Medicare network.
- To keep scheduled appointments and pay any necessary copayments/coinsurance at the time you receive treatment.
- To ask questions and seek clarification until you understand the care you are receiving.
- To follow the advice of your physician or health care professional and be aware of the possible consequences if you do not.
- To express your opinions, concerns and complaints to us.
- To provide information as necessary to UnitedHealthcare and contracted physicians and health care professionals that would help enhance your health status.
- To use emergency room services only for an injury or illness that appears to pose a serious threat to your life or health if not treated immediately.
- To follow the treatment plan agreed upon by you and your physician.
- To treat all UnitedHealthcare personnel respectfully and courteously.
- To notify us of any change in address.
- A copy of this statement is also available on [AARPMedicareComplete.com](http://AARPMedicareComplete.com).

## **Guide supplement section**

### **Important information regarding the use of this section**

The following documents are supplements to this 2010 UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("Guide"): American Medical Security & Golden Rule Supplement, Leased Network Supplement, and Mid-Atlantic Regional Supplement.

In the event of any inconsistency between the Guide and any of these supplements, the supplement and the member's benefit plan will prevail for those members subject to the supplement. In the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your participation agreement and any of these supplements, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix. Additionally, in the event of a conflict or inconsistency between your participation agreement and any of these supplements, the provisions of your participation agreement will control, unless your agreement provides otherwise. These supplements are subject to change.

# American Medical Security & Golden Rule Supplement

## Important information regarding the use of this supplement

The American Medical Security & Golden Rule Supplement applies to services provided to members enrolled in American Medical Security or Golden Rule benefit plans. In the event of any inconsistency between the Guide and the American Medical Security & Golden Rule Supplement or the member's benefit plan, the American Medical Security & Golden Rule Supplement and the member's benefit plan will prevail for American Medical Security and Golden Rule members.

You may request a printed copy of this or other Protocols and Payment Policies by contacting the United Voice Portal at (877) 842-3210.

## How to contact us

### American Medical Security

RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Notification</b>	Call the number on the back of the member's health care ID card or (800) 232-5432	To notify of hospitalizations exceeding three (3) days or transplant services outlined in the notification requirements section of this Supplement.
<b>Benefits and Eligibility</b>	Call the number on the back of the member's health care ID card or (800) 232-5432	To inquire about a member's plan benefits or eligibility.
<b>Pharmacy Services (Prescription Solutions)</b>	Call the pharmacy number on the back of the member's health care ID card or (800) 797-9791	To request a copy of the Prescription Drug List.

### Golden Rule

RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Notification</b>	Call the number on the back of the member's health care ID card or (800) 999-3404	To notify of hospitalizations exceeding three (3) days or transplant services outlined in the notification requirements section of this Supplement.
<b>Benefits and Eligibility</b>	Call the number on the back of the member's health care ID card or (800) 657-8205	To inquire about a member's plan benefits or eligibility.
<b>Pharmacy Services (Medco)</b>	GoldenRule.com	To review the Prescription Drug List.
	Call the pharmacy number on the back of the member's health care ID card (877) 884-3256	To request a copy of the Prescription Drug List.

## Our claims process

We know that you want to be paid promptly for the services you provide. Here's what you can do to help promote prompt payment:

1. Notify American Medical Security or Golden Rule on or before the 4th day of hospitalizations that are expected to exceed three (3) days.
2. Notify American Medical Security or Golden Rule as soon as possible of proposed transplant procedures.
3. Prepare a complete and accurate claim form (see *Complete claims* section of this Supplement).
4. For American Medical Security members - submit electronic claims using Payor ID # 81400. This is the electronic claims routing number for American Medical Security members. Submit paper claims to the address on the member's health care ID card.
5. For Golden Rule members - submit electronic claims using Payor ID # 37602. This is the electronic claims routing number for Golden Rule members. Submit paper claims to the address on the member's health care ID card.

## Complete claims

Whether you submit your CMS-1500 form or UB-04 form electronically or via paper form, a complete claim includes the following information. Additional information may be required by us for particular types of services, or based on particular circumstances or state requirements.

- Patient's name, address, sex, date of birth
- Primary member's name and ID number
- Name, signature, 'remit to' address, and phone number of the physician or health care provider performing the service, as described in the participation agreement
- Physician's or health care provider's National Provider Identifier (NPI) and federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT-4 and HCPCS procedure codes with modifiers where appropriate
- Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity
- Referring physician's name and tax ID number (if applicable)
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby)
- Attach an anesthesia report for claims submitted with a 23, QS, G8 or G9 modifier
- Attach nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services
- Purchase price for DME rental claims exceeding \$500
- Medical records for growth hormone, co-surgeries, dental care resulting from an accident or injury to the teeth, maternity (except routine)
- For bone marrow/stem cell or organ transplant claims: transplant evaluation and transplant treatment protocols
- For reconstructive and/or cosmetic procedures regarding the cranio-facial region, breast, nose, eyes or abdomen: treatment plan, medical records for the last two (2) years regarding the condition, operative notes

- For experimental and/or investigational treatments (including Phase I or II clinical trials): consent forms signed by the patient, medical records for the last two (2) years regarding the condition, admission and discharge summaries, treatment protocols
- For medical claims involving self-inflicted injuries or illnesses: admission and discharge summaries and progress notes during the confinement
- For HIV-related diseases and AIDS: onset information (first date diagnosed) and admission and discharge summaries for inpatient claims
- For accident and injury claims: summary of accident and injury (including date, place, and circumstances)
- Electronic claims must be HIPAA-compliant in order to be considered clean claims, using the applicable format that complies with all federal laws related to electronic health care claims, including any applicable implementation guides, companion guides, and trading partner agreements

## **Additional information needed for a complete UB-04 form**

- Date and hour of admission and discharge as well as member status-at-discharge code
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current four-digit revenue code(s)
- Current principal diagnosis code (highest level of specificity) with the applicable Present of Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current ICD-9-CM (or its successor) procedure codes for inpatient procedures
- Attending physician ID
- Bill all outpatient surgeries with the appropriate revenue and CPT or HCPCS codes
- Provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g. laboratory, radiology, diagnostic or therapeutic) for outpatient services
- Complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-04
- Attach an itemized statement if submitting a claim that will reach the contracted stop loss
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement)
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount (\$.01 or \$1.00) must be reported on all other surgical revenue code lines to assure appropriate adjudication

## **Claim correction/resubmit**

If you need to correct and resubmit a claim, submit a new CMS-1500 or UB-04 indicating the correction being made. When correcting or submitting late charges on a UB-04 or 837 Institutional claim, resubmit all original lines and charges as well as the corrected or additional information using bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. **Hand-corrected resubmissions will not be accepted.**

## Submission of unlisted medical surgical codes

Include a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or “other” revenue codes as well as experimental or reconstructive services.

## Submission of CMS-1500 form drug codes

Include a current National Drug Code (NDC) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 form or the LIno3 segment of the HIPAA 837 electronic form.

If you have questions about submitting claims, please contact American Medical Security or Golden Rule at the phone number listed on the member’s health care ID card.

## Reporting requirements for anesthesia services

- One of the CMS required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with a “MJ” qualifier in loop 2400 SV103. For CMS-1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.
- When medically directing residents for anesthesia services, the modifier GC must be reported in conjunction with the AA or QK modifier.
- When reporting obstetrical anesthesia minutes, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

## Claim adjustments

If you believe you were underpaid, please call American Medical Security at (800) 232-5432 or Golden Rule at (800) 657-8205 and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. If you or our staff identify a claim where you were overpaid, we ask that you send us the overpayment within thirty (30) calendar days from the date of your identification of the overpayment or of our request.

If you disagree with a claim adjustment, you can appeal the determination (see *Claims appeals*).

## Claims appeals

If you disagree with a claim payment determination, send a letter of appeal to the following address:

### American Medical Security Members

American Medical Security – Appeals Review, P.O. Box 13597, Green Bay, WI 54307-3597. Your appeal must be submitted to American Medical Security within 180 days from the date of payment shown on the EOB, unless your participation agreement or applicable law provide otherwise.

### Golden Rule Members

Golden Rule – Appeals Department, 7440 Woodland Drive, Indianapolis, IN 46278. Your appeal must be submitted to Golden Rule within twelve (12) months from the date of payment shown on the EOB, unless your participation agreement or applicable law provide otherwise.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your participation agreement.



## Notification requirements

Notification, in order to be effective, must contain all necessary information including, but not limited to, member's name, member's health care ID number, hospital name, hospital tax identification number, primary diagnosis description, anticipated dates of service, type of service and volume of service when applicable. In addition, such notifications must be made to the appropriate place as described on the member's health care ID card.

Notify American Medical Security or Golden Rule at the number listed on the member's health care ID card for any inpatient facility admission that will exceed three (3) days and for proposed transplant services.

Notify us prior to:

Procedures and services	Explanation
<b>Inpatient facility admissions</b>	Inpatient admissions expected to exceed three (3) days including: Acute hospitalizations (includes long term acute care), rehabilitation facilities, and skilled nursing facilities (includes subacute and hospice) that will exceed three (3) days. Notify on or before 4th inpatient day.
<b>Transplant services</b>	Proposed transplant services including evaluations.

American Medical Security and Golden Rule use Milliman® Care Guidelines®, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, American Medical Security and Golden Rule may also utilize the medical policies available online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies and Protocols.

Notification does not guarantee coverage or payment (unless mandated by the state). The member's eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact American Medical Security or Golden Rule at the number on the back of the member's health care ID card.

# Leased Network Supplement

*(May apply to providers in HI, ID, KY, ME, MI, MN, ND, SD, USVI, WI; reference your agreement for applicability)*

## Important information regarding the use of this supplement

UnitedHealthcare's *Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide* (the "Guide") is supplemented by this *Leased Network Supplement* (the "Leased Supplement") for physicians, health care professionals, facilities and ancillary providers who participate with UnitedHealthcare through a leased network accessed by UnitedHealthcare in an area UnitedHealthcare does not have a direct network.

Physicians, health care professionals, facilities and ancillary providers participating in UnitedHealthcare's network through a leased network are subject to both the Guide and the Leased Supplement in their respective entireties; however, in the event of any inconsistency between the Guide and this Leased Supplement, the Leased Supplement will prevail for providers participating in a leased network arrangement.

## Leased supplement

Any reference in the Guide to a physician's, health care professional's, facility's, or ancillary provider's "agreement with us" are to be considered simply an "agreement" for purposes of this Leased Supplement and refer to your participation agreement with the entity operating the leased network (your "Master Contract Holder").

Several items that appear in the Guide are covered by your agreement with your Master Contract Holder, not the provisions stated in the Guide. Any reference to updating demographic information, submitting National Provider Identification information, credentialing or recredentialing processes and appeal guidelines should follow the processes as indicated in your agreement with your Master Contract Holder.

# Mid-Atlantic Regional Supplement

(May apply to providers in DE, DC, MD, NC, PA, VA, WV; reference your agreement for applicability)

## Important information regarding the use of this Supplement

This Mid-Atlantic Regional Supplement applies to services provided to members enrolled in MD-Individual Practice Association, Inc. (“M.D. IPA”), Optimum Choice, Inc. (“Optimum Choice”), MAMSI Life and Health Insurance Company (“MLH”) Benefits Plans or any Benefit Plan serviced or administered by OneNet PPO, LLC (“OneNet”) (collectively “MAHP members”). In the event of any inconsistency between the Guide and this Mid-Atlantic Regional Supplement, the Mid-Atlantic Regional Supplement and all Protocols and Payment Policies found on MAMSIUnitedHealthcare.com will prevail for MAHP members. You may request a printed copy of said Protocols and Payment Policies by contacting the Professional Services Department at (800) 342-3289.

## Product Summary

This table provides information about M.D. IPA, Optimum Choice and MAMSI Life and Health Insurance Company (MLH) products for the Mid-Atlantic region.

<b>Attributes</b>	<b>M.D. IPA and Optimum Choice</b>	<b>M.D. IPA Preferred and Optimum Choice Preferred</b>	<b>MAMSI Life and Health Insurance Company Products</b>
<i>How do members access physicians and health care professionals?</i>	Members' care must be arranged or coordinated by their primary care physician, except OB/GYN and routine eye refraction care.	In-network benefits: Members' care must be arranged or coordinated by their primary care physician, except OB/GYN and routine eye refraction care.  Out-of-network benefits: Members' care is not required to be arranged or coordinated by their primary care physician.	Members can choose to access any network physician or health care professional. MAMSI Life and Health Insurance Company members have out-of-network benefits.
<i>Does a primary care physician have to make a referral to a specialist?</i>	Yes, except routine annual visits to an OB/GYN and routine eye refraction care.	In-network benefits: Yes, except routine annual visits to an OB/GYN and routine eye refraction care.  Out-of-network benefits: No referral needed.	No, a referral is not needed.
<i>Is the treating physician required to obtain pre-certification for some procedures?</i>	Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional Supplement.	Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional Supplement.	Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional Supplement.

## OneNet PPO

OneNet PPO, LLC (OneNet) maintains a large network of physicians, health care practitioners and facilities offering medical, behavioral health and workers' compensation services in the Mid-Atlantic region. OneNet customers accessing the OneNet network include:

- Insurance carriers
- Third party administrators
- Union health and welfare funds
- Workers' Compensation administrators
- And others

OneNet offers a variety of services to assist its customers in managing health care services. The OneNet network is constantly growing as more physicians, health care practitioners, and facilities are contracted each year to give our participants access to quality health care from a large network throughout our service area.

Due to the nature of the OneNet network, OneNet claims policies and administrative guidelines can differ from M.D. IPA, Optimum Choice and MLH. Please refer to the OneNet Physician, Health Care Practitioner, Hospital and Facility Manual available from your network representative, our Professional Services Department at (800) 342-3289, or in the provider publications section of the OneNet Web site, [onenetppo.com](http://onenetppo.com), for information about OneNet's protocols, policies and procedures. You may also use [onenetppo.com](http://onenetppo.com) to check claim re-pricing and find other participating physicians, health care practitioners, hospitals and facilities in the OneNet network. A secure login specific to the OneNet website is available by calling our Professional Services Department at (800) 342-3289, and is required to access the OneNet Physician, Health Care Practitioner, Hospital and Facility Manual and the claim pricing sheets.

The OneNet Physician, Health Care Practitioner, Hospital and Facility Manual is also available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) through secure login.

If you need assistance or have any questions about OneNet PPO, please call our Professional Services Department at (800) 342-3289.

## Health care ID cards

Effective October 1, 2006, we began to introduce updated M.D. IPA and Optimum Choice benefit plans. Medical services for these plans will be administered and adjudicated on different technology systems, including different claims systems. It is important to check your patient's health care ID card as these will be different for those enrolled in an updated plan.

Members enrolled in M.D. IPA and Optimum Choice updated benefit plans will present with a plastic health care ID card. For Optimum Choice updated benefits plans, the health care ID card will display the UnitedHealthcare logo and will indicate "Optimum Choice, Inc." For M.D. IPA updated benefit plans, the health care ID card will display the M.D. IPA logo. All M.D. IPA and Optimum Choice members enrolled in updated benefit plans will have a member number without an asterisk. Be sure to use the telephone numbers and addresses noted on these health care ID cards.

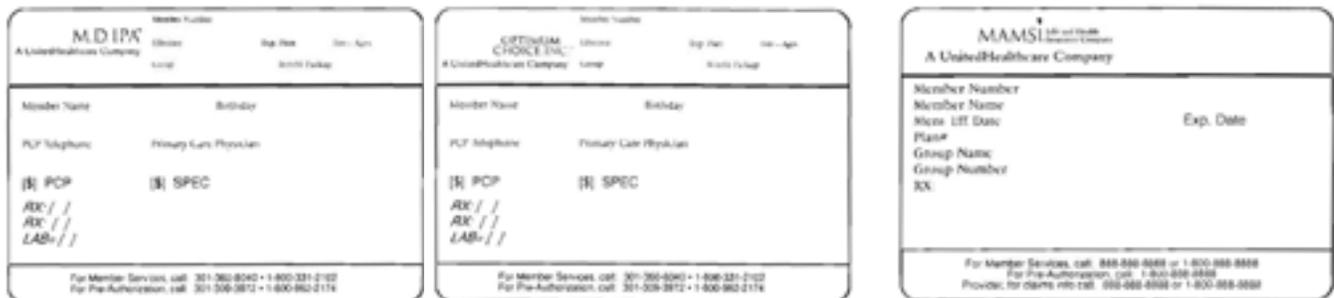
Sample health care ID cards for M.D. IPA and Optimum Choice updated benefit plans:



Members enrolled in M.D. IPA and Optimum Choice current (non-updated) benefit plans will present with a paper health care ID card; they will have a member number that includes an asterisk. Be sure to use the telephone numbers and addresses noted on these health care ID cards.

Sample health care ID cards for non-updated M.D. IPA and Optimum Choice benefit plans:

Sample health care ID card for MAMSI Life and Health Insurance Company products:



## How to contact us

RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Online services</b>	<p>Use UnitedHealthcareOnline.com for members enrolled in updated M.D. IPA and Optimum Choice benefit plans.</p> <p>Use MAMSIUnitedHealthcare.com for members enrolled in non-updated M.D. IPA and Optimum Choice benefit plans, and for members enrolled in MAMSI Life and Health Insurance Company products.</p>	<p>Real-time enrollee eligibility and benefit information</p> <p>Payment Policies, Protocols and Guides</p> <p>Check claim status</p> <p>Electronic claims submission- UnitedHealthcareOnline.com only (Use Payer ID 87726; see Guide for more detail)</p> <p>Electronic Referral System</p>
<b>Voice Activated Telephone System</b>	<p>For members enrolled in updated M.D. IPA and Optimum Choice benefit plans, call (877) 842-3210.</p> <p>For members enrolled in non-updated M.D. IPA and Optimum Choice benefit plans, and MAMSI Life and Health Insurance Company products, call (800) 582-3377.</p>	<p>To inquire about a member's eligibility or benefits, check claim status, check to see if a procedure requires pre-certification, verify copayment information and more.</p> <p>You will need your provider and tax identification numbers.</p>

## Our claims process

Please refer to the Guide for information about our claims process for members enrolled in updated benefit plans (members with numbers without an asterisk). Be sure to send paper claims for M.D. IPA and Optimum Choice members enrolled in non-updated benefit plans (members with numbers that include an asterisk) to the following address:

Claims Department  
P.O. Box 930  
Frederick, MD 21705-0930

If you submit your claims electronically, please refer to the Payer Numbers listed on MAMSIUnitedHealthcare.com for M.D. IPA and Optimum Choice members enrolled in non-updated benefit plans (members with numbers that include an asterisk). For claims appeals for OCI, M.D. IPA or MLH, please send your letter of appeal to the address on the member's health care ID card or per the instructions on the Provider Remittance Advice (PRA).

## Health services

This section applies to all MAMSI Life and Health Insurance Company, M.D. IPA and Optimum Choice members and includes both the updated and non-updated OCI/M.D. IPA products.

To notify us of the procedures and services outlined in the Preauthorization, Precertification section of this Mid-Atlantic Regional Supplement, call:

- Inpatient Preauthorization or Precertification call (800) 962-2174;
- Outpatient Preauthorization or Precertification call (800) 738-1837;
- The Health Services staff is available during the business hours of 8:30 a.m. to 5:30 p.m. EST.

## Inpatient admission notification

All participating facilities are required to notify the health plan of an admission of a member within twenty-four (24) hours or the next business day following a weekend or federal holiday, whichever comes first. The health plan will initiate a case review upon receipt of your notification. If notification is not provided in a timely manner, the health plan may still review the case and request additional medical information. If you fail to notify in a timely manner, the health plan may retroactively deny one (1) or more days based upon its case review. If the patient is eligible for benefits on the date of admission, the health plan will not deny the first day of the admission if the treating provider previously received pre-authorization of the scheduled admission. Provide admission notification to Health Services via phone at (800) 962-2174 or via fax at (800) 352-0049.

In the event a member receiving outpatient services needs an inpatient admission, the facility must notify the health plan as noted above. Emergency room services that culminate in a covered admission will be payable as part of the inpatient stay provided the facility has notified the health plan of the admission as noted above.

## **Delay in service**

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to ensure that covered services are provided to members in a timely manner. A clinical Delay in Service is defined as any delay in medical decision-making, test, procedure, transfer, or discharge that is not caused by the clinical condition of the member. Services should be scheduled the same day as the physician's order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day, unless emergent treatment was required. A delay may result in sanction of the facility by the health plan and non-reimbursement for the delay day(s), if permissible under State law.

A Delay in Service will be assessed for any of the following reasons:

- A failure to execute a physician order in a timely manner that will result in a longer length of stay
- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- A facility resource needed to execute a physician's order is not available
- Facility does not discharge the patient on the day the physician's discharge order is written

## **Concurrent review**

Review is conducted on-site at the facility or telephonically for each day of the stay using nationally-accepted criteria. You must cooperate with all requests for information, documents or discussions from the health plan for purposes of concurrent review including, but not limited to, clinical information on patient status and discharge planning. When criteria are not met, the case is referred to a medical director for determination. The health plan will deny payment for hospital days that do not have a documented need for acute care services. The health plan requires that physicians' progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the hospital and the physician.

## **Hospital post-discharge review**

When a member has been discharged before notification to the health plan can occur or before information is available for certification of all the days, a post-discharge review will be conducted. A health plan representative will request the member's records from the Medical Records Department or via a telephonic review and review each non-certified day for appropriateness and acuity. Inpatient Days that do not meet acuity criteria will be referred to a medical director for determination and may be retrospectively denied. Delays in service or days that do not meet criteria for intensity of service may be denied for payment.

## **Hospital-to-hospital transfers**

The hospital must notify the health plan of a request for hospital-to-hospital transfer. In general, transfers are approved when there is a service available at the receiving hospital that is not available at the sending hospital; the patient would receive a medically appropriate change in the level of care at the receiving facility; or the receiving facility is in-network and has appropriate services for the member. If any of the conditions above are not met, coverage for the transfer will be denied. Services at the receiving hospital would be approved if medical necessity criteria for admission were met at the receiving hospital, and there is no delay in providing services at the receiving hospital.

## Preauthorization and precertification requirements

Preauthorization is required for all non-emergency, planned admissions for all MAMSI Life and Health Insurance Company, M.D. IPA and Optimum Choice members.

### Services requiring preauthorization or precertification

Certain services require preauthorization or precertification for M.D. IPA, Optimum Choice and MAMSI Life and Health Insurance Company members. These requirements vary for M.D. IPA and Optimum Choice members enrolled in updated and non-updated benefit plans.

Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon member eligibility, benefits and applicable state law.

### Procedures requiring precertification

The following list applies to M.D. IPA and Optimum Choice Members in updated and non-updated plans, and M.D. IPA Preferred and Optimum Choice Preferred Members in updated benefit plans.

Be sure to submit your request at least two (2) business days prior to the provision of services. Also, please keep in mind some procedures and services listed here may not be covered under the member's benefit plan. If you have any questions, please contact the Professional Services Department at the number on the back of the member's health care ID card.

Procedures and services requiring preauthorization or precertification: written request	
<ul style="list-style-type: none"> <li>• Acupuncture<sup>1</sup></li> <li>• Angiomas/hemangioma (with pictures)</li> <li>• Biofeedback</li> <li>• Blepharoplasty (with pictures/visual fields)</li> <li>• Breast Implant Removal</li> <li>• Breast Reconstruction (non-cancer diagnoses only)</li> <li>• Chiropractic Services<sup>1</sup> (if not subject to a maximum dollar amount)</li> <li>• Clinical Trials</li> <li>• Cochlear Implants</li> <li>• Congenital Anomaly Repair (with pictures if indicated)</li> <li>• Cosmetic and Reconstructive Surgery (with pictures if indicated)</li> <li>• Dental Procedures in a Facility</li> <li>• Dental Services (except removal of cysts/tumors and fracture care)</li> <li>• Discectomy/Fusion (inpatient or outpatient)</li> <li>• Durable Medical Equipment (for a complete list of DME items which do not require preauthorization, visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>)</li> <li>• Elective inpatient procedures and admissions must be preauthorized Precertification also required for:               <ul style="list-style-type: none"> <li>– Joint replacement (hip, knee, ankle, shoulder)</li> <li>– Morbid Obesity surgery</li> </ul> </li> <li>• Experimental Services/New Technologies</li> <li>• General Anesthesia for Dental Procedures</li> <li>• Gynecomastia Surgery (with pictures)</li> <li>• Home Care</li> <li>• Hysterectomy (inpatient or outpatient)</li> <li>• Infertility Services<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Joint Replacement (hip, knee, ankle, shoulder)</li> <li>• Laminectomy/Fusion (inpatient or outpatient)</li> <li>• Occupational Therapy<sup>2,3</sup> (after eight visits)</li> <li>• Morbid Obesity (surgery/procedures)</li> <li>• Pelvic Laparoscopy</li> <li>• Physical Therapy<sup>2,3</sup> (after eight visits)</li> <li>• Prosthetic devices except for prosthetic contact lenses</li> <li>• Psychiatric Therapies including, but not limited to:<sup>4</sup> <ul style="list-style-type: none"> <li>– Electroconvulsive Therapy (ECT)</li> <li>– Psychological Testing including Psychological and Neuropsychological testing and extended developmental testing</li> <li>– Substance Abuse Treatment (Outpatient, detoxification, Intensive Outpatient Services, Routine Outpatient Services with a Primary Diagnosis of Substance Abuse)</li> </ul> </li> <li>• Pulmonary Rehabilitation</li> <li>• Radiology               <ul style="list-style-type: none"> <li>– Capsule Endoscopy</li> <li>– CT's- Brain, Chest, Musculoskeletal, colonography</li> <li>– MRI of Brain, Heart, Chest, Musculoskeletal</li> <li>– PET Scans (non-cancer diagnoses)</li> <li>– Virtual procedures</li> </ul> </li> <li>• Reduction Mammoplasty (with pictures)</li> <li>• Rhinoplasty/Septo-rhinoplasty (with pictures)</li> <li>• Sclerotherapy (with pictures)</li> <li>• Sleep Apnea (oral appliances and surgery)</li> <li>• Speech Therapy<sup>2</sup> (after eight visits)</li> <li>• Temporomandibular Disorder (TMD) or related Myofascial Pain Dysfunction Syndrome (MPD) Treatment</li> <li>• Transplants (and evaluations)</li> <li>• Vagal Nerve Stimulator</li> </ul>

1 Initial preauthorization/precertification request must be submitted by the member's Primary Care Physician (PCP). However, the treating physician or health care practitioner may submit the initial request for OCI Direct members.

2 All Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.

3 For OCI Direct members, precertification required from first visit and may be requested by telephone.

4 Precertify these services through the Behavioral Health Department.

<b>Procedures and services requiring preauthorization or precertification: telephone or written request</b>	
<ul style="list-style-type: none"> <li>• Ambulance Services (non-emergency)</li> <li>• Cardiac Angioplasty (inpatient or outpatient)</li> <li>• Coronary Artery Bypass Graft</li> <li>• Dialysis<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatric Therapies (pre-authorization/precertifications can be made by telephone)<sup>4</sup> <ul style="list-style-type: none"> <li>– Inpatient Services (non-emergency)</li> <li>– Psychiatric Partial Hospitalization and Intensive Outpatient Treatment</li> <li>– Substance Abuse Treatment (Inpatient Rehabilitation, Partial Hospitalization)</li> </ul> </li> <li>• Radiation Therapy<sup>1</sup></li> </ul>
<p><b>Exception Requests</b></p> <p>All exceptions to the health plan's policies and procedures must be preauthorized. The most common, but not a comprehensive list of, exception requests are:</p> <ul style="list-style-type: none"> <li>• Immunizations (outside the scope of health plan guidelines)</li> <li>• Lower level ambulatory surgery procedures rendered in Montgomery and Prince George's counties in Maryland in a hospital (Medicare levels one to four)</li> <li>• Refer a member out-of-network to a non-participating physician, health care practitioner or facility</li> </ul>	
<p><b>The following list of services requiring pre-certification applies to all MAMSI Life and Health Insurance Company and M.D. IPA Preferred and Optimum Choice Preferred members in non-updated plans using their out-of-network benefits.</b></p> <p>Be sure to submit your request at least two (2) business days prior to the provision of services. Please keep in mind some procedures and services listed here may not be covered under the member's health plan policy. If you have any questions, please contact the Professional Services Department at <a href="mailto:maprofessionalservices@uhc.com">maprofessionalservices@uhc.com</a>, or call (800) 342-6141.</p>	
<ul style="list-style-type: none"> <li>• Acupuncture (if covered)</li> <li>• Angioma/Hemangioma Treatment</li> <li>• Biofeedback</li> <li>• Blepharoplasty</li> <li>• Breast Impact Removal</li> <li>• Breast Reconstruction</li> <li>• Cataract Surgery</li> <li>• Chiropractic services (if no dollar limit)</li> <li>• Cholecystectomy by laparoscopy</li> <li>• Cochlear Implants</li> <li>• Congenital Anomaly Repair</li> <li>• Cosmetic and Reconstructive Surgery</li> <li>• Durable Medical Equipment (for a complete list of DME items which do not require preauthorization, visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>)</li> <li>• Elective Inpatient Procedures and Admissions must be preauthorized</li> <li>• Endoscopic Transthoracic Sympathectomy (ETS)</li> <li>• Enhanced External Counterpulsation</li> <li>• General Anesthesia for Denal Procedures</li> <li>• Growth Hormone Treatment</li> <li>• Gynecomastia Surgery</li> <li>• Infertility Services (if covered)</li> </ul>	<ul style="list-style-type: none"> <li>• Occupational Therapy</li> <li>• Pelvic Laparoscopy</li> <li>• Physical Therapy</li> <li>• Prometheus Laboratory Tests for Inflammatory Bowel Disease</li> <li>• Psychiatric Outpatient Therapies, including but not limited to: <ul style="list-style-type: none"> <li>– Eye Movement Desensitization and Reprocessing (EMDR)</li> <li>– Psychiatric Day Treatment and/or Intensive Outpatient Treatment Programs (programs providing more than one treatment session/day)</li> <li>– Psychological Testing including Psychological and Neuropsychological Testing, Extended Development Testing, neuro-Behavioral Status Exams or Assessment of Aphasia</li> <li>– Reduction Mammoplasty if covered</li> </ul> </li> <li>• Rhinoplasty</li> <li>• Speech Therapy (under age 10)</li> <li>• Substance Abuse Treatment</li> <li>• Temporomandibular Disorder (TMD) and/or related Myofascial Pain Dysfunction Syndrome (MPDS) Treatment</li> <li>• Transplants Evaluation</li> <li>• Uvulopalatoharyngoplasty</li> </ul>

<sup>1</sup> Initial preauthorization/precertification request must be submitted by the member's Primary Care Physician (PCP). However, the treating physician or health care practitioner may submit the initial request for OCI Direct members.

<sup>2</sup> All Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.

<sup>3</sup> For OCI Direct members, precertification required from first visit and may be requested by telephone.

<sup>4</sup> Precertify these services through the Behavioral Health Department.

## Obtaining Select, Provider-Administered Injectable Medications

Following are key drugs requiring use of a particular vendor and pre-authorization:

- Botox (Botulinum Toxin Type A)
- Myobloc (Botulinum Toxin Type B)
- Synagis (palivizumab)
- Xolair (omalizumab)

Following are key drugs requiring pre-authorization:

- Amevieve (alfacept)
- Erythrocyte Stimulating Agents
- Hyaluronic Acid Injection Agents
- Remicade (infliximab)
- Rituxan (rituximab)
- Tysabri (natalizumab)

**Note:** The list above is valid as of May 12, 2009. Medications not included above may require inclusion of a specific diagnosis for payment. For current listings, go to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or call contact numbers below.

Information on our medical evidence-based policies is available at: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Policies → Medical Policies. For additional policies and information, call (800) 355-8530.

Specialty pharmaceutical vendor information available at: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies & Protocols → Protocols, or call (866) 429-8177. All drugs are appropriate for office-based administration. (Call to request an exception to office-based administration.)

Requests for pre-authorization must be faxed to (800) 787-5325. Include clinical notes and name of specialty pharmacy vendor. For questions, call (800) 355-8530.

If authorized, Pharmacy Services will provide a written authorization number and coverage dates. This authorization should be submitted to the specialty pharmacy vendor along with the medication order. UnitedHealthcare will call provider's office within three (3) business days if conditions are not met for providing the drug.

### Procurement of Synagis

M.D. IPA and Optimum Choice, Inc. contract with PharmaCare/CVS Caremark<sup>®</sup> as a specialty pharmacy for Synagis. Synagis treatment requires prior authorization which can be obtained by faxing the RSV Enrollment form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain the RSV fax enrollment form at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Pharmacy Resources. You can reach PharmaCare/CVS Caremark at (800) 952-4065.

If you have questions about obtaining Synagis from PharmaCare/CVS Caremark, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-8177.

### Procurement of Botox/Myobloc and Xolair

M.D. IPA and Optimum Choice, Inc. contract with Prescription Solutions as a specialty pharmacy for Botox/Myobloc and Xolair. Botox/Myobloc and Xolair require prior authorization which can be obtained by faxing the prior authorization request form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain the prior authorization request forms at [PrescriptionSolutions.com](http://PrescriptionSolutions.com) → Prior Authorizations → Prior Authorization Request Forms, under the Specialty Pharmacy heading. You can reach Prescription Solutions High Touch team at (888) 293-9309.

If you have questions about obtaining Botox/Myobloc or Xolair from Prescription Solutions, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-8177.

## **Clinical appeals**

To appeal an adverse decision (a decision by us not to preauthorize or precertify a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter or PRA will provide you with the filing deadlines and the address listed on the member's health care ID card to use to submit the appeal.

## **Member rights and responsibilities**

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

These rights and responsibilities can be found on:

- [myuhc.com](http://myuhc.com) for M.D. IPA and Optimum Choice members enrolled in updated benefit plans; or
- [mamsiUnitedHealthcare.com](http://mamsiUnitedHealthcare.com) for MAMSI Health and Health Insurance Company members as well as M.D. IPA and Optimum Choice members enrolled in non-updated benefit plans.

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## COMPARISON DOCUMENT

- This Comparison Document shows the changes between the new 2010 UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the “Guide”) and the 2009 UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide.
- The new 2010 text is shown in bold-faced, double-underlined font. The replaced 2009 text is shown in bold-faced, strike-out font.
- This Comparison Document is intended to highlight, at a high level, the key changes that have been made to the Guide for 2010 and is required in certain states.
- The Comparison Document should only be used to review changes made from 2009 to 2010. For a .pdf of the most recent 2010 Administrative Guide, please refer to the [UnitedHealthcare Administrative Guide - 2010](#) 

Physician, Health Care  
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# Important ~~Information Regarding~~ information ~~regarding~~ the Use of this ~~Guide~~ guide

~~In~~ in the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this Guide, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix . Additionally, in the event of a conflict or inconsistency between your agreement and this Guide, the provisions of your agreement with us will control . This entire Guide is subject to change .

All items within this Guide that describe how you must do business with us are Protocols under the terms of your agreement .

This Guide applies to all covered services rendered to members covered under a benefit plan insured by or receiving administrative services from UnitedHealthcare and its affiliates, unless otherwise noted . Please note that, in the event your agreement indicates that additional protocols or guides are applicable to members covered under certain benefit plans, those other protocols and guides will control with respect to such members as described in your agreement .

~~The Medicare section, previously a separate chapter within this Guide, is now consolidated with the rest of the Guide for ease of reference. This means that, unless otherwise noted for a particular section or item, this~~ This entire Guide applies to Medicare ~~members. If~~ Advantage members . Unless otherwise noted, reference to Medicare Advantage members includes Erickson Advantage members . if a particular section does not apply to Medicare, Advantage

or ~~applies solely to Medicare~~ Erickson Advantage members, that will be clearly indicated in this Guide . As used in this Guide, references to “Medicare members” ~~do not~~ only include those Medicare members enrolled in Medicare benefit plans ~~administered by AmeriChoice~~ offered through AARP® Medicarecomplete, SecureHorizons, Evercare, and Erickson Advantage.

Unless otherwise specified herein, this Guide is effective on April 1, ~~2009 for~~ 201 0 for physicians, health care professionals, facilities and ancillary providers currently participating in the UnitedHealthcare network and effective immediately for physicians, health care professionals, facilities and ancillary providers who join the UnitedHealthcare network on or after January 1, ~~2009-2010.~~

**Note:** “Member” is used in this Guide to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us . “~~Commercial~~ commercial” as used in this Guide refers to all UnitedHealthcare medical products that are not Medicare, Medicaid or other governmental products . “Guide” refers to this ~~2009~~ 201 0 Physician, Health ~~Care~~ care Professional, Facility and Ancillary Provider Administrative Guide . “You” or “your” refers to any provider subject to this Guide, including physicians, health care professionals, facilities and ancillary providers; unless otherwise specified in the specific item, all items are applicable to all types of providers subject to this Guide . “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself, and its other affiliates for those products and services subject to this Guide .

The codes and code ranges listed in this Guide were current at the time this Guide was published . ~~Codes~~ codes and coding requirements, as established by the organizations that create the codes, may periodically change . Please refer to the applicable coding guide for appropriate codes or visit UnitedHealthcareOnline .com for further information .

# How to ~~Contact Us~~ contact us

## Commercial & Medicare products

RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>COMMERCIAL &amp; MEDICARE PRODUCTS</b>		
UnitedHealthcareOnline®	<u>UnitedHealthcareOnline.com</u>	<ul style="list-style-type: none"> <li>• Register for UnitedHealthcare Online®</li> <li>• Review a member's eligibility or benefits and view their current HRA balances</li> <li>• Provide inpatient admission, outpatient surgery, radiology, home health care services or durable medical equipment notification</li> <li>• Check status of or update existing notifications</li> <li>• Check claims status</li> <li>• Submit claims with Real-Time Adjudication</li> <li>• Update facility/practice data</li> <li>• Review the physician, health care professional, and facility directory</li> <li>• Look up your fee schedule, ten (10) codes at a time</li> <li>• Review/print a current copy of this Guide</li> <li>• View UnitedHealthcare policies</li> <li>• View claim pre-determination and bundling logic using Claim Estimator (not applicable to Medicare)</li> </ul>
	(866) UHC-FAST (866) 842-3278	<ul style="list-style-type: none"> <li>• Get technical support for UnitedHealthcareOnline</li> </ul>
Electronic Claim Submission (EDI Support Line)	(800) 842-1109	<ul style="list-style-type: none"> <li>• Obtain information on submitting claims electronically</li> <li>• Use our payer ID 87726</li> </ul>
United Voice Portal	(877) UHC-3210 (877) 842-3210	<ul style="list-style-type: none"> <li>• Inquire about a member's eligibility or benefits</li> <li>• Check claim status, reason code explanation and claims pending</li> <li>• Update facility/practice demographic data</li> <li>• Check credentialing status or request for participation inquiries</li> <li>• Check appeal submission process information, or claim project submission process information</li> </ul>

**RESOURCE**

[UnitedHealthcare Online®](#)

<p><b>Advance &amp; Admission Notification</b></p>	<p><a href="#">UnitedHealthcareOnline.com</a> Call United Voice Portal at (877) UHC-3210 (877) 842-3210 See member's health care ID card for Customer Care contact information</p>	<p>• <b>Notify us of the procedures and services outlined in the Notification Requirements section of this Guide</b></p>
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**WHERE TO GO**

<p><a href="#">UnitedHealthcareOnline.com</a></p>
<p>(800) 842-1109</p> <p><a href="#">To obtain information on HIPAA Transactions &amp; code sets go to <a href="#">hipaa_uhc.com</a>. Uniprise companion document</a></p> <p><a href="#">Additional UnitedHealthcare and Affiliates' payer ids can be found on <a href="#">UnitedHealthcare Online.com</a> - claims &amp; Payments - Electronic claims Submissions, under Edi Tools &amp;</a></p>
<p><a href="#">(877) UHC-3210, Option 2</a> <a href="#">(877) 842-3210, Option 2</a></p>
<p><a href="#">To obtain a United Voice Portal Quick Reference Process Overview, go to <a href="#">UnitedHealthcareOnline.com</a> - contact Us, then reference the Service &amp; Support Section - click on the quick reference link under <a href="#">UnitedHealthcare for Health care Professionals (United Voice Portal)</a></a></p>

**WHAT YOU CAN DO THERE**

- [Register for UnitedHealthcare Online](#)
  - [Review a member's eligibility or benefits and view their current HRA balances](#)
  - [Submit notifications](#)
  - [View claim pre-determination and bundling logic using claim Estimator \(not applicable to Medicare\)](#)
  - [Submit claims with Real-Time Adjudication \(for commercial members only\)](#)
  - [check status of or update existing notifications](#)
  - [check claims status](#)
  - [Request a claims adjustment or a reconsideration when attachments are not needed](#)
  - [Submit a claim research project for 20 or more claims using the claim Research Project online form](#)
  - [Update facility/practice data \(except TiN\)](#)
  - [Review the physician, health care professional, and facility directory](#)
  - [look up your fee schedule, ten \(10\) codes at a time](#)
  - [Review/print a current copy of this Guide](#)
  - [View UnitedHealthcare policies](#)
  - [View current and past issues of our Network Bulletin](#)
  - [Access and review clinical program information and patient safety resources](#)
- |   |
|---|
| <ul style="list-style-type: none"> <li>• <a href="#">Get technical support for UnitedHealthcare Online</a></li> </ul> |
|---|

[Electronic Claim Submission](#)  
(Edi Support line)

[United Voice Portal](#)

- [Obtain information on submitting claims electronically](#)
- [Use our payer id 87726](#)

- [inquire about a member's eligibility or benefits \(including copayments, deductibles, past/ current coverage, coinsurance, and out-of-pocket information\) and obtain a faxed confirmation](#)
- [check claim status, reason code explanation and claims pending and mailing addresses](#)
- [Update facility/practice demographic data \(except TIN\)](#)
- [check credentialing status or request for participation inquiries](#)
- [check appeal or claim project submission process information](#)
- [check care Notification process information](#)

<a href="#">Commercial &amp; Medicare products</a>		
RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<a href="#">Advance &amp; Admission Notification</a>	<a href="#">UnitedHealthcareOnline.com</a> or call <a href="#">United Voice Portal</a> at (877) UHc-321 0 (877) 842-3210 or <a href="#">See member's health care id card for customer care contact information</a>	<ul style="list-style-type: none"> <li>• <a href="#">Notify us about the procedures and services outlined in the Notification Requirements section of this Guide</a></li> <li>• <a href="#">Access Utilization Staff regarding utilization management issues</a></li> </ul>
<b>Erickson Advantage®</b> ( <del>applies only to</del> <a href="#">UnitedHealthcare Medicare members Advantage network product for</a> )	See member's health care <b>ID</b> card for <del>Customer Care</del> <a href="#">customer care</a> contact information	<ul style="list-style-type: none"> <li>• <b>Inquire</b> <a href="#">inquire</a> about benefits and services as indicated in this Guide, including Notification Requirements</li> </ul>
<b>Pharmacy Services</b> ( <del>applies only to</del> (For commercial members) <a href="#">only</a> )	<a href="#">UnitedHealthcareOnline.com</a>  <b>Phone:</b> (877) 842-1508 <b>Fax:</b> (877) 842-1435 <b>Fax:</b> (888) 327-9791	<ul style="list-style-type: none"> <li>• View the Prescription <b>Drug List</b> <a href="#">drug list (PDL/Pdl)</a> and a current list of participating specialty pharmacy provider(s) by drug</li> <li>• Request a copy of the <b>PDL/Pdl</b></li> <li>• <b>Call</b> <a href="#">call</a> for medications requiring notification</li> <li>• <del>Fax for easy Rx service</del></li> </ul>
<b>Pharmacy Services</b> ( <del>applies only to</del> (For Medicare Advantage members <a href="#">only</a> ))	<a href="#">Go to</a> <a href="#">securehorizons.com/ourplans/searchformulary.html</a> <a href="#">.com/Search the drug list</a>  <b>Fax:</b> (877) <b>MDRXFAX</b> <a href="#">MdRXFAX</a> (877) 637-9329  <a href="#">http://Go to</a> <a href="#">evercarehealthplans.com/</a> <a href="#">prescription_drug_coverage.jsp</a>  Phone: (800) 711-4555  Fax: (800) 527-0524	<ul style="list-style-type: none"> <li>• View the SecureHorizons Formulary or request a copy</li> <li>• View the Evercare Formulary</li> <li>• Request a prior authorization</li> <li>• <b>For</b> <a href="#">Submit request for</a> oral medications</li> <li>• <b>For</b> <a href="#">Submit request for</a> injectable medications</li> <li>• Request information on the Medicare Medication Management Program</li> </ul>
<a href="#">Behavioral Health Services</a>	<a href="#">See member's health care id card for carrier information and contact numbers</a>	<ul style="list-style-type: none"> <li>• <a href="#">inquire about a member's behavioral health benefits</a></li> </ul>
<a href="#">Vision Services</a>	<a href="#">See member's health care id card for carrier information and contact numbers</a>	<ul style="list-style-type: none"> <li>• <a href="#">inquire about a member's vision benefits</a></li> </ul>
<b>Mental Health, Substance</b>	See member's health care <b>ID</b> card for carrier information and contact numbers.	<ul style="list-style-type: none"> <li>• <b>Inquire</b> <a href="#">inquire</a> about a member's <b>behavioral health, vision or</b> transplant</li> </ul>
<b>Customer Care</b>	See member's health care <b>ID</b> card for <del>Customer Care</del> <a href="#">customer care</a> contact	<ul style="list-style-type: none"> <li>• Obtain information for services as indicated in this Guide</li> </ul>
<b>Electronic Payments and Statements (EPS)</b>	<a href="#">UnitedHealthcareOnline.com</a> (866) <b>UHC</b> <a href="#">UHc</a> -FAST, Option <b>5,5</b> (866) 842-	<ul style="list-style-type: none"> <li>• Sign up for EPS</li> <li>• <b>Call</b> <a href="#">call</a> for questions or issues with EPS</li> </ul>
<a href="#">Outpatient Radiology Notification Submission and Status</a> ( <del>Does not currently apply to</del> )	<a href="#">UnitedHealthcareOnline.com</a> Phone: (866) 889-8054 Fax: (866) 889-8061	<ul style="list-style-type: none"> <li>• Notify us of certain radiology procedures as described in the Outpatient Radiology Notification section of this Guide</li> </ul>
<b>Chiropractic, PT/OT/ST Physical Therapy, Occupational Therapy and Speech</b>	<b>OptumHealth-Care Solutions (formerly-ACN Group)</b>	<ul style="list-style-type: none"> <li>• <a href="#">Verify benefits and eligibility</a></li> <li>• <b>Check</b> <a href="#">check</a> Notification process requirements</li> </ul>

RESOURCE	WHERE TO GO
<b>Medicare Contracted Network Plans</b>	
<del>For information on Erickson products and services</del>	<del><a href="http://ericksoncommunities.com">ericksoncommunities.com</a></del>
<del>For information on Evercare products and services</del>	<del><a href="http://evercarehealthplans.com">evercarehealthplans.com</a></del>
<del>For information on SecureHorizons products and services administered by Oxford, indicated by OHP on the health care ID card</del>	<del><a href="http://oxfordhealth.com">oxfordhealth.com</a></del>
<del>For information on SecureHorizons products and services administered by PacifiCare, indicated by the PHS on the health care ID card</del>	<del><a href="http://pacificare.com">pacificare.com</a></del>
<del>For information on SecureHorizons products and services administered by UnitedHealthcare Plan of the River Valley as indicated on the health care ID card</del>	<del><a href="http://uhcrivervalley.com">uhcrivervalley.com</a></del>
<del>For information on SecureHorizons products and services administered by UnitedHealthcare as indicated by the UHC on the health care ID card</del>	<del><a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></del>
<b>Medicare Non-Contracted, Non-Network Plans</b>	
<del>For information about SecureHorizons Medicare Direct or UnitedHealthcare Medicare Direct (Private Fee For Service) products and services administered by UnitedHealthcare</del>	<del><a href="http://UnitedHealthcareOnline.com/pffs">UnitedHealthcareOnline.com/pffs</a></del>

## Our ~~Claims Process~~ claims process

### Prompt ~~Claims Processing~~ claims processing

We know that you want your claims to be processed promptly for the covered services you provide to our members .

We work hard to process your claims timely and accurately . Here's what you can do to help us:

#### 1 Review the member's eligibility at [UnitedHealthcareOnline .com](http://UnitedHealthcareOnline.com), using swipe card technology or keying in the member's information .

You can also check member eligibility by phone by calling the United Voice Portal at (877) 842-~~3210~~321 0 or the ~~Customer Care~~customer care number on the back of the member's health care ~~ID~~ID card .

[Disclaimer: Eligibility & benefit information provided is not a guarantee of payment or coverage in any specific amount . Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date\(s\) of services rendered and benefit plan terms and conditions .](#)

#### 2 Notify us in accordance with the Standard Notification Requirements list .

#### 3 Prepare complete and accurate claims (see "Complete Claims" below) .

#### 4 Submit claims online at [UnitedHealthcareOnline .com](http://UnitedHealthcareOnline.com) or use another electronic option .

- a) **Connectivity Director is a free direct connection** for those who can create a claim file in the ~~HIPAA~~HIPAA 837 format . This Web-based application enables ~~faster~~ real-time and batch submissions direct to UnitedHealthcare-~~Connectivity~~ connectivity Director provides immediate response back to all transaction submissions (claims, eligibility, and more) . Additional information can be found at [UnitedHealthcareCDUnitedHealthcareCD .com](http://UnitedHealthcareCDUnitedHealthcareCD.com), including a comprehensive User Guide and information on how to get started .

- b) **UnitedHealthcare Online All-Payer Gateway™** is a Web-based connectivity solution which links

UnitedHealthcare Online users to a leading clearinghouse vendor (~~ENS, an Ingenix Company~~[ingenix](#)) that offers multi- payer health transactions and services at preferred pricing . Using your current UnitedHealthcare Online User [ID](#) and password, you can register with ~~ENS~~[ingenix](#) to submit batch claims to many of your governmental and commercial payers . For more information: [UnitedHealthcareOnline .com](#) • ~~Claims~~ [claims](#) and Payments • Electronic ~~Claims~~[claims](#) Submission • ~~EDI~~ [EDi](#) Options .

c) **EDI [Gateway and Clearinghouse Connections](#)** – ~~UnitedHealthcare's preferred clearinghouse is ingenix, but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare .~~ Both participating and ~~non-participating~~[nonparticipating](#) physician/[health care professional](#), facility [and ancillary provider](#) claims are accepted electronically using UnitedHealthcare's payer ID ~~87726. The payer ID numbers for United Healthcare's affiliates can be found at UnitedHealthCareOnline.com. UnitedHealthcare's preferred clearinghouse is ENS (an Ingenix Company), but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare~~[87726 . Other UnitedHealthcare and affiliate payer IDs can be found on \[UnitedHealthcareOnline .com\]\(#\)](#) .

~~UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically . Please review your agreement with us and abide by its requirements .~~

While some claims may require supporting information for initial review, UnitedHealthcare has reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more, ~~and prefers to receive your claims electronically~~ . We will request additional information when needed.~~UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements .~~

## 5 Receive Electronic Payments and Statements (EPS)

~~If~~[if](#) you are enrolled with us for EPS, payments are electronically deposited into one or more checking accounts which ~~are designated by~~ you [designate](#) . Take the next step by auto-posting the electronic 835/Electronic Remittance Advice (ERA) that you receive from your clearinghouse, or obtain one free of charge from our Web site at ~~UnitedHealthcareOnline.com~~[UnitedHealthcareOnline .com](#) .

Explanations of Benefits (EOBs) that match each daily/weekly consolidated deposit are available on [UnitedHealthcareOnline .com](#), where you can review, store and print hard copies to use for manual posting .

EPS is ~~the standard for our operations~~[UnitedHealthcare's preferred method for receiving payments and statements](#) and results in faster and easier payment to you . ~~If~~[if](#) you have not yet enrolled in this standard operating process, start receiving electronic payments and statements now by enrolling online at [UnitedHealthcareOnline .com](#) or by contacting us at (866) 842-3278, Option ~~5~~ [EPS5](#) . ~~Please note EPS is not available in all markets~~ for our Medicare Advantage plans ~~is not available in all markets~~ .

## ~~Pass-Through Billing/CLIA Requirements/Reimbursement Policy~~

### ~~Pass-through billing/CLIA requirements/reimbursement policy~~

~~If~~[if](#) you are a physician, practitioner or medical group, you must only bill for services that you or your staff perform . Pass-through billing is not permitted and may not be billed to our members .

For laboratory services, you will only be reimbursed for the services for which you are certified through the ~~Clinical~~[clinical](#) Laboratory ~~Improvement~~[improvement](#) Amendments (~~CLIA~~[cLiA](#)) to perform, and you must not bill our members for any laboratory services for which you lack the applicable ~~CLIA certification~~[cLiA certification; however, this requirement does not apply to laboratory services rendered by physicians, practitioners or medical groups in office settings that have been granted "waived" status under cLiA](#) .

Payment of a claim is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact .

## Complete ~~Claims~~claims

For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services (according to national coding guidelines) . ~~If~~it is particularly important to accurately code because a member's level of coverage under his or her benefit plan may vary for different services . You must submit a claim for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the member at the time of service .

To assist you in understanding how your claims will be paid, UnitedHealthcare's ~~Claim~~claim Estimator includes a feature called Professional ~~Claim~~claim Bundling Logic which helps you determine allowable bundling logic and other claims processing edits for a variety of ~~CPT~~cPT (~~CPT~~cPT is a registered trademark of the American Medical Association) and ~~HCPCS~~HcPcs procedure codes . Note: Only bundling logic and other claims processing edits are available under this option . Pricing and payment calculations are not included .

Allow enough time for your claims to process before sending second submissions or tracers, then check their status online at UnitedHealthcareOnline .com . ~~If~~if you do need to submit second submissions or tracers, be sure to submit them electronically no sooner than forty-five (45) days after original submission .

~~Whether you submit your CMS-1500 form or UB-04 form electronically or via paper form, a complete claim includes~~complete claims include the information listed under the "~~Complete Claims~~complete claims Requirements" section of this Guide.~~Additional~~We may require additional information ~~may be required by us~~ for particular types of services, or based on particular circumstances or state requirements .

~~If~~if you have questions about submitting claims to us, please contact ~~Customer Care~~customer care at the phone number listed on the member's health care ~~ID~~iD card . For questions specific to ~~submitting~~electronic submission of claims ~~electronically~~, please review the information at UnitedHealthcareOnline .com ~~Claims~~claims and Payments ~~Electronic~~Claimsclaims Submission (~~EDI~~EDi) . ~~If~~if you need additional information on ~~EDI~~EDi, contact the ~~EDI~~EDi Support Line at (800) 842-1109, Option ~~3~~3.

Learn about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at UnitedHealthcareOnline .com including: ~~Claim~~claim Estimator with bundling logic and Real-Time Adjudication . Training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-by-Step Help and Tutorials are available by clicking "Help" at the top of any page .

**Note: At the time of publication of this Guide, the Claim Estimator is not available for Medicare products.**

To order 1500 ~~HICF (CMS-1-500)~~HicF (cMS-1500) and UB-04 (~~CMS~~cMS-1450) forms, contact the U .S . Government Printing Office, call (202) 512-0455, or visit their Web site at ~~www~~www.cms .hhs .gov/~~CMSForms~~cMSForms

## Complete ~~Claims Requirements~~claims requirements

- Member's name
- Member's address
- Member's gender
- Member's date of birth (dd/mm/yyyy)
- Member's relationship to subscriber
- Subscriber's name (enter exactly as it appears on the member's health care ~~ID~~iD card)
- Subscriber's ~~ID~~iD number
- Subscriber's employer group name

- Subscriber's employer group number
- Rendering Physician-~~or,~~ Health **Carecare** Professional, or Facility Name
- Rendering Physician-~~or,~~ Health **Carecare** Professional, or Facility Representative's Signature
- Address where service was rendered
- Physician-~~or,~~ Health **Carecare** Professional, or Facility "remit to" address
- ~~Phone number of Physician-~~or,~~ Health **Carecare** Professional, or Facility performing the service (provide this **above** information in a manner consistent with how that information is presented in your agreement with us)~~
- Physician's-~~or,~~ Health **Carecare** Professional's, or Facility's National Provider **Identifier (NPI)** identifier (N Pi) and federal Tax **Identification** identification Number (**TIN** TiN)
- Referring physician's name and **TIN** TiN (if applicable)
- Date of service(s)
- Place of service(s) (for more information see: cms .hhs .gov/**PlaceofServiceCodes** PlaceofServiceCodes/Downloads/placeofservice .pdf)
- Number of services (day/units) rendered
- **Current CPT** current cPT-4 and **HCPGS** HcPcS procedure codes, with modifiers where appropriate
- **Current ICD** current icD-9-**CM** cM (or its successor) diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- **Charges** charges per service and total charges
- Detailed information about other insurance coverage
- **Information** information regarding job-related, auto or accident information, if available
- ~~Attach operative notes with CMS-1500 Form paper claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby)~~
- Retail purchase cost or a cumulative retail rental cost for DME greater than \$~~1,000~~ 1,000
- current NDC (National Drug code) 11-digit number for all claims submitted with drug codes . The NDC number must be entered in the 24D field of the cMS-1 500 Form or the LiN03 segment of the HiPAA 837 Professional electronic form .

### Additional information needed for a complete UB-04 form:

- Date and hour of admission
- Discharge date and hour of discharge
- Member status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e .g . emergency, urgent, elective, newborn)
- **Current** current four-digit revenue code(s)
- **Current** current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per **CMS** cMS guidelines
- **Current** current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per **CMS** cMS guidelines
- **Current ICD** current icD-9-**CM** cM (or its successor) procedure codes for inpatient procedures
- Attending physician **ID** iD
- Bill all outpatient procedures with the appropriate revenue and **CPT** cPT or **HCPGS** HcPcS codes

- Provide specific **CPT** or **HCPCS** codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services
- **Complete** box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status
- **If** charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount (\$ .01 or \$ **1.00**) must be reported on all other surgical revenue code lines to assure appropriate adjudication

## **Claim ~~Correction/Resubmit~~ correction/resubmit**

**If** you need to correct and re-submit a claim, submit a new **CMS-1500** or UB-04 indicating the correction being made. When correcting or submitting late charges on a **CMS-1 500** UB-04 or 837 **Institutional** claim, resubmit all original lines and charges as well as the corrected or additional information **using** When correcting UB-04 or 837 institutional claims, use bill type xx7, Replacement of Prior **Claim**. Do not submit corrected or additional charges using bill type xx5, Late **Charge-Claim**. **Hand-corrected claim re-submissions will not be accepted.**

### **Submission of Unlisted Medical or Surgical Codes**

~~Include a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or "other" revenue codes, as well as for experimental or reconstructive services.~~

~~Submission of CMS-1 500 Form Drug Codes Include the current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 electronic form.~~

## **Reporting ~~Requirements for Anesthesia Services~~ requirements for anesthesia services**

- One of the **CMS**-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV **1041 04** with an **"MJMi"** qualifier in loop 2400 SV1 **03 03**. For **CMS**-1 500 paper claims, report the actual number of minutes in Box 24G with qualifier **MJMi** in Box 24H.
- When medically directing residents for anesthesia services, the modifier **GGGc** must be reported in conjunction with the AA or QK modifier.
- When reporting obstetrical anesthesia services, use add-on codes **01968** or 01969, as applicable, on the same claim as the primary procedure **01967**.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

## **National Provider Identification (NPI)**

~~UnitedHealthcare and its affiliates are able to accept the National Provider Identifier (NPI) on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions.~~

~~A valid NPI is required on all covered claims (paper and electronic) in addition to the tax identification number (TIN). For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy.~~

~~Since May 23, 2008, The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations,~~

and many state Medicaid agencies **require** the adoption and use of **your** standardized National Provider

~~Identifier (NPI) on all electronic and paper claim submissions. You must include a valid NPI on all Medicare and Medicaid claims submitted for payment to SecureHorizons, Evercare and AmeriChoice. Any changes to our NPI policy will be preceded by communications to physicians, identifier (N Pi) for all health care professionals, organizations and trading partners. Such communications will indicate when we will reserve the right to no longer accept HIPAA transactions that do not contain a valid NPI. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPi for identification purposes in standard electronic transactions. In addition, based on state specific regulations NPi may be required to be submitted on paper claims. HIPAA defines a covered health care provider as any provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPi and use this number in all HIPAA transactions, in accordance with the instructions in the implementation Guides.~~

• To avoid payment delays or denials, UnitedHealthcare requires a valid Billing NPi and Taxonomy code(s) be submitted on both paper and electronic claims. In addition, UnitedHealthcare strongly encourages the submission of all other NPis as defined below.

• It is important that, in addition to the NPi, you continue to submit your Tax identification Number (TiN). The NPi information that you report to us now and on all future claims is essential in allowing us to efficiently process claims and to avoid delays or denials.

~~If you have not yet applied for and received your NPI, please do so immediately by visiting [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov).~~

UnitedHealthcare will continue to accept **NPIs** submitted through any of the following methods:

**1-1.** UnitedHealthcare Online (UnitedHealthcareOnline .com)

To update your **NPI** and related information online: [login to](#) UnitedHealthcareOnline .com [Go to](#) Practice/Facility Profile [Log in with your User Identification and Password \(your tax identification number will allow you to access these screens online\)](#) [Continue](#) [View/Update NPI Information](#) [and select your tax id](#) . [click continue, then select the View/Update NPI information](#) tab .

**2-2.** For members covered under benefit plans administered by **AmeriChoice**, please consult the applicable **AmeriChoice** state-specific physician section on [www.americhoice .com](http://www.americhoice.com) for details on where and how to submit **NPI**.

**3-3.** For all UnitedHealthcare business, fax your **NPI** to the appropriate fax number based on your geographic location/state . The fax form can be found under “Most Visited” and “National Provider **Identifier**” at [UnitedHealthcareOnline .com](http://UnitedHealthcareOnline.com) .

~~4. Call (877) 842-3210, the United Voice Portal.~~

**4.** ~~call (877) 842-3210, the United Voice Portal.~~ Select the “Health **Care** Professional Services” prompt . State “Demographic changes” and your call will be directed to the Service **Center** to collect your **NPI**, corresponding **NUCC** Taxonomy **Codes**, and other **NPI**-related information .

**5-NPI** and **NUCC** taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and recontracting efforts .

## How to submit NPI, TIN and taxonomy on a claim

The information below provides the location for NPI, TIN and Taxonomy on paper and electronic claims . See definitions in the UB-04 Data Specifications Manual .

<u>HIPAA 837P (Professional) Claim Transaction</u>	
<u>Primary identifier</u>	<u>Loop 201 0AA, NM1 09</u>
<u>Pay-To Provider Federal Tax id</u>	<u>Loop 201 0AB, NM1 09</u>
<u>Referring Physician</u>	<u>Loop 231 0A, NM1 09</u>
<u>Rendering Physician</u>	<u>Loop 2420A, NM1 09</u>
<u>HIPAA 837I (Institutional) Claim Transaction</u>	
<u>Billing Provider Primary id</u>	<u>Loop 201 0AA, NM1 09</u>
<u>Billing Provider Taxonomy</u>	<u>Loop 2000A, PRV03</u>
<u>Billing Provider Secondary id (EiN)</u>	<u>Loop 201 0AA, REF02</u>
<u>Attending Physician</u>	<u>Loop 231 0A, NM1 09</u>
<u>Operating Physician</u>	<u>Loop 231 0B, NM1 09</u>
<u>HICF 1500 (08-05) Professional Claim Form</u>	
<u>Referring Provider N Pi</u>	<u>Field 1 7b</u>
<u>Rendering Provider NPi</u>	<u>Field 24j</u>
<u>Service Facility Location NPi</u>	<u>Field 32a</u>
<u>Billing Provider NPi</u>	<u>Field 33a</u>
<u>Billing Provider Legacy identifier</u>	<u>Field 33b</u>
<u>important: Make sure that your claim software supports the revised 1500 claim form (08-05) Reference instruction Manual at <a href="http://nucc.org">nucc .org</a> for specific details on completing</u>	
<u>. Reference the 1500</u>	
<u>UB-04 Paper Institutional Claim Form</u>	
<u>Billing Provider NPi</u>	<u>Locator 56</u>
<u>Billing Provider Taxonomy code</u>	<u>Locator 81</u>

<a href="#"><u>Attending Provider NPi</u></a>	<a href="#"><u>Locator 76</u></a>
<a href="#"><u>Operating Provider NPi</u></a>	<a href="#"><u>Locator 77</u></a>
<a href="#"><u>Other Provider N Pi</u></a>	<a href="#"><u>Locator 78-79</u></a>

## **Laboratory ~~Claim Submission Requirement~~claim submission requirement**

Many UnitedHealthcare benefit plan designs exclude from coverage outpatient diagnostic services that were not ordered by a participating physician . UnitedHealthcare benefit plans may also cover diagnostic services differently when a portion of the service (e .g ., the draw) occurs in the physician's office, but the analysis is performed by a laboratory provider . ~~In~~in addition, many state laws require that most, if not all, laboratory services are ordered by a licensed physician .

Therefore, all laboratory claims must include the ~~NPINPI~~NPINPI number of the referring physician, in addition to the other elements of a ~~Complete Claim~~complete claim described in this Guide.~~Laboratory . laboratory~~ claims that do not include the identity of the referring physician will be ~~processed as though no physician ordered the service. This may affect the level of benefits and payment associated with the laboratory claim~~rejected or denied .

This requirement applies to claims for laboratory services, both anatomic and clinical .

This requirement applies to claims received from both participating and non-participating laboratories, unless otherwise provided under applicable law . This requirement does not apply to claims for laboratory services provided by physicians in their offices.~~Cross reference . Please also refer to~~ the Protocol on Use of Non-Participating ~~Laboratory~~laboratory Services .

## **Assistant surgeons or surgical assistants claim submission requirements**

The practice of directing or using non-participating providers significantly increases the costs of services for our members . as such, UnitedHealthcare requires our participating providers to use reasonable commercial efforts to utilize the services of in network providers, including in-network surgical assistants or assistant surgeons to render services to our members . Health care professionals acting as assistant surgeons must report their health care services under the primary surgeon's TIN . Payment is subject to our payment policies (reimbursement policies) .

## **Submission of ~~Claims for Services Subject to Medical Claim Review~~claims for services subject to medical claim review**

~~In~~in some instances, a claim may be pended for medical claim review under an applicable medical or drug policy, in order to determine whether the service rendered is a covered service, for example, Erythropoietin . To facilitate claim processing for such services, you are encouraged to include additional information or reports along with your original claim . For more information about UnitedHealthcare drug and medical policies, please ~~visit~~see UnitedHealthcareOnline .com ~~Most Visited~~ ~~Policies, Protocols and~~ ~~Administrative~~administrative Guides ~~Policies~~ .

## **Erythropoietin (For Commercial members)**

For Erythropoietin (EPO) claims submitted via paper to UnitedHealthcare on a ~~CMS-1500~~CMS-1 500 Form, enter the Hematocrit (Hct) level in the shaded area of line 24~~Aa~~Aa in the same row as the J-code . Enter Hct and the lab value (Hctxx) . For electronic claims, the Hct level is required in the (837P) Standard Professional ~~Claim~~claim Transaction, ~~Loop~~loop 2400 – Service ~~Line~~line, segment ~~MEAMEa~~MEAMEa, Data Element ~~MEA03-MEa03~~MEA03-MEa03 . The ~~MEAMEa~~MEAMEa segment should be reported as follows:

- ~~MEAMEa~~MEAMEa01 = qualifier “TR”, meaning test results
- ~~MEAMEa~~MEAMEa02 = qualifier “R2”, meaning hematocrit
- ~~MEAMEa~~MEAMEa03 = hematocrit test result

Example: ~~MEAMEa~~MEAMEa\*TR\*R2\*33~

~~For EPO claims submitted on a UB04 claim form, an Hct level is not required. EXCEPTION: Medicare facility claims also require the Hct to be submitted on the claim.~~ The following J codes require an Hct level on the claim:

- J0881 Darbepoetin alfa (non-ES RD use)
- J0882 Darbepoetin alfa (ESRD on dialysis)
- J0885 Epoetin alfa (non-ES RD use)
- J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)
- Q4081 Epoetin alfa (ESRD on dialysis)

For EPO claims submitted on a UB04 claim form, an Hct level is not required.

- **J0881 Darbepoetin alfa (non-ESRD use)**
- **J0882 Darbepoetin alfa (ESRD on dialysis)**
- **J0885 Epoetin alfa (non-ESRD use)**
- **J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)**
- **Q4081 Epoetin alfa (ESRD on dialysis)**

## **Herceptin** [KRAS](#)

~~Historically, [Effective April 1, 2009](#), UnitedHealthcare required a pathology report demonstrating over-expression of the HER2 protein prior to reimbursement of Herceptin claims. In fourth quarter 2008, this requirement was removed, and we no longer require a pathology report for members receiving Herceptin requires the submission of a pathology report documenting KRAS gene type in order to determine coverage for Erbitux® (cetuximab J9055) and Vectibix® (panitumumab J9303) for members with colorectal cancer.~~

[Please fax the pathology reports to \(915\) 231-1970 using the dedicated fax cover sheet that is located at UnitedHealthcareOnline.com clinician Resources cancer-Oncology KRAS Testing.](#)

## **Member Financial Responsibility** [financial responsibility](#)

Members are responsible for applicable copayments, deductibles and coinsurance associated with their plans . You should collect copayments at the time of service; however, to determine the exact member responsibility related to plan deductibles and coinsurance, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) when billing members .

~~If~~ [if](#) you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility using the tools we make available, and collect no more than that amount at the time of services . Several tools are available on our Web site to help you determine member and health plan responsibility, including **Claim** [claim](#) Estimator and HRA Balance viewing through the Eligibility [Inquiry](#) [inquiry](#) function . (Note: **Claim** [claim](#) Estimator is not available for Medicare members .)

You can also use the claim submission feature on UnitedHealthcareOnline .com while the member is still in the office and, ~~in a matter of seconds~~, receive a fully adjudicated claim value showing the plan's responsibility and the member's responsibility, based on contracted discounts and plan benefits . This will help promote accurate collections and avoid overpayment or underpayment situations . [In](#) [in](#) the event the member pays more than the amount indicated on the medical claim EOB, you are responsible for promptly refunding the difference to the member .

## **Claim Reconsideration**

~~If you believe you were underpaid by us, the first step in addressing your concern is submission of a Claim Reconsideration request. You can simplify the submission of requests for claim reconsideration and receive more efficient resolution of claim issues by using [UnitedHealthcareOnline.com](#).~~

- ~~• You may submit a single claim in a paid or denied status directly to UnitedHealthcare for research and review online, or you can call the Customer Care number on the back of the health care ID card to request an adjustment. If written documentation such as proof of timely filing is needed, please use the claim reconsideration request form found on [UnitedHealthcareOnline.com](#) and submit the form to the claim address on the back of the member's health care ID card.~~
- ~~• If you have issues involving twenty (20) or more paid or denied claims, you can aggregate these claims on the Claim Research Project online form and submit them for research and review.~~

~~The UnitedHealthcare Claim Reconsideration Request Form can be found on [UnitedHealthcareOnline.com](#) • [Claims & Payments](#) • [Claim Reconsideration](#) • [Claim Reconsideration Request Form](#).~~

[For Medicare Advantage members, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage member who is eligible for both Medicare and Medicaid, or his or her representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing \(e.g., copayments, deductibles, coinsurance\) when the state is responsible for paying such amounts. You will either: \(a\) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or \(b\) bill the appropriate state source for such cost sharing amount.](#)

## Overpayments

**If** you identify a claim for which you were overpaid by us, or if we inform you in writing or electronically of an overpaid claim that you do not dispute, you must send us the overpayment within thirty (30) calendar days (or as required by law), from the date of your identification of the overpayment or our request . We may also apply the overpayment against future claim payments to the extent permitted by your agreement with us and applicable law .

All refunds of overpayments in response to overpayment refund requests received from UnitedHealthcare, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter . Refunds of any credit balances existing on your records should be sent to:

**UnitedHealthcare**  
**Attn: Audit and Recovery Operations**  
**2717 N 118th Circle**  
**Omaha, NE 68164-9672**

UnitedHealth Group Recovery Services  
P.O. Box 740804  
Atlanta, GA 30374-0804

Please include appropriate documentation that outlines the overpayment, including member's name, health care **ID** number, date of service and amount paid . **If** possible, please also include a copy of the remittance advice that

corresponds with the payment from UnitedHealthcare . **If** the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund .

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician/health care professional~~-In, facility or ancillary provider . in~~ the case of an overpayment, we will request a refund at least thirty (30) days prior to implementing a claim ~~reconsideration~~adjustment, or as provided by applicable law or contractual agreement. You will see the adjustment on the EOB or Provider Remittance Advice (PRA) . When additional or correct information is needed, we will ask you to provide it .

**If** you disagree with a claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination (see Claimclaim Appeals section of this Guide) .

## Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits (COBCOB) rules .

- 1 Subrogation ~~==~~ To the extent permitted under applicable law and the applicable benefit plan, we reserve the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness .
- 2 Coordination of Benefits (COB) ~~-COB~~ COB is administered according to the member's benefit plan and in accordance with applicable law . UnitedHealthcare can accept secondary claims electronically . To learn more, go to UnitedHealthcareOnline .com ~~Claims~~ claims & Payments ~~Electronic~~ Claimsclaims Submission (EDIEdi), contact your EDIEdi vendor, or call EDIEdi support at (800) 842-~~1109~~-1109 .

<b>Primary Plan</b>	Plan that pays benefits first .	Benefits under the primary plan will not be reduced due to benefits payable under other plans .
<b>Secondary Plan</b>	Plan will pay benefits after the primary plan .	Benefits under the secondary plan may be reduced due to benefits payable under other primary plans .
<b>Tertiary Plan</b>	Three or more group benefit plans may provide benefits for the same medical expense .	Tertiary plans would offset the incurred expenses with the benefits paid by the primary and secondary carriers, and provide benefits for any remaining unreimbursed expenses .

**NOTE**Note: When coordinating benefits with Medicare, all COBCOB Types coordinate up to Medicare's allowed amount when the provider accepts assignment . Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary .

- 3 Workers' Compensation ~~-In~~ in cases where an illness or injury is employment-related, workers' compensation is primary . **If** notification is received that the workers' compensation carrier has denied the claim, the provider should submit the claim to UnitedHealthcare, regardless of whether the case is being disputed . **If** it is also helpful to send the other carrier's denial statement with the claim .

## Retroactive ~~Eligibility Changes~~eligibility changes

Eligibility under a benefit contract may change retroactively if:

- 1 We receive information that an individual is no longer a member;
- 2 The member's policy/benefit contract has been terminated;
- 3 The member decides not to purchase continuation coverage; or
- 4 The eligibility information we receive is later determined to be incorrect .

**If** you have submitted a claim(s) that is affected by a retroactive eligibility change, a claim reconsideration may be necessary . The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA) .

**If** you are enrolled in EPS, you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us .

# Appeals Claim reconsideration and appeals processes

## Claim Appeals

### Step 1: Claim reconsideration

if you believe you were underpaid by us, the first step in addressing your concern is to request a claim Reconsideration .

- The quickest way to submit a claim Reconsideration request is directly through UnitedHealthcareOnline .com . Go to UnitedHealthcareOnline .com claims & Payments claim Reconsideration . Please identify the specific claims in “paid” or “denied” status which you believe should be adjusted and give a description of the requested adjustment

- if written documentation, such as proof of timely filing is needed, you must use the claim Reconsideration Request Form found on UnitedHealthcareOnline .com claims & Payments claim Reconsideration claim Reconsideration Request Form . The form should be mailed to the claim address on the back of the member’s health care ID card .

if you are submitting a claim Reconsideration Request Form for a claim which was denied because filing was not timely:

1. Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim .

2. Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim .

Note: All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit .

- Alternatively, you can call the customer care number on the back of the health care ID card to request an adjustment for issues which do not require written documentation .
- if you have issues involving twenty (20) or more paid or denied claims, aggregate these claims on the claim Project online form and submit the form for research and review . Go to UnitedHealthcareOnline .com claims & Payments claim Research Project .

### Step 2: Claim appeal

if you believe you were underpaid by us, the first step in resolving your concern is to submit a claim Reconsideration as described above .

**if you disagree still do not agree with the outcome of a the claim reconsideration Reconsideration decision or an overpayment refund request, in Step 1, you may submit a formal appeal by completing the UnitedHealthcare Claim Reconsideration Request Form. The form can be found on UnitedHealthcareOnline.com • Claims & Payments • Claim Reconsideration • Claim Reconsideration Request Form under Related Links. Please check the second submission box at the top of the form. You may also send a letter of appeal request to:**

**UnitedHealthcare United Healthcare Provider Appeals**

P .O . Box 30559

Salt Lake **Citycity**, UT 84130-0575

Your appeal must be submitted to us within twelve (~~12~~12) months from the date of the adjustment decision shown on the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) . Attach all supporting materials such as member-specific treatment plans or clinical records to the **Formal Appeal Request, as instructed on the Form formal appeal request**, based on the reason for the request . **Include include** information **that which** supplements your prior adjustment submission that you wish to have included in the appeal review . Our decision will be rendered based on the materials available at the time of formal appeal review .

~~If~~ you are appealing a claim that was denied because filing was not timely, ~~for~~:

1. Electronic claims ~~=~~ include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim .
2. Paper claims ~~=~~ include a copy of a screen print from your accounting software to show the date you submitted the claim .

**Note: All proof of timely filing must also include documentation that the claim is for the correct patient and the correct visit.**

~~If~~

~~if~~ you ~~disagree with an overpayment~~ are disputing a refund request, please send a your letter of appeal to the address noted on the refund request letter . Your appeal must be received within thirty (30) calendar days of the date of the refund request letter, or as required by law or your participation agreement, in order to allow sufficient time for processing the appeal, and to avoid possible offset of the overpayment against future claim payments to you . When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe we have made the refund request ~~is~~-in error .

~~If~~ if you disagree with the outcome of ~~the~~ any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution as described ~~below~~ in the Resolving disputes section and in your agreement with us .

~~In~~ in the event that a member has authorized you to appeal a clinical or coverage determination on the member's behalf, ~~that~~ such an appeal will follow the process governing member appeals as outlined in the member's benefit contract or handbook .

## Resolving ~~Disputes~~ disputes

### Agreement ~~Concern~~ concern or ~~Complaint~~ complaint

~~If~~ if you have a concern or complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us . ~~A~~ a representative will look into your complaint and try to resolve it through an informal ~~discussions~~ discussion . ~~If~~ if you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described below and in your agreement with us .

~~If~~ if your concern or complaint relates to a matter ~~which is generally administered by certain~~ involving UnitedHealthcare administrative procedures, such as the credentialing ~~or~~ , notification ~~process~~ , or ~~the~~ claim appeal process processes described in this Guide, you and we will follow the dispute procedures set forth in those plans to resolve the concern or complaint . ~~After~~ after following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in our agreement .

~~If~~ if we have a concern or complaint about your agreement with us, we'll send you a letter containing the details . ~~If~~ if we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us .

~~Arbitration~~ arbitration proceedings will be held at the location described in your agreement with us or if a location is not specified in your agreement, then at a location as described ~~below~~ in the "Arbitration Counties counties by Location" location section .

## Arbitration ~~Counties~~counties by ~~Location~~location

Unless your agreement with us provides otherwise, the following list contains locations where arbitration proceedings will be held . Locations listed under the state in which you provide care are the locations applicable to you .

### Alabama

Jefferson  
~~County~~county, AL

### Alaska

Anchorage, AK

### Arizona

Maricopa  
~~County~~county, AZ

### Arkansas

Pulaski  
~~County~~county, AR

### California

Los Angeles  
~~County~~county,  
~~CA~~cA San Diego  
~~County~~county,  
~~CA~~cA San Francisco  
~~County~~county, ~~CA~~  
cA

### Colorado

Arapahoe  
~~County~~county, ~~CO~~  
cO

### Connecticut

Hartford  
~~County~~county, ~~CT~~cT  
New Haven  
~~County~~county, ~~CT~~  
cT

### Delaware

Montgomery  
~~County~~county, MD

### District of Columbia

Montgomery  
~~County~~county, MD

### Florida

Broward  
~~County~~county, FL  
Hillsborough  
~~County~~county, FL  
Orange  
~~County~~county, FL

### Georgia

Gwinnett  
~~County~~county, GA

### Hawaii

Honolulu  
~~County~~county, ~~HI~~Hi

### Idaho

Boise, ~~ID~~iD  
Salt Lake  
~~County~~county, UT

### Illinois

~~Cook County, IL~~  
cook county, il

### Indiana

Marion  
~~County~~county, ~~IN~~in

### Iowa

Polk ~~County~~county,  
~~IA~~iA

### Kansas

Johnson  
~~County~~county, KS

### Kentucky

Fayette  
~~County~~county, KY

### Louisiana

Jefferson Parish, LA

### Maine

~~Cumberland~~  
~~County~~cumberland  
county, ME

### Maryland

Montgomery  
~~County~~county, MD

### Massachusetts

Hampden  
~~County~~county, MA  
Suffolk  
~~County~~county, MA

### Michigan

Kalamazoo  
~~County~~county, ~~MI~~Mi  
Oakland  
~~County~~county, ~~MI~~  
Mi

### Minnesota

Hennepin  
~~County~~county, MN

### Mississippi

Hinds ~~County~~county,  
MS

### Missouri

St . Louis  
~~County~~county, MO  
Jackson  
~~County~~county, MO

**Montana**  
Yellowstone  
**County**[county](#), MT

**Nebraska**  
Douglas  
**County**[county](#), NE

**Nevada**  
**Clark County**[clark county](#), NV Washoe  
**County, NV Carson City County, NV county, NV carson city county, NV**

**New Hampshire**  
Merrimack  
**County**[county](#), NH  
Hillsboro  
**County**[county](#), NH

**New Jersey**  
Essex  
**County**[county](#), NJ

**New Mexico**  
Bernalillo  
**County**[county](#), NM

**New York**  
New York  
**County**[county](#), NY  
Onondaga  
**County**[county](#), NY

**North Carolina**  
Guilford  
**County**[county](#), **NC-Nc**

**North Dakota**  
Hennepin  
**County**[county](#), MN

**Ohio**  
Butler  
**County**[county](#), OH  
**Cuyahoga County**[cuyahoga county](#), OH Franklin  
**County**[county](#), OH

**Oklahoma**  
Tulsa **County**[county](#), OK

**Oregon**  
Multnomah  
**County**[county](#), OR

**Pennsylvania**  
Allegheny  
**County**[county](#), PA  
Philadelphia  
**County**[county](#), PA

**Rhode Island**  
Kent **County, RI**[county, Ri](#)

**South Carolina**  
Richland  
**County**[county](#), **SC-Sc**

**Tennessee**  
Davidson  
**County**[county](#), TN

**Texas**  
Dallas  
**County**[county](#), TX  
Harris  
**County**[county](#), TX Travis  
**County**[county](#), TX

**Utah**  
Salt Lake  
**County**[county](#), UT

**Vermont**  
**Chittenden County**[chittenden county](#), VT  
Washington  
**County**[county](#), VT  
Windham  
**County**[county](#), VT

**Virginia**  
Montgomery  
**County**[county](#), VA

**Washington**  
King

**County**[county](#), WA

**West Virginia**  
Montgomery  
**County**[county](#), MD

**Wisconsin**  
Milwaukee  
**County**[county](#), **WI**  
**Waukesha County**[county](#), **WI**

**Wyoming**  
Laramie  
**County**[county](#), WY

# Health ~~Care Identification Cards~~ care identification cards

## Health ~~Care~~ care ID ~~Cards~~ cards

UnitedHealthcare members receive a health care **identification**ID card containing information **that helps**needed for you to submit claims **accurately and completely**. Information may vary in appearance or location on the card due to payer or other unique requirements . However, cards display essentially the same information (e .g ., claims address, copayment information, telephone numbers such as those for **Customer Care and Notification**)customer care and Notification) and are viewable on UnitedHealthcareOnline .com in the Patient Eligibility section . click on the “View Patient’s iD card” link located in the Patient Search results section of the Eligibility Detail page .

**It is important to**Please check the member’s health care **identification**iD card at each visit and keep a copy of both sides of the card for your records .

## **Checking ~~Health Care Benefit Eligibility and Copayment Using the UnitedHealthcare Health Care ID Swipe Card at the Time of Service~~**UnitedHealthcare has discontinued the use of the MasterCard® Terminal as an option for checking **health care benefit eligibility and copayment information when** using the UnitedHealthcare health care ID swipe card.This capability has been replaced with the use of a 3-track card reader which provides greater access to a wide variety of additional information and multipayer functionality with other WEDI-compliant cards. at the time of service

UnitedHealthcare uses a 3-track card reader for checking health care eligibility and copayment information . The 3-track card reader can be used in conjunction with **UnitedHealthcare’s Physician and Health Care Professional Web site**, UnitedHealthcareOnline .com; **swipe** . Swipe the member’s health care **ID**iD card to access the member’s Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions **with limited hand-keying for improved efficiency, accuracy and security. Manual entry of member information will also continue to be an option available on UnitedHealthcareOnline.com.** UnitedHealthcare uses the national WEDI (Workgroup for Electronic Data interchange) card standards for our member iD cards .

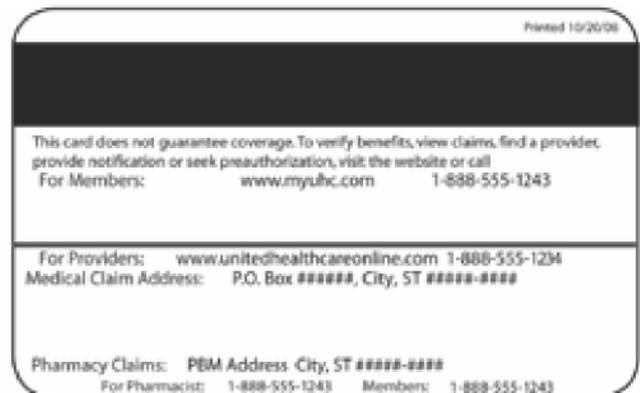
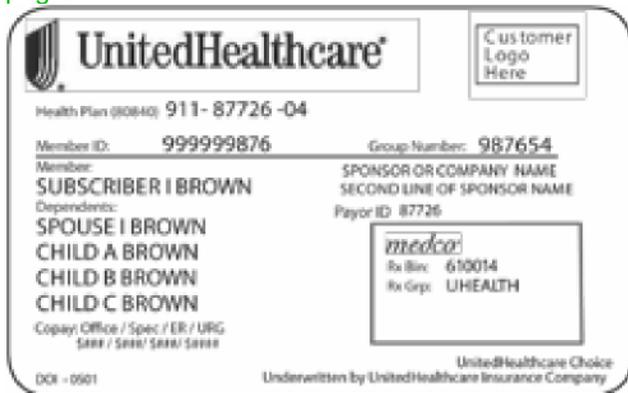
UnitedHealthcare has arranged a discounted 3-track card reader purchase price for physicians and health care professionals in our network, through a preferred distributor – Bayscan Technologies . To order your **discounted** reader(s) **through BayScan Technologies**, contact **BayScan** directly at **(877) 229-7226** or at **bayscan .com** . **To receive the special discounted price, you must** indicate that you are part of the UnitedHealthcare Network and supply your **TIN**TIN to receive the discounted price when ordering- .

As an additional resource **for you**, we have created a **Swipe ~~health~~Health care ~~ID Card~~ iD cards Quick Reference Guide for your reference when using the 3-track card reader, which can be found** at UnitedHealthcareOnline .com . **Tools & Resources** . **Health ~~Information~~information** Technology . **Health Care ID Card** Health care iD card **Swipe Technology** . This resource will enable you to learn more about how the UnitedHealthcare Medical - Rx **ID Card**iD card and **Integrated**integrated Financial & Medical - Rx **ID Card**iD card can simplify your transaction entry and accelerate payments .

## Sample ~~Health Care~~ health care ID ~~Card~~ card

**\*There is a link to the health care ID card on UnitedHealthcareOnline.com in the Patient Eligibility**

section. Click on the “View Patient’s ID card” link located in the Patient Search results section of the Eligibility Detail page.



[Medicare Advantage health care ID cards in order to help identify those members associated with our Medicare Advantage products offered through AARP® Medicarecomplete, SecureHorizons, Evercare, and Erickson Advantage, please go to the following provider Web site for iD card guides: UnitedHealthcareOnline.com Tools & Resources Products & Services Medicare 2010 UnitedHealthcare Medicare Solutions Physician/Provider information. Scroll to the “Member iD card information” section at the bottom of the page.](#)

## ~~Medicare Health Care ID Cards~~ Our products

~~Our Medicare Advantage members receive a health care ID designed to help you access our automated phone or online systems to verify benefits, eligibility and claim status.~~

~~A transition to more standard health care ID cards is being implemented throughout 2009; however, existing members will retain their current health plan identification card until a qualifying event requires a revised health care ID card.~~

### ~~Sample SecureHorizons Medicare Health Care ID Card~~

#### Protocol Designations

~~Each SecureHorizons health care ID card includes a unique identifier that designates the SecureHorizons benefit plan as one of the following types of plans: OHP (Oxford), PHS (PacifiCare), UHC (UnitedHealthcare) or UnitedHealthcare Plan of the River Valley. For services provided to members enrolled in SecureHorizons benefit plans designated as PHS, OHP or UnitedHealthcare Plan of the River Valley plans, you may be subject to additional protocols described in a separate administrative guide or provider manual.~~

<del>For information on SecureHorizons products and services administered by Oxford, indicated by OHP on the member identification card</del>	<del><a href="http://oxfordhealth.com">oxfordhealth.com</a></del>
<del>For information on SecureHorizons products and services administered by PacifiCare, indicated by the PHS on the member</del>	<del><a href="http://pacificare.com">pacificare.com</a></del>
<del>For information on SecureHorizons products and services administered by UnitedHealthcare Plan of the River Valley as indicated on the member identification card</del>	<del><a href="http://uhcrivervalley.com">uhcrivervalley.com</a></del>
<del>For information on SecureHorizons products and services administered by UnitedHealthcare as indicated by the UHC on the member</del>	<del><a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></del>

### ~~Sample AARP<sup>®</sup> Medicare Complete Health Care ID Card~~

## ~~Sample Evercare Medicare Health Care ID Cards~~

~~With the new Evercare health care ID Card, you can obtain member information in seconds, just by swiping the card through your card reader\*.~~

## ~~Sample AARP® Health Medicare Select ID Card (not a Medicare Advantage Plan) Our Products~~

### ~~Our Commercial **Products**products~~

~~This table provides information about some of the most common UnitedHealthcare products (your agreement with us may use “benefit contract types” or “Benefit Plan types” or **some** similar term to refer to our products) .~~

~~Visit~~

~~UnitedHealthcareOnline .com for more information about our products in your area . Medicare and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in these products . **If** a member presents an identification card with a product name with which you are not familiar, please contact **Customer Care**[customer\\_care](#) at the number on the back of the member’s health care **ID** card . This product list is provided for your convenience and is subject to change over time .~~

<del>Product Name</del>	<del>UnitedHealthcare Choice and Choice Plus</del>	<del>UnitedHealthcare Select and Select Plus</del>	<del>UnitedHealthcare Options PPO</del>	<del>UnitedHealthcare Indemnity</del>
<del>How do members access physicians and health care professionals?</del>	<del>Members can choose any network physician or health care professional without a referral and without designating a primary physician.* Choice Plus provides out-of-network coverage,** Choice does not (except for emergency).</del>	<del>Members choose a primary physician the network of physicians for each family member. The primary physician coordinates their care.* Select Plus provides out-of-network coverage,** Select does not (except for emergency).</del>	<del>Members can choose any network physician or health care professional without a referral and without designating a primary physician.* Options PPO provides out-of-network coverage.**</del>	<del>Members can choose any physician or health care professional.*</del>
<del>Is the treating physician and/or facility required to give notice when providing certain services?</del>	<del>Yes, on selected procedures. See guidelines in Notification Requirements section.</del>	<del>Yes, on selected procedures. See guidelines in Notification Requirements</del>	<del>No. Members are responsible for us at the phone on their Health care ID card, as described under the Member’s benefit plan. Please refer members to Customer Care for questions about</del>	<del>No. Members are responsible for notifying us at the number on their Health care ID card. Please refer members to Customer Care for questions about their responsibilities.</del>

<del><a href="#">Product Name</a></del>	<del><a href="#">How do members access physicians and health care professionals?</a></del>	<del><a href="#">Is the treating physician and/or facility required to give notice when providing certain services?</a></del>
<del><a href="#">UnitedHealthcare Choice and Choice Plus and CORE Choice Plus</a></del>	<del>Members can choose any network physician or health care professional without a referral and without designating a primary physician . * choice Plus provides out-of-network coverage,** choice does not (except for emergency) .</del>	<del>Yes, on selected procedures . See guidelines in Notification Requirements section .</del>

<a href="#">UnitedHealthcare Select and Select Plus</a>	<a href="#">Members choose a primary physician from the network of physicians for each family member. The primary physician coordinates their care.*</a> <a href="#">Select Plus provides out-of-network coverage,** Select does not (except for</a>	<a href="#">Yes, on selected procedures. See guidelines in Notification Requirements section.</a>
<a href="#">UnitedHealthcare Options PPO</a>	<a href="#">Members can choose any network physician or health care professional without a referral and without designating a primary physician.*</a> <a href="#">Options PPO provides out-of-network coverage.**</a>	<a href="#">No. Members are responsible for notifying us at the phone number on their health care ID card, as described under the member's benefit plan.</a> <a href="#">Please refer members to customer care for questions about their responsibilities.</a>
<a href="#">UnitedHealthcare Indemnity</a>	<a href="#">Members can choose any physician or health care professional.*</a>	<a href="#">No. Members are responsible for notifying us at the phone number on their health care ID card.</a> <a href="#">Please refer members to customer care for questions about their responsibilities.</a>

\* Physicians and health care professionals must be licensed for the health services provided and the health care services provided must be covered under the member's benefit contract.

\*\* The benefit level for [non-emergency](#) services from non-network physicians and health care professionals ~~may~~[will generally](#) be less than for services from network physicians and health care professionals.

**Definity<sup>SM</sup>**

## Definity<sup>SM</sup>

### Consumer-Driven Health Plans

UnitedHealthcare offers consumer-driven health plans to our members under the Definity<sup>SM</sup> name . These products may be identified via the health care **IDiD** card or by looking up your patient's eligibility information at **UnitedHealthcareOnlineUnitedHealthcareOnline**. com . The **Definity<sup>SM</sup>Definity** products each include three major components:

- 1 Traditional medical insurance that includes preventive care not charged against the deductible;
- 2 A Health Reimbursement Account (HRA) or Health Savings Account (HSA) for routine health care expenses;**and**
- 3 Educational tools and other support resources designed to positively impact consumer behavior and health care choices.

#### **Definity<sup>SM</sup> HRA Fast Facts**

#### Definity HRA fast facts

- The **Definity<sup>SM</sup>Definity** HRA plan's medical benefit includes a deductible, but enrollees typically use their HRA to pay for out-of-pocket expenses before they meet the deductible . The HRA is a type of medical savings account that is most often funded by the employer .
- The **Definity<sup>SM</sup>Definity** HRA plan includes an enrollee out-of-pocket maximum . Once the maximum is met, the plan provides **1001.00%** reimbursement for covered services, including pharmacy benefits .
- **Definity<sup>SM</sup>Definity** HRA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not **appliedsubject** to the deductible .

#### **Definity<sup>SM</sup> HSA Fast Facts**

#### Definity HSA fast facts

- The **Definity<sup>SM</sup>Definity** HSA plan's medical benefit includes a deductible, but enrollees can use their HSA to pay for out-of-pocket expenses before they meet the deductible . The HSA is a type of medical savings account that is most often funded by the employee .
- **If Definity<sup>SM</sup>if Definity** enrollees do not have sufficient funds in their HSA, or choose to save those funds for a later date, they pay any remaining plan deductible and coinsurance out-of-pocket . The HSA belongs to the account holder even if he or she changes employers, and the **Internalinternal** Revenue Service allows annual deposits that can equal the plan's deductible .
- The **Definity<sup>SM</sup>Definity** HSA plan includes an enrollee out-of-pocket maximum . Once the maximum is met, the plan provides **1001.00%** reimbursement for covered services, including pharmacy benefits .
- **Definity<sup>SM</sup>Definity** HSA enrollees are encouraged to access routine preventive care, so eligible services are covered under the basic medical benefit and are not **appliedsubject** to the deductible .

### **Estimating ~~Treatment Costs~~treatment costs for Definity**

To help facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of UnitedHealthcare's free online **Claimclaim** Estimator . The **Claimclaim** Estimator tool provides a fast and simple way to obtain your professional claim predeterminations through **UnitedHealthCareOnline.comUnitedHealthcareOnline.com**. With **Claimclaim** Estimator, you can receive an estimate on whether **the cost of** a procedure will be covered, at what amount and what the claim **reimbursementpayment** will be . **Claimclaim** Estimator allows you to share **the cost of the procedurethis information** with your patient before treatment .

### **Claims Submission**

~~To ensure timely claims turnaround and accurate reimbursement for services you render to patients with Definity<sup>SM</sup> HRAs or HSAs, please note the following:~~

• ~~Verify~~ To promote timely claims turnaround and accurate reimbursement for services you render to patients with Definity HRAs or HSAs, please verify patient eligibility and benefits coverage online at UnitedHealthcareOnline .com <sup>▲</sup>. Patient Eligibility, or you can call the Member Service number on the back of your patient's health care **ID** card .

Special note regarding **Definity<sup>SM</sup> Definity** HRA enrollees: Once logged into the Patient Eligibility section of UnitedHealthcareOnline .com, the "HRA Balance" field will be displayed if the patient is enrolled in any **Definity<sup>SM</sup> Definity** consumer-driven health plan . When there are funds available in an HRA account, the current balance will be displayed . This amount is based on the most recent information available and is subject to change . The actual balance may differ

from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed .

Balances for **Definity**<sup>SM</sup> [definity](#) HSA enrollees are not available through the Patient Eligibility application .

- Most **Definity**<sup>SM</sup> [definity](#) plans do not require copayments; therefore, please do not ask your **Definity**<sup>SM</sup> [definity](#)-enrolled patients to make a copayment at the time of service unless it is expressly indicated on their health care **ID** [id](#) card .

- Submit claims [electronically through UnitedHealthcareOnline .com or through your clearinghouse relationship to payer id 87726 . Alternatively, you may submit claims](#) to the address on the back of your patient's health care **ID**-~~card~~. [Alternatively, you may submit claims electronically through UnitedHealthcareOnline.com or through your clearinghouse relationship to payer ID 87726.id card .](#)

- Please wait until after a claim is processed and you receive your EOB before collecting funds from your patient because the patient responsibility may be reimbursable through their HRA account and paid directly to you . The EOB will indicate any remaining patient balance . UnitedHealthcare will not automatically transfer the HSA balance for payment; however, the patient can pay with their HSA debit card or convenience checks linked directly to their account balance .

### **Consumer ~~Account Cards and Qualified Medical Expenses~~[account cards and qualified medical expenses](#)**

Providers may charge **UnitedHealthcare**[United Healthcare](#) HRA or FSA consumer account cards only for expenses that are "qualified medical expenses" (as defined in Section 213(d) of the **Internal**[internal](#) Revenue **Code**[code](#)) incurred by the cardholder or the cardholder's spouse or dependent . "Qualified medical expenses" are expenses for medical care which provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for the purpose of affecting any structure or function of the body. ~~A determination as to whether or not something is . An expense can be defined as~~ a "qualified medical expense" ~~is not the same thing as whether something is, but may not be~~ covered under an enrollee's benefit plan . Providers may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses, including, but not limited to:

- **Cosmetic**[cosmetic](#) surgery/procedures (which include procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), including the following:

- ~~Face lifts~~

- ~~Liposuction~~

- [liposuction](#)

- ~~Hair transplants~~

- ~~Hair removal (electrolysis)~~

- ~~Breast augmentation or reduction~~

**Note, however,:** [Surgery or procedures](#) that ~~surgery or a procedure that is~~ [are](#) necessary to ameliorate a deformity arising from a congenital abnormality, and ~~reconstruction~~[reconstructive](#) surgery following a mastectomy for cancer, may be a-qualified medical ~~expense~~[expenses](#) .

- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight loss programs (note, however, that disease-specific nutritional counseling may be covered)
- ~~Illegal~~[illegal](#) operations or procedures

For updated information regarding qualified medical expenses, please consult the **IRS**[internal Revenue Service](#)

(iRS) Web site at: <http://www.irs.gov> or call the **IRS**iRS toll-free telephone number at (800) TAX-FORM; (800) 829-~~3676~~-3676.

# Our Medicare Advantage ~~Products~~ products

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for individuals and employer group retirees. Visit [securehorizons.com](http://securehorizons.com) ~~and~~, [evercarehealthplans.com](http://evercarehealthplans.com), or

[UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) for more information about our Medicare Advantage products in your area. ~~If~~ a member presents a health care ~~identification~~ ID card with a product name with which you are not familiar, please contact the United Voice Portal at (877) 842-3210, or the phone number on the back of the member's health care ~~ID~~ ID card. This product list is provided for your convenience and is subject to change over time.

Product Name	<b>MedicareComplete</b> <b>MedicareComplete</b> <b>Essential and</b> <b>MedicareComplete Plus</b> (HMO and HMO-POS plans under the SecureHorizons or AARP® brands); <a href="#">MedicareComplete</a>	<b>MedicareComplete-Choice</b> (PPO and RPPO plans under the SecureHorizons or AARP® brands); <a href="#">MedicareComplete Choice</a> <a href="#">MedicareComplete Choice Essential</a>	Evercare Plan DH Evercare Plan DH-POS Evercare Plan DH-U Evercare Plan DP Evercare Plan RDP
<i>Member Eligibility</i>	Members who are Medicare eligible.	Members who are Medicare eligible.	Members who are Medicare and Medicaid eligible.
<i>How do members access physicians and health care professionals?</i>	Members choose a primary physician from the network of physicians. The primary physician coordinates their care. <b>MedicareComplete</b> <a href="#">MedicareComplete Plus</a> provides <b>HMO-POS plans</b> provide out-of-network coverage for some covered benefits.*** <b>MedicareComplete</b> <a href="#">MedicareComplete</a> and <b>MedicareComplete</b> <a href="#">MedicareComplete Essential</a> <b>HMO</b> plans do not cover <b>out-</b>	<del>Members may in most plans,</del> <a href="#">members</a> choose a primary physician from the network of physicians. <del>If</del> a primary physician is chosen, the primary physician coordinates their care. <b>MedicareComplete Choice</b> provides <a href="#">MedicareComplete choice PPO plans</a> provide out-of-network coverage <a href="#">for all benefits also covered in-network</a> .***	Members choose a primary physician from the network of physicians. The primary physician coordinates their care. Evercare Plan DP, RDP and DH-POS provide <del>out-</del> <a href="#">of-network-of-network</a> coverage.*** Evercare Plan DH does not except for emergency services
<i>Does a primary physician have to make a referral to a specialist?</i>	A referral may or may not be required to see a specialist <del>based</del> <a href="#">depending</a> on <del>service area</del> <a href="#">the plan</a> .** For further information, call the number on the back of the health care <del>ID</del> <u>ID</u> card. Please have the health care <del>ID</del> <u>ID</u> and your tax <del>ID</del> <u>ID</u> available. Primary care	No. A referral is not needed.	A referral may or may not be required to see a specialist <del>based</del> <a href="#">depending</a> on <del>service area</del> <a href="#">the plan</a> .** For further information, call the number on the back of the health care <del>ID</del> <u>ID</u> card. Please have the health care <del>ID</del> <u>ID</u> and your tax <del>ID</del> <u>ID</u> available.
<i>Is the treating physician <del>and/or</del> <a href="#">facility</a> required to <b>notify</b> <a href="#">give notice when providing certain</a></i>	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.	Yes. See guidelines in the Notification Requirements section.

\*\* ~~\*~~ [Physicians in both the St. Louis, MO market and the Miami-Dade county, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.](#)

\*\*\* The benefit level for [non-emergency](#) services from non-network physicians and health care professionals ~~may~~ [will generally](#) be less than that for services from network physicians and health care professionals.

Product Name	Evercare Plan IH Evercare Plan IH- POS Evercare Plan IP	<del>Plan AD</del> <del>(offered in Arizona only)</del> <del>Erickson Advantage</del>	<del>Erickson Advantage</del>	Evercare Plan MP Evercare Plan MH Evercare Plan MH- POS Evercare Plan
<i>Member Eligibility</i>	Members who are Medicare eligible and reside in a	Members who are Medicare eligible and <b>have Alzheimer's Disease</b>	<b>Members who are Medicare eligible and</b>	Members who are Medicare eligible and have one or more specific long
<i>How do members access physicians and health care professionals?</i>	Members choose a primary physician from the network of physicians . The primary physician coordinates their care .  Evercare Plan <b>IPiP</b> and <b>IHiH</b> -POS provides out-of-network coverage .*** Evercare Plan <b>IHiH</b> does	Members <del>may choose</del> <b>are assigned</b> a primary physician from the <b>Erickson Health<sup>SM</sup></b> network of physicians. <del>If a primary physician is chosen, the</del> <b>The</b> primary physician coordinates their care .  <del>Plan AD</del> <b>Erickson</b>	<b>Members are assigned a primary physician from the Erickson Health<sup>SM</sup> network of physicians. The primary physician coordinates their care.</b>	Members choose a primary physician from the network of physicians . The primary physician coordinates their care .  Evercare Plans MP, MH-POS and RMP provide out-of-network coverage .***
<i>Does a primary physician have to make a referral to a specialist?</i>	No . A referral is not needed .	No . A referral is not needed .	<b>No. A referral is not needed.</b>	A referral may or may not be required to see a specialist <b>based</b> <del>depending</del> on <b>service area</b> <del>the plan</del> .** For further information, call the number on the back of the health care <b>IDiD</b> card . Please have the health care <b>IDiD</b> and your tax <b>IDiD</b>
<i>Is the treating physician and/or facility required to notify? provide</i>	Yes . See guidelines in the Notification Requirements section .	<b>No. Contact Customer Service for specific benefit information</b> <b>Yes . See guidelines in the Notification Requirements</b>	<b>Yes. See guidelines in the Notification Requirements section.</b>	Yes . See guidelines in the Notification Requirements section .

\*\*<sup>\*</sup> [Physicians in both the St . Louis, MO market and the Miami-Dade county, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement .](#)

\*\*\* The benefit level for [non-emergency](#) services from non-network physicians and health care professionals ~~may will generally~~ be less than that for services from network physicians and health care professionals .

<u>Product Name</u>	<u>MedicareComplete Group Retiree (HMO and HMO-POS) plans under the SecureHorizons or AARP® brands</u>	<u>MedicareComplete Group Retiree (PPO and RPPO) plans under the SecureHorizons or AARP® brands</u>	<u>UnitedHealthcare Group Medicare Advantage (PPO)</u>
<u>Member Eligibility</u>	<u>Members who are Medicare eligible and meet employer's requirements</u>	<u>Members who are Medicare eligible and meet employer's requirements</u>	<u>Members who are Medicare eligible and meet employer's requirements</u>
<u>How do members access physicians and health care professionals?</u>	<u>Members choose a primary physician from the network of physicians . The primary physician coordinates their care . Medicarecomplete (POS) provides out-of-network coverage for some covered benefits .*** Medicarecomplete HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area travel services .</u>	<u>Members may choose a primary physician from the network of physicians . if a primary physician is chosen, the primary physician coordinates their care . Medicarecomplete (PPO and RPPO) provide out-of-network coverage .***</u>	<u>Members are not required to choose a primary physician from the network of physicians .</u>
<u>Does a primary physician have to make a referral to a specialist?</u>	<u>A referral may or may not be required to see a specialist based on service area .** For further information, call the number on the back of the health care iD card . Please have the health care iD and your tax iD available . Primary care physicians should coordinate</u>	<u>No . A referral is not needed .</u>	<u>No . A referral is not needed .</u>
<u>Is the treating physician and/or facility required to notify?</u>	<u>Yes . See guidelines in the Notification Requirements section .</u>	<u>Yes . See guidelines in the Notification Requirements section .</u>	<u>in-network providers are required to follow the policies, protocols and provisions of their contract and this Guide .</u>

\*\* Physicians in both the St . Louis, MO market and the Miami-Dade county, FL market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement .

\*\*\* The benefit level for non-emergency services from non-network physicians and health care professionals will generally be less than that for services from network physicians and health care professionals .

# Medicare Select (AARP<sup>®</sup> Health)

## What Is Medicare Select?

• Medicare Select is a Medicare Supplement product available only to AARP<sup>®</sup> members who reside within the service area of a hospital ~~that~~which participates in our Medicare Select network . ~~It~~is a lower cost alternative to Standardized Medicare Supplement coverage .

## Responsibilities of Medicare Select ~~Members~~members

• To offer the plan at a lower premium, we require that Medicare Select members utilize a participating hospital for all inpatient and outpatient hospital services (except emergency care and ~~travel~~)services provided when members are outside of their service area .

## Hospital ~~Responsibilities~~responsibilities

• Participating hospitals agree to a reduced/waived reimbursement of Medicare's Part A ~~In~~in-Hospital deductible . ~~Cost~~cost savings associated with hospitals' reduction/waiver of Medicare's Part A ~~In~~in-Hospital deductible are passed on to Medicare Select members in the form of lower premium cost .

• To submit a Medicare Part A or Part B ~~Intermediary~~intermediary claim for a Medicare Select insured, mail a copy of the standard ~~CMS~~cMS billing form along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

**AARP<sup>®</sup> Health**  
**~~United HealthCare Claim Division~~**  
**~~P~~Medicare Select**  
**~~UnitedHealthcare claim division~~**  
**~~P~~.O . Box 740819**  
**Atlanta, GA 30374-0819**

Note: Medicare Part B claims billed to a Medicare carrier are, in most cases, received electronically from the Medicare carrier .

• To promote timely processing on all claim submissions, follow standardized Medicare billing practices . Be sure to include the 11-digit AARP<sup>®</sup> ~~Health~~Health Medicare Select member's health care ~~ID~~id number on the standard ~~CMS~~cMS billing form .

## What does Medicare Select ~~Plan C~~ cover in addition to Part A In-Hospital deductible?

- ~~In~~in-Hospital Part A coinsurance for days 61 through 90 in a Medicare Benefit Period .
- ~~In~~in-Hospital Part A coinsurance for days in which ~~Lifetime~~lifetime Reserve days are used .
- Medicare Part A eligible expenses for a ~~Lifetime~~lifetime Maximum of 365 days after all Medicare Part A benefits are exhausted .
- Medicare Part B coinsurance (generally 20% of Medicare's approved amount) .
- Medicare Part B deductible amount applied each calendar year .
- Skilled Nursing Facility stays - the daily coinsurance amount for days 21 to ~~1001.00~~1001.00 for stays eligible under Medicare .
- Medicare Parts A and B Blood deductible: ~~Charge~~charge incurred for the first three pints of unreplaced blood furnished in a calendar year .

• ~~Foreign Travel Emergency~~Foreign Travel Emergency .

• ~~Foreign Travel Emergency~~ .

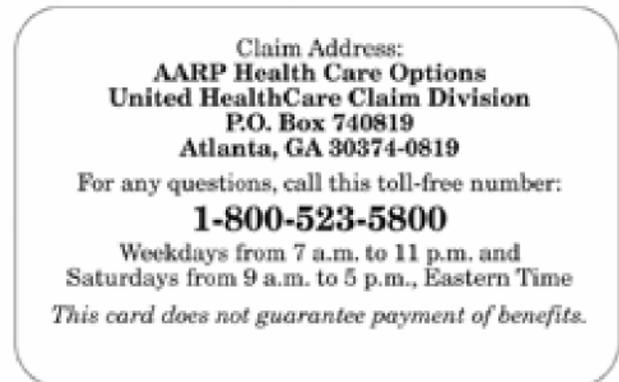
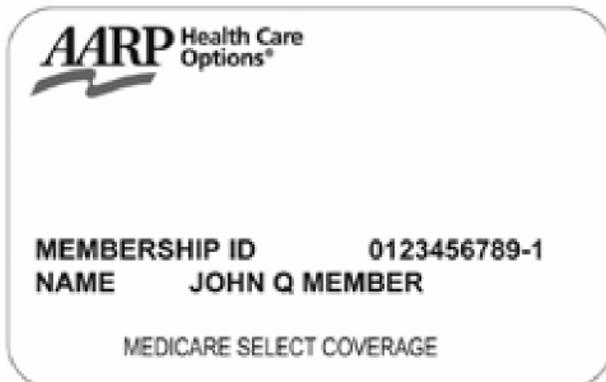
## What advantages does Medicare Select give to participating hospitals?

- Medicare Select will increase the hospital's access to AARP® **Health** members . The hospital will be included in AARP® **Health's** Medicare Select marketing materials within their service area .
- By participating in Medicare Select, the hospital will be limiting its financial exposure . The hospital agrees to a reduced reimbursement of Medicare's Part A deductible . UnitedHealthcare reimburses all other Medicare Part A eligible expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare .
- Hospitals can expect to receive claim payment in a timely fashion as more than **99.0%** of all claims are processed within **ten (10) 1.0** business days . This may reduce hospital collection efforts .
- This product meets "Safe Harbor" requirements under Federal Anti-Kickback legislation . **For More Information**

### [For more information](#)

• — For more information on Medicare Select and other AARP® **Health Medicare Supplement** product offerings, contact our Member Service **Centercenter** at (800) 523-**5800-5800** .

### [Sample AARP® Health Medicare Select ID Card](#)



# Notification ~~Requirements~~requirements

## Standard ~~Notification Requirements~~notification requirements (for most states\*)

~~Information~~information gathered about planned member care supports the care coordination process .

UnitedHealthcare's notification requirements are designed to **most**-effectively gather the pertinent information in a timely manner .

### ~~Effective December 3, 2007 (for most states)\*:~~

- Physicians, Health ~~Care~~care Professionals and ~~Ancillary~~ancillary Providers are responsible for ~~Advance~~advance Notification for certain planned services .
- Facilities are responsible for ~~Admission~~admission Notification for inpatient admissions described in this Guide .
- ~~Notify us at UnitedHealthcareOnline.com for any inpatient admission, outpatient surgery, radiology, home health care services or durable medical equipment notification required under this Guide .com~~  
Notifications Notification Submission . We will accept daily composite census logs for inpatient admissions, with complete and relevant information, via fax . ~~If~~if you do not have electronic access, please call us at the number on the back of the member's health care ~~ID~~ID card .

\* For information showing each state's status, please refer to UnitedHealthcareOnline .com ~~Tools and Resources~~ ~~Policies and Protocols~~ ~~Advance~~advance and ~~Admission~~admission Notification . ~~If~~if additional states are added, you will receive a written notice if you participate in that state . This Protocol was previously communicated to providers, so the effective date of this Protocol supersedes the overall effective date of this Guide . Please refer to UnitedHealthcareOnline .com for state-specific variations of this Protocol .

## Advance ~~Notification~~notification

(applies to Physicians, Health ~~Care~~care Professionals and ~~Ancillary~~ancillary Providers only)

- Notification is required only for those planned services on the *Advance Notification List* .
- ~~certain services may not be covered within an individual member's plan . Notification should be submitted as far in advance of the planned service as possible to allow for coverage review .~~ Notification is required at least five (5) business days prior to the planned ~~service~~serviced date (unless otherwise specified within the *Advance Notification List*) . Note that notification for home health services is required within forty-eight (48) hours after the physician's order .
- ~~If services are planned less than five (5) business days prior to the service date, notification is required as soon as the service is scheduled.~~
- ~~Advance~~advance Notifications must contain the following information associated with the planned service:—
  - ~~Member/enrollee name and member/enrollee ID~~  
: Member/enrollee name and member/enrollee ID
  - —Ordering physician or health care professional name and ~~TIN~~TIN or ~~NPI~~NPI
  - —Rendering physician or health care professional name and ~~TIN~~TIN or ~~NPI~~NPI
  - —~~ICD~~icD-9-~~CM~~CM (or its successor) diagnosis code for primary diagnosis
  - —~~Anticipated~~anticipated date(s) of service
  - —Type of service (procedure code(s)) and volume of service (when applicable)
  - —Facility name and ~~TIN~~TIN or ~~NPI~~NPI where service will be performed (when applicable)—~~Original start date of dialysis (ESRD only)~~  
: Original start date of dialysis (ES RD only)
  - Please refer to the individual services listed in the Advance Notification List below for specific, additional required information .

## Clinical coverage review: clinical information

- You must cooperate with all requests for information, documents or discussions from UnitedHealthcare for purposes of a clinical coverage review including, but not limited to, pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment. Please refer to the individual services listed in the *Advance Notification List* for specific, additional required information.
- You must return/respond to calls from the care management team and/or medical director. You must provide complete clinical information as required within four (4) hours if request is received before 1:00 p.m. local time, or make best efforts to provide within the same business day if request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

- [You can obtain copies of the coverage Determination Guidelines \(cDG\) and Medical Policies which UnitedHealthcare uses to determine whether a particular medical procedure or treatment is covered online at UnitedHealthcareOnline.com Tools & Resources Policies and Protocols.](#)
- **Physicians who have received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation are exempt from the Advance Notification requirement for certain services as indicated on the Advance Notification List.** [In addition to cDGs and Medical Policy, UnitedHealthcare uses Milliman<sup>®</sup> care Guidelines<sup>®</sup>, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.](#)

## Admission Notification (applies to Facilities only)

- Admission Notification is required for the following admission types:
  - ⋮ ~~All~~ planned/elective admissions for acute care
  - ⋮ ~~All~~ unplanned admissions for acute care
  - ⋮ ~~All~~ SNF admissions
  - ⋮ ~~All~~ admissions following outpatient surgery
  - ⋮ ~~All~~ admissions following observation
  - ⋮ ~~All newborns admitted to NicU~~
  - ⋮ ~~All newborns admitted to NICU or~~ **All newborns** who remain hospitalized after the mother is discharged [\(within twenty-four \(24\) hours of the mother's discharge\)](#)
- Admission Notification must be received within twenty-four (24) hours after actual [weekday admission \(or by 5:00 p.m. local time on the next business day if twenty-four \(24\) hour notification would require notification on a weekend or federal holiday\)](#). [For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.](#)
- Admission Notification is required by the hospital even if Advance Notification was supplied by the physician.
- Admission Notifications must contain the following details regarding the admission:
  - ⋮ ~~Member/enrollee name and member/enrollee ID~~
  - ⋮ ~~Facility name and TIN or NPI~~
  - ⋮ ~~Admitting/attending physician name and TIN or NPI~~
  - ⋮ ~~Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code~~
  - ⋮ ~~Actual admission date~~
- For emergency admissions ~~where~~ [when](#) a member/enrollee is unstable and not capable of providing coverage information ~~at the time of admission~~, the facility should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances. We will flag the case for payment without any notification-related reimbursement adjustments.
- For all admissions: ~~If~~ [if](#) admission notification is provided after twenty-four (24) hours, but within seventy-two (72) hours after admission, the reimbursement will be 50% of the average daily payment rate for each day preceding notification and 100% thereafter (not applicable to DRG/case rate contracts without outlier provisions). The average daily payment rate will be calculated by dividing the contracted rate for the admission by the admission length of stay.
- For all admissions: ~~If~~ [if](#) admission notification is provided after seventy-two (72) hours or not at all, the reimbursement will be 50% of the contracted rate for the entire admission (applicable to all contracts, regardless of payment methodology).
- Reimbursement reductions ~~for weekend and federal holiday admissions~~ will not be applied ~~to Critical Access Hospitals~~ when notification is received by 5:00 p.m. local time on the next business day: [\(a\) for weekend and federal holiday admissions; or \(b\) if twenty-four \(24\) hour notification would require notification on a weekend or federal holiday.](#)

- ~~UnitedHealthcare will suspend any reimbursement adjustments associated with the Admission Notification Protocol for facilities that signed the electronic interface agreement to submit admission notification via the EDI 278 transaction until March 31, 2009.~~

## Concurrent review: clinical information

- You must cooperate with all requests for information, documents or discussions from UnitedHealthcare for purposes of concurrent review and discharge planning including, but not limited to, clinical information ~~on patient status and needs, prevention initiatives and readmission, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date~~ . When available, provide clinical information via access to Electronic Medical Records (EMR) .
- You must return/respond to inquiries from the inpatient care management team and/or medical director . You must provide complete clinical information and/or documents as required within four (4) hours if request is received before 1:00 p .m . local time, or make best efforts to provide within the same business day if request is received after 1:00 p .m . local time (but no later than 1 2:00 p .m . the next business day) .
- UnitedHealthcare uses Milliman<sup>®</sup> Carecare Guidelines<sup>®</sup>, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, ~~including~~ . This includes acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities . a copy of the clinical criteria may be obtained upon request .

## Provide access to your facility

in support of UnitedHealthcare's clinical and quality initiatives, including Healthcare Effectiveness data and Information Set (HEDIS) notification and concurrent review activities, you will provide us access to: (1) your facilities, including the emergency room; (2) our members and their medical records; and (3) your hospital and medical staff for purposes of obtaining necessary clinical information regarding our member's condition or treatment plan . in addition, you will participate in discharge planning activities . This Protocol also applies when providing continued care to our members following termination of your agreement .

# Advance Notification List

The following list does not indicate or imply coverage . **Coverage** is determined in accordance with the member's benefit plan .

## **Notification Requirements for Physician Services\***

### **Procedures and Services**

<u>Notification Requirements for Procedures and Services</u>	<u>Physician Services*</u>
<b>Bariatric Surgery+</b> <u>(Does not apply to Erickson Advantage members)</u>	<u>Bariatric Surgery and specific obesity-related services (as defined by the icD-9-cM and cPT codes below, or their successor codes) whether scheduled as inpatient or outpatient .</u> <u>ICD-9-CM (or its successor) 44 .31, 44 .38, 44 .39, 44 .68, 44 .95, 44 .96, 44 .98</u> <u>cPT 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845</u> <u>43846, 43847, 43848, 43886, 43887, 43888, 43999</u>  <u>As a reminder, bariatric surgery and other obesity services are not covered in some benefit plans . in some situations, there is a center of Excellence (cOE) requirement for coverage of bariatric surgery/services .</u> <u>Medicare coverage is based on the guidelines outlined by the centers for Medicare and Medicaid Services (cMS) . For additional information, consult the cMS National coverage Determination Database .</u>
<b>BRCA Genetic Testing Program</b> <u>(Does not apply to Medicare Advantage members)</u>	<u>BRcA 1 and BRcA 2 (Breast cancer Susceptibility) are genetic tests performing DNA sequencing to look for known gene mutations that are associated with the development of breast and ovarian cancer .</u>  <u>BRcA testing requires an advance notification prior to performing the DNA sequencing .</u> <u>HCPCS: S3818-S3820; S3822-S3823</u>  <u>Genetic counseling is a service that members may elect to receive if they would like a board-certified genetic counselor to explain the BRcA testing, and help them make decisions about the clinical indications for such testing . Once we receive notification for BRcA testing from the provider, members will receive a letter outlining the available genetic counseling service, and how to access that service if they wish . As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans .</u>  <u>Please note: Medicare coverage for genetic testing is based on the guidelines outlined by the centers for Medicare and Medicaid Services (cMS) . For additional information, consult the cMS National coverage Determination Database .</u> <u>For services listed in this section, fax to (866) 756-9733 .</u>
<b>Cancer Treatment Initiation</b> <u>(For commercial members only)</u>	<u>initiation of cancer Treatment for a diagnosis other than skin cancer or cervical cancer . Notification is requested to assist UnitedHealthcare in identifying members that may be eligible for additional UnitedHealthcare programs and services .</u>  <u>For services listed in this section, call OptumHealth directly at (866) 936-6002 .</u>
<b>Congenital Heart Disease</b>	<u>congenital Heart Disease-related services, including the following codes:</u> <u>icD-9-cM (or its successor) 745 .0 through 747 .81</u>  <u>cPT 33250-33252, 33254-33259, 33261, 33404, 33414-33417, 33476-33478, 33500-33506, 33600-33619, 33641-33647, 33660, 33665, 33670, 33675-33688, 33690-33697, 33702-33853, 33917, 33920-33922, 33924, 33945 and 93580-9358 1</u>  <u>For services listed in this section, call OptumHealth directly at (888) 936-7246 or the number on the back of the health care iD card .</u>

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions . in addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without cPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services . For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability .

This notification list may change from time to time . if there is such a change, we will provide you with information about the change before it takes effect .

[This list does not indicate or imply coverage for benefits . coverage decisions are determined by the member's benefit plan and the physician/provider participation agreement . if you have questions about a member's coverage, visit \[UnitedHealthcareOnline .com\]\(#\) or call the United Voice Portal at \(877\) 842-3210.](#)

<a href="#">Notification Requirements for Procedures and Services</a>	<a href="#">Physician Services*</a>
<a href="#">Intensity Modulated Radiation Therapy (IMRT) (For commercial members only)</a>	<p><a href="#">UnitedHealthcare requires advance notification for the following iMRT codes:</a></p> <p><a href="#">77301 – intensity modulated radiotherapy plan</a></p> <p><a href="#">77418 - intensity modulated treatment delivery, single or multiple fields / arcs, per treatment session</a></p> <p><a href="#">0073T – compensator-based beam modulation treatment delivery</a></p> <p><a href="#">Fax the completed UnitedHealthcare iMRT Data collect form and all supporting information to (866) 756-9733 . The UnitedHealthcare iMRT Data collection form can be found at <a href="#">UnitedHealthcareOnline .com .</a></a></p>
<a href="#">MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroids</a>	<p><a href="#">MR-guided focused ultrasound procedures and treatments, as defined by but not limited to the cPT codes listed below .</a></p> <p><a href="#">0071T and 0072T</a></p> <p><a href="#">MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those plans:</a></p> <p><a href="#">The physician and/or facility must confirm coverage of the service for the member .</a></p> <p><a href="#">The hospital and or/facility must be contracted with UnitedHealthcare . UnitedHealthcare enrollees have no out-of-network benefits for MRgFUS .</a></p> <p><a href="#">The enrollee must consent in writing to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective . The enrollee must agree in writing to hold UnitedHealthcare harmless if the enrollee is dissatisfied with the results of treatment .</a></p> <p><a href="#">The consent form can be found at: <a href="#">UnitedHealthcareOnline .com . Tools &amp; Resources . Policies &amp; Protocols . Medical &amp; Drug Policies and coverage Determination Guidelines .</a></a></p> <p><a href="#">The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare .</a></p> <p><a href="#">The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use .</a></p> <p><a href="#">inpatient admissions for spinal surgeries, total knee replacements and total hip replacements .</a></p>
<a href="#">Orthopaedic and Spine Surgeries</a>	
<a href="#">Part B Occupational Therapy, Speech Therapy or Physical Therapy (For Medicare Advantage members only)</a>	<a href="#">Part B occupational therapy, speech therapy or physical therapy provided in a skilled nursing facility .</a>
<a href="#">Pregnancy, Healthy Pregnancy Notification (Does not apply to Erickson Advantage members)</a>	<a href="#">Upon confirmation of pregnancy, a notification is required by physicians or other health care professionals who provide obstetrical care to a pregnant member for: icD-9-cM (or its successor) V72 .42 or any other diagnosis code related to pregnancy . Notification is required only once per pregnancy . Notification is not required for ancillary services such as ultrasound and lab work . if, after you have notified us of a pregnancy, you obtain information that would cause you to conclude that the member is no longer appropriate for a Healthy Pregnancy Program, e .g ., termination of pregnancy, we ask that you notify us of</a>

[\\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions . in addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without cPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services . For other services on the Advance Notification list, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability .](#)

[This notification list may change from time to time . if there is such a change, we will provide you with information about the change before it takes effect .](#)

[This list does not indicate or imply coverage for benefits . coverage decisions are determined by the member's benefit plan and the physician/provider participation agreement . if you have questions about a member's coverage, visit \[UnitedHealthcareOnline .com\]\(#\) or call the United Voice Portal at \(877\) 842-3210 .](#)

**Notification Requirements for Physician Services\***  
**Procedures and Services Explanation**

<p><b><u>Radiology</u></b>          (For commercial members only)</p>	<p>For commercial programs, UnitedHealthcare requires prior notification for the following defined set of outpatient imaging procedures: cT, MRI, MRA, PET, Nuclear Medicine, and Nuclear cardiology. The Physician/Health care Professional ordering the imaging service is responsible for obtaining a notification number prior to scheduling the outpatient imaging procedures. Ordering Physicians/Health care Professionals can obtain the required notification number by contacting UnitedHealthcare through any of the following:</p> <p><u>Online: UnitedHealthcareOnline.com . Notifications . Radiology Notification Submission and Status</u></p> <p><u>Phone: (866) 889-8054 (Direct line), or using the United Voice Portal line at (877) 842-3210 and selecting the Radiology Option</u></p> <p><u>Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline.com . Notifications . Radiology Notification Submission and Status)</u></p> <p><u>Additional details regarding this notification requirement, including a list of the cPT codes for which notification is required are available online at: UnitedHealthcareOnline.com . clinician Resources . Radiology . Radiology Notification, and in the Outpatient Radiology Notification section of this Guide.</u></p>
<p><b><u>Reconstructive/Potentially Cosmetic Procedures</u></b></p>	<p>cosmetic Procedures are procedures or services that change or improve physical appearance, without significantly improving or restoring physiological function, as determined by us. Reconstructive Procedures are procedures or services that either treat a medical condition or improve or restore physiologic function.</p> <p><u>To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to:</u></p> <ul style="list-style-type: none"> <li>• <u>Ablation, ligation, Vein Stripping – removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins</u></li> <li>• <u>Blepharoplasty, upper lid – reconstructive procedures including repair of brow ptosis, includes canthoplasty and unlisted procedure, eyelids</u></li> <li>• <u>Breast Reconstruction – reconstruction of the breast other than following mastectomy</u></li> <li>• <u>Breast Reduction – removal of breast tissue in men or women other than mastectomy for cancer</u></li> <li>• <u>cranial remolding helmet – for treatment of congenital musculoskeletal deformities</u></li> <li>• <u>Genioplasty - sliding, augmentation with interpositional bone grafts</u></li> <li>• <u>Mastectomy for gynecomastia</u></li> <li>• <u>Orthognathic Surgery – treatment of maxillofacial functional impairment</u></li> <li>• <u>Palatopharyngoplasty – oral pharangeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup)</u></li> <li>• <u>Panniculectomy or Abdominoplasty– Excision, excessive skin and subcutaneous tissue (includes lipectomy)</u></li> <li>• <u>Thoracoscopy – sympathectomy for treatment of hyperhidrosis</u></li> </ul>

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without cPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification list, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

This notification list may change from time to time. If there is such a change, we will provide you with information about the change before it takes effect.

This list does not indicate or imply coverage for benefits. Coverage decisions are determined by the member's benefit plan and the physician/provider participation agreement. If you have questions about a member's coverage, visit UnitedHealthcareOnline.com or call the United Voice Portal at (877) 842-3210.

**Notification Requirements for Physician Services\***  
**Procedures and Services Explanation**

<p><b><u>Referral for Non-Network Services</u></b>          (Does not apply to Erickson Advantage members)</p>	<p><b><u>Explanation</u></b> Please note that your agreement with UnitedHealthcare may include <u>restrictions on directing members outside the UnitedHealthcare network. Your patients who utilize non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses.</u></p>
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<p><del>Bariatric Surgery and specific obesity ICD-9-CM and CPT codes below, or scheduled as inpatient or outpatient notification prior to the anticipated ICD-9-CM (or its successor) 44.31, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999</del></p> <p><del>As a reminder, bariatric surgery and other obesity services are not covered in some benefit plans. In some markets, there is a Center of Excellence (COE) requirement for bariatric surgery / services.</del></p> <p><del>Medicare coverage is based on the guidelines outlined by the Centers for Medicare and Medicaid Services (CMS). For additional information, consult the CMS National Coverage Determination Database.</del></p>	<p><del>Congenital Heart Disease</del></p> <p><del>For services listed in this section, call OptumHealth directly at (888) 936-7246 or the notification on the back of the Health Care ID card.</del></p>	<p><del>3 days'</del></p>
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<p><b><u>Functional Maintenance Programs</u></b>          (Applies to Erickson Advantage members only)</p>	<p><u>Notification is required when a network physician or health care professional directs a member to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a member's benefit plan has benefits for out-of-network services.</u></p>
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<p><del>Congenital Heart Disease related services ICD-9-CM (or its successor) CPT 33250-33261, 33404, 33414-33416, 33417, 33418, 33419, 33420, 33421, 33422, 33423, 33424, 33425, 33426, 33427, 33428, 33429, 33430, 33431, 33432, 33433, 33434, 33435, 33436, 33437, 33438, 33439, 33440, 33441, 33442, 33443, 33444, 33445, 33446, 33447, 33448, 33449, 33450, 33451, 33452, 33453, 33454, 33455, 33456, 33457, 33458, 33459, 33460, 33461, 33462, 33463, 33464, 33465, 33466, 33467, 33468, 33469, 33470, 33471, 33472, 33473, 33474, 33475, 33476, 33477, 33478, 33479, 33480, 33481, 33482, 33483, 33484, 33485, 33486, 33487, 33488, 33489, 33490, 33491, 33492, 33493, 33494, 33495, 33496, 33497, 33498, 33499, 33500, 33501, 33502, 33503, 33504, 33505, 33506, 33507, 33508, 33509, 33510, 33511, 33512, 33513, 33514, 33515, 33516, 33517, 33518, 33519, 33520, 33521, 33522, 33523, 33524, 33525, 33526, 33527, 33528, 33529, 33530, 33531, 33532, 33533, 33534, 33535, 33536, 33537, 33538, 33539, 33540, 33541, 33542, 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Notification Requirements for Physician Services\*  
Procedures and Services Explanation

Transplant Services

For services listed in this section, call OptumHealth directly at (888) 936-7246 or the notification number on the back of the health care iD card.

~~\*\*\*The notification requirements with this indicator are not applicable to physicians who have received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation, during the period they are designated, in recognition of their demonstration of adherence to nationally recognized evidence-based quality and~~

**Notification Requirements for Physician Services\***  
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efficiency of care standards.  
Additional information  
regarding the UnitedHealth  
Premium<sup>®</sup> Designation  
Program is available at  
[UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com)  
or by calling (866) 270-5588.

+ The notification requirements  
with this indicator are not  
applicable to Erickson  
Advantage members.

This notification list may  
change from time to time. If  
there is such a change, we  
will provide you with  
information about the  
change before it takes  
effect.

This list does not indicate or  
imply coverage for benefits.  
Coverage is determined by  
the member's benefit plan. If  
you have questions about a  
member's coverage, visit  
[UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com)  
or call the United Voice Portal  
at (877) 842-3210.

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**Notification Requirements for Physician Services**

<p><b>Implantable Cardiac Defibrillators***</b> <b>(Applies to Medicare members only)</b></p>	<p><b>Initial placement or replacement of automatic implantable cardiac defibrillators CPT</b></p> <p><b>33240 insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator</b></p> <p><b>33249 insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator</b></p> <p><b>G0297 insertion of single chamber pacing cardioverter defibrillator pulse</b></p> <p><b>Request for transplant or transplant-related services prior to pre-treatment or evaluation, including the following CPT Procedure codes for Specifically Requested Transplantations:</b></p>
<p><b>Initiation of Cancer Treatment other than surgery. Call Cancer Resource Services (CRS)* at (866) 936-6002.</b> <b>(Applies to commercial members only)</b></p>	<p><b>BONE MARROW-Peripheral stem cell</b></p> <p><b>38230 Bone marrow harvesting for transplantation</b></p> <p><b>38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic</b></p> <p><b>38241 Bone marrow or blood-derived peripheral stem cell transplantation; autologous</b></p> <p><b>38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor</b></p>
<p><b>MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroids</b></p>	<p><b>lymphocyte infusions</b></p> <p><b>In order for a claim to be paid for MR-guided focused ultrasound for HEART / LUNG</b></p> <p><b>33930 Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft</b></p> <p><b>33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy</b></p> <p><b>HEART</b></p> <p><b>33940 Donor cardiectomy, with preparation and maintenance of allograft</b></p> <p><b>33945 Heart transplant, with or without recipient cardiectomy</b></p> <p><b>0051 T implantation of a total replacement heart system (artificial heart) with recipient cardiectomy</b></p> <p><b>0052 T Replacement or repair of thoracic unit of a total replacement heart system (artificial heart)</b></p> <p><b>0053 T Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit</b></p> <p><b>of</b></p> <p><b>the procedure by calling our Notification department at (877) 842-3210 or online at <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>.</b></p> <p><b>In addition to notifying UnitedHealthcare, the physician and/or facility must confirm enrollee eligibility for coverage because the enrollee must be covered by benefit plans renewed under the 2007 Certificate of Coverage and not earlier benefit plans.</b></p> <ul style="list-style-type: none"> <li><b>The hospital and/or facility must be contracted with UnitedHealthcare. UnitedHealthcare enrollees have no out-of-network benefits.</b></li> <li><b>The enrollee must consent in writing to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective, and the enrollee must agree in writing to hold UnitedHealthcare harmless if the enrollee is dissatisfied with the results of treatment.</b></li> <li><b>The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare.</b></li> <li><b>The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.</b></li> </ul>

\*\*\*The notification requirements with this indicator are not applicable to physicians who have received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation, during the period they are designated, in recognition of their demonstration of adherence to nationally recognized evidence-based quality and efficiency of care standards. Additional information regarding the UnitedHealth Premium<sup>®</sup> Designation Program is available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or by calling (866) 270-5588.

+ The notification requirements with this indicator are not applicable to Erickson Advantage members.

This notification list may change from time to time. If there is such a change, we will provide you with information about the change before it takes effect.

This list does not indicate or imply coverage for benefits. Coverage is determined by the member's benefit plan. If you have questions about a member's coverage, visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or call the United Voice Portal at (877) 842-3210.

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\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification

**Notification Requirements for Physician Services\***  
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requirements for most inpatient admissions . in addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without cPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services . For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability .

<b>Procedures and Services</b>	<b>Explanation</b>
<b>Medication Delivery System (Applies to Erickson Advantage members only)</b>	<b>A provider order is required to access benefits for assistance with medications.</b>
<b>Orthopaedic and Spine Surgeries</b>	<b>Inpatient admissions for spinal surgeries, total knee replacements and total hip replacements.</b>
<b>Pain Management Alternative Medicine (Applies to Erickson Advantage members only)</b>	<b>A provider order is required for referral to massage therapy or acupuncture provider.</b>
<b>Part B Occupational Therapy, Speech Therapy or Physical Therapy (Applies to Medicare members only)</b>	<b>Part B occupational therapy, speech therapy or physical therapy provided in a skilled nursing facility.</b>
<b>Pregnancy, Healthy Pregnancy Notification+</b>	<b>Upon confirmation of pregnancy, a notification is required by physicians or other health care professionals who provide obstetrical care to a pregnant member for: ICD-9-CM (or its successor) V72.42 or any other diagnosis code related to pregnancy. Notification is required only once per pregnancy. Notification is not required for ancillary services such as ultrasound and labwork. If, after you have notified us of a pregnancy, you obtain information that would cause you to conclude that the member is no longer appropriate for a Healthy Pregnancy Program, e.g., termination of pregnancy, we ask that you notify us of that fact.</b>
<b>Prosthetic and orthotic services exceeding \$1,000 (Applies to Medicare members only)</b>	<b>Prosthetic and orthotic services exceeding \$1,000.</b>

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+ The notification requirements with this indicator are not applicable to Erickson Advantage members.

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**Notification Requirements for Physician Services**  
**Procedures and Services Explanation**

change before it takes effect.

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Procedures and Services	Explanation
<p><b>Radiology*** †</b>            (Does not currently apply to Medicare members)</p>	<p>UnitedHealthcare requires prior notification for the following defined set of outpatient imaging procedures: CT, MRI, MRA, PET, Nuclear Medicine, Nuclear Cardiology. The Physician/Health Care Professional ordering the imaging service is responsible for obtaining a notification number prior to scheduling the outpatient imaging procedures. Ordering Physicians/Health Care Professionals can obtain the required notification number by contacting UnitedHealthcare through any of the following:</p> <p>Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> • Notifications • Radiology Notification Submission and Status</p> <p>Phone: (866) 889-8054 (Direct Line), or using the United Voice Portal line at 842-3210 and selecting the Radiology Option</p> <p>Fax: (866) 889-8061 (A fax form is available to download at <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> • Notifications • Radiology • Notification Submission and Status)</p> <p>Additional details regarding this notification requirement, including a list of the CPT codes for which notification is required are available online at: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> • Clinician Resources • Radiology • Radiology Notification and in the Outpatient Radiology Notification section of this Guide.</p>

\*\*\*The notification requirements with this indicator are not applicable to physicians who have received the UnitedHealth Premium® quality and efficiency of care designation, during the period they are designated, in recognition of their demonstration of adherence to nationally recognized evidence-based quality and efficiency of care standards. Additional information regarding the UnitedHealth Premium® Designation Program is available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or by calling (866) 270-5588.

**Notification Requirements for Physician Services\***  
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UnitedHealthcare

Procedures and Services	Explanation
<b>Reconstructive/Potentially Cosmetic Procedures</b>	<p><b>Cosmetic Procedures are procedures or services that change or improve appearance, without significantly improving or restoring physiological function, as determined by us.</b></p> <p><b>Reconstructive Procedures are procedures or services that either treat a medical condition or improve or restore physiologic function.</b></p> <p><b>To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to:</b></p> <p><b>Ablation, Ligation, Vein Stripping — removal of varicose veins</b></p> <p><b>Blepharoplasty, upper lid — reconstructive procedures including repair of brow ptosis, includes Canthoplasty &amp; unlisted procedure, eyelids</b></p> <p><b>Breast Reconstruction — reconstruction of the breast other than following mastectomy</b></p> <p><b>Breast Reduction — removal of breast tissue in men or women other than mastectomy for cancer</b></p> <p><b>Cranial remolding helmet — for treatment of congenital musculoskeletal deformities</b></p> <p><b>Genioplasty — sliding, augmentation with interpositional bone grafts</b></p> <p><b>Mastectomy for gynecomastia</b></p> <p><b>Orthognathic Surgery — treatment of maxillofacial functional impairment</b></p> <p><b>Palatopharyngoplasty — oral pharyngeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup)</b></p> <p><b>Panniculectomy or Abdominoplasty — Excision, excessive skin and subcutaneous tissue (includes lipectomy)</b></p> <p><b>Rhinoplasty — treatment of nasal functional impairment</b></p> <p><b>Sclerotherapy — an alternative method for treating varicose veins and other vein abnormalities (including, but not limited to, CPT codes 36478</b></p> <p><b>Thoracoscopy — sympathectomy for treatment of hyperhidrosis</b></p>
<b>Referral for Non-Network Services+</b>	<p><b>A referral from a network physician or health care professional to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a member's benefit plan permits out-of-network services.</b></p> <p><b>Please note that your agreement with UnitedHealthcare may include restrictions on referring members outside the UnitedHealthcare network.</b></p>

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**Notification Requirements for Physician Services**  
**Procedures and Services Explanation**

adherence to nationally recognized evidence-based quality and efficiency of care standards. Additional information regarding the UnitedHealth Premium<sup>®</sup> Designation Program is available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) or by calling (866) 270-5588.

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Procedures and Services	Explanation
<p><b>Transplant Services:</b>            For services listed in this section call OptumHealth directly at (888) 936-7246 or the notification on the back of the health care ID card.</p>	<p>Request for transplant or transplant-related services prior to pre-treatment or evaluation, including the following CPT Procedure Codes for Specifically Requested Transplantations:</p> <p><b>HEART / LUNG</b></p> <p>33930 Donor cardiectomy-pneumonectomy, with preparation and maintenance allograft</p> <p>33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy</p> <p><b>HEART</b></p> <p>33940 Donor cardiectomy, with preparation and maintenance of allograft</p> <p>33945 Heart transplant, with or without recipient cardiectomy</p> <p>0051T Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy</p> <p>0052T Replacement or repair of thoracic unit of a total replacement heart (artificial heart)</p> <p>0053T Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit</p> <p><b>LUNG</b></p> <p>32850 Donor pneumonectomy(ies) with preparation and maintenance of (cadaver)</p> <p>32851 Lung transplant, single; without cardiopulmonary bypass</p> <p>32852 with cardiopulmonary bypass</p> <p>32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass</p> <p>32854 with cardiopulmonary bypass</p> <p><b>KIDNEY</b></p> <p>50300 Donor nephrectomy, with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral</p> <p>50320 Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)</p> <p>50340 Recipient nephrectomy</p> <p>50360 Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy</p> <p>50365 with recipient nephrectomy</p> <p>50370 Removal of transplanted renal allograft</p> <p>50380 Renal autotransplantation, reimplantation of kidney</p> <p>50547 Laparoscopic donor nephrectomy from living donor (excluding preparation</p>

**Notification Requirements for Physician Services\***  
**Procedures and Services Explanation**

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Procedures and Services	Explanation
<b>Transplant Services (Continued)</b>	<p><b>PANGREAS</b></p> <p>48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells</p> <p>48550 Donor pancreatectomy, with preparation and maintenance of allograft from</p> <p>48554 Transplantation of pancreatic allograft</p> <p>48556 Removal of transplanted pancreatic allograft</p> <p><b>LIVER</b></p> <p>47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living</p> <p>47136 heterotopic, partial or whole, from cadaver or living donor, any age</p> <p><b>INTESTINE</b></p> <p>44132 Donor enterectomy, open, with preparation and maintenance of allograft;</p> <p>44133 partial, from living donor</p> <p>44135 Intestinal allotransplantation; from cadaver donor</p> <p>44136 from living donor</p>
<b>Ancillary Provider and Other Health</b>	<b>Care Professional Notification Requirements</b>
<b>Accidental Dental Services+</b>	<p>Dental services that meet the following criteria may be eligible for medical coverage depending on the member's benefit contract:</p> <ul style="list-style-type: none"> <li>• Date of initial contact for dental evaluation is within plan limits following the accident.</li> <li>• Initiation of definitive treatment services within guidelines.</li> <li>• Estimated completion date of treatment services is known.</li> <li>• Certification that the injured tooth was a sound natural tooth.</li> </ul> <p>This does not apply to dental services that are excluded under the member's benefit plan. Dental implants are not covered under most</p>
<b>Ambulance Transportation (Non-Urgent)</b>	<p>Non-urgent ambulance transportation between specified locations for who cannot travel by other forms of transportation.</p>

Notification Requirements for Physician Services  
Procedures and Services Explanation

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**Notification Requirements for Physician Services\***  
**Procedures and Services Explanation**

<p><b><u>Transplant Services</u></b>  <b><u>(continued)</u></b></p>	<p><b><u>LUNG</u></b></p> <p><a href="#"><u>32850 Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)</u></a></p> <p><a href="#"><u>32851 Lung transplant, single; without cardiopulmonary bypass</u></a></p> <p><a href="#"><u>32852 with cardiopulmonary bypass</u></a></p> <p><a href="#"><u>32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass</u></a></p> <p><a href="#"><u>32854 with cardiopulmonary bypass</u></a></p> <p><b><u>KIDNEY</u></b></p> <p><a href="#"><u>50300 Donor nephrectomy, with preparation and maintenance of allograft, from cadaver donor, unilateral or bilateral</u></a></p> <p><a href="#"><u>50320 Donor nephrectomy, open from living donor (excluding preparation and maintenance of allograft)</u></a></p> <p><a href="#"><u>50340 Recipient nephrectomy</u></a></p> <p><a href="#"><u>50360 Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy</u></a></p> <p><a href="#"><u>50365 with recipient nephrectomy</u></a></p> <p><a href="#"><u>50370 Removal of transplanted renal allograft</u></a></p> <p><a href="#"><u>50380 Renal autotransplantation, reimplantation of kidney</u></a></p> <p><a href="#"><u>50547 Laparoscopic donor nephrectomy from living donor (excluding preparation and maintenance of allograft)</u></a></p> <p><b><u>PANCREAS</u></b></p> <p><a href="#"><u>48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells</u></a></p> <p><a href="#"><u>48550 Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation</u></a></p> <p><a href="#"><u>48554 Transplantation of pancreatic allograft 48556</u></a></p> <p><a href="#"><u>Removal of transplanted pancreatic allograft</u></a></p> <p><b><u>LIVER</u></b></p> <p><a href="#"><u>47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age</u></a></p> <p><a href="#"><u>47136 heterotopic, partial or whole, from cadaver or living donor, any age</u></a></p> <p><b><u>INTESTINE</u></b></p> <p><a href="#"><u>44132 Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor</u></a></p> <p><a href="#"><u>44133 partial, from living donor</u></a></p> <p><a href="#"><u>44135 intestinal allotransplantation; from cadaver donor</u></a></p> <p><a href="#"><u>44136 from living donor</u></a></p>
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\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions. In addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without cPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services. For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability.

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<u>Ancillary Provider and Other Procedures and Services</u>	<u>Health Care Professional notification requirements</u> <u>Explanation</u>
<u>Accidental Dental Services</u> <u>(Does not apply to Erickson Advantage members)</u>	<p>Dental services that meet the following criteria may be eligible for medical coverage depending on the member's benefit contract:</p> <ul style="list-style-type: none"> <li>• <u>Date of initial contact for dental evaluation is within plan limits following the accident .</u></li> <li>• <u>initiation of definitive treatment services within guidelines .</u></li> <li>• <u>Estimated completion date of treatment services is known .</u></li> <li>• <u>certification that the injured tooth was a sound natural tooth .</u></li> </ul> <p><u>This does not apply to dental services that are excluded under the member's benefit plan .</u> <u>Dental implants are not covered under most plans .</u></p>
<u>Ambulance Transportation</u> <u>(Non-Urgent)</u>	<u>Non-urgent ambulance transportation between specified locations for members who cannot travel by other forms of transportation .</u>
<u>Durable Medical Equipment</u> <u>(DME) Greater than \$1,000</u>	<u>in general, we require notification for DME with a retail purchase cost or a cumulative retail rental cost over \$1,000 . Prosthetics are not DME (see separate Prosthetics and Orthotics notification requirement) . Some payer groups may have different DME notification requirements imposed upon members through their benefit plans . For further information, please call Member care at the number on the back of the member's health care ID card .</u>
<u>End Stage Renal Disease/ Dialysis Services</u> <u>(Does not apply to Erickson Advantage members)</u>	<p><u>Services for the treatment of End Stage Renal Disease (ESRD), including outpatient dialysis services (as defined by, but not limited to, the revenue and CPT codes below), require notification .</u></p> <p><u>No notification is required for end stage renal disease when a Medicare member travels outside of the service area .</u></p> <p><u>Dialysis:</u></p> <p><u>90935, 90937, 4052F, 4054F - hemodialysis</u> <u>90945, 90947, 4055F - peritoneal</u> <u>90963 - 90970 - ESRD</u></p> <p><u>90989 - patient training, completed course</u> <u>90993 - patient training, per session</u> <u>90999 - unlisted dialysis procedure, inpatient or outpatient</u></p> <p><u>Revenue codes:</u></p> <p><u>304 - Nonroutine Dialysis</u> <u>800 - 804, 809 - Renal Dialysis 820 -</u> <u>825, 829 - Hemo/op or home</u> <u>830 - 835, 839 - Other outpatient/peritoneal dialysis</u> <u>840 - 845, 849 - capd/op or home 850</u> <u>- 855, 859 - ccpd/op or home 880 -</u> <u>882, 889 - Dialysis / misc</u></p> <p><u>For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to our online provider directory at UnitedHealthcareOnline .com or call us at (877) 842-3210 . in an effort to maximize member benefit coverage and lifetime maximum limits, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible . Note that your agreement with us may include restrictions on referring members outside the UnitedHealthcare network .</u></p>
<u>Home Health Care Services</u> <u>(Does not apply to Erickson Advantage members)</u>	<u>All services which are based in the home including, but not limited to, Enteral Formula, Home infusion Therapy, Home Health Aid (HHA), Occupational Therapy (OT), Physical Therapy (PT), Private Duty Nursing (T1 000), Respiratory Therapy (RT), Skilled Nursing (SNV), Social Worker (MSW) and Speech Therapy (ST) .</u>
<u>Hospice</u>	<u>inpatient Hospice services only .</u>

\* Effective December 3, 2007, the list of planned services requiring advance notification by physicians was significantly reduced by eliminating notification requirements for most inpatient admissions . in addition, there is no reimbursement impact for failure to notify for congenital Heart Disease without CPT code, cancer Treatment initiation, Pregnancy or Referral for Non-Network Services . For other services on the Advance Notification List, failure to provide notification will result in a full reimbursement reduction equal to 100% of the contracted rate with no member liability .

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**Ancillary Provider and Other Health Care Professional notification requirements**

Procedures and Services	Explanation
<p><b>Durable Medical Equipment (DME) Prosthetic and Orthotic Services</b> Greater than \$1,000 <del>In general, we</del></p>	<p><u>Prosthetic and orthotic services with a retail purchase cost or cumulative retail rental cost exceeding \$1,000.</u></p>
<p><b>End Stage Renal Services+</b>  <b>Note: No end-stage renal Medicare member the service area.</b></p>	<p>Services for the treatment of End Stage outpatient dialysis services (as defined codes below), require notification.</p> <p>Dialysis:</p> <p>90918 – 90925 – ESRD</p> <p>90940 – hemodialysis</p> <p>90945 – peritoneal</p> <p>90947 – peritoneal</p> <p>90989 – patient training, completed</p> <p>90993 – patient training, per session</p> <p>90999 – unlisted dialysis procedure,</p> <p>Revenue Codes:</p> <p>0800 – Renal Dialysis</p> <p>0820-0829 – Hemo/op or home</p> <p>0830-0839 – Peritoneal/op or home</p> <p>0840-0849 – Capd/op or home</p> <p>0850-0859 – Ccpd/op or home</p> <p>0880-0889 – Dialysis / misc</p> <p>ESRD-related services</p> <p>Place of service that is billed will</p> <p>Place of service 11 – Office:</p> <p>Billing the G codes listed below with place of service 11, office, will not require notification. Billing with place</p> <p>Place of service 12 – Home:</p> <p>Billing the G codes listed below with place of service 12, home, will require that notification be obtained PRIOR to the service being rendered. Billing with place of service 12 will also count</p> <p>G0317 – G0319</p>

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Other notification requirements Procedures	Explanation
<p><u>Specific Medications as Indicated on the PDL (Applies to commercial members only)</u></p>	<p>call (877) 842-1435 when prescribing medications that require notification . These medications are so designated on the Prescription Drug List (PDL) . To view the Prescription Drug List (PDL), visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline .com</a> . Tools &amp; Resources . Pharmacy Resources, or call (877) 842-1508 to request a copy of our PDL .</p>

<a href="#"><u>Behavioral Health Services</u></a> (Does not apply to Erickson Advantage members)	<a href="#"><u>Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network . Therefore, it is important for you to call the number on the member's health care iD card when referring for any mental health or substance abuse services .</u></a>
<a href="#"><u>Chiropractic Services</u></a> (Does not apply to Erickson Advantage members)	<a href="#"><u>Many of our benefit plans only provide coverage for chiropractic services through a designated arrangement subject to a benefit review . Therefore, it is important for you to call the number on the member's health care iD card when referring for any chiropractic services .</u></a>
<a href="#"><u>Physical Therapy/ Occupational Therapy (PT/OT)</u></a> (Does not apply to Erickson Advantage members)	<a href="#"><u>Many of our benefit plans only provide coverage for PT/OT through a designated arrangement subject to a benefit review . Therefore, it is important for you to call the number on the member's health care iD card when referring for any PT/OT services .</u></a>
<a href="#"><u>Arizona - Additional Notification Requirements for Physician Services, Ancillary Provider and other Health Care Professional Services Rendered in Arizona</u></a>	
<a href="#"><u>Capsule Endoscopy</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Non-invasive procedure in which an ingested capsule containing a miniature video camera takes a video recording of the mucosal lining of the esophagus or small bowel as it moves through the gastrointestinal tract .</u></a>
<a href="#"><u>Cochlear Implants</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Surgically-placed devices used to improve sound recognition .</u></a>
<a href="#"><u>Hyperbaric Oxygen Treatment</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Non-emergent hyperbaric oxygen treatments require advanced notification and benefit review .</u></a>
<a href="#"><u>Joint Replacement</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Joint replacement procedures in addition to total hip and knee .</u></a>
<a href="#"><u>Sleep Apnea Procedures and Surgeries</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea .</u></a>
<a href="#"><u>Outpatient Spine Surgeries</u></a> (Does not apply to Medicare Advantage members)	<a href="#"><u>Outpatient Spinal Surgeries (in addition to inpatient Spinal Surgeries) .</u></a>

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<del>Procedures and Services</del>	<del>Explanation</del>
<del>End Stage Renal Disease Services+ (Continued)</del>	<del>G0323 G0327  In an effort to maximize member benefit coverage, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible. Note that your agreement with us may include restrictions on referring members outside the UnitedHealthcare network. For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to our online provider directory at <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> or call us at</del>

<del>Home Health Care Services+</del>	<del>All services which are based in the home including, but not limited to: Enteral Formula, Home Infusion Therapy, Home Health Aid (HHA), Occupational Therapy (OT), Physical Therapy (PT), Private Duty Nursing (T1 000), Respiratory Therapy (RT), Skilled Nursing (SNV), Social Worker (MSW) and Speech Therapy (ST).</del>
<del>Hospice</del>	<del>Inpatient Hospice services only.</del>
<del>Prosthetic and Orthotic Services Greater than \$1,000*** (Applies to Medicare members only) Other Notification Requirements Specific Medications as Indicated on the PDL (Applies to commercial members only)</del>	<del>Prosthetic and orthotic services exceeding \$1,000.  Call (877) 842-1435 when prescribing medications that require notification. These medications are so designated on the Prescription Drug List (PDL). To view the Prescription Drug List (PDL), visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> •Tools &amp; Resources • Pharmacy Resources, or call (877) 842-1508 to request a copy of our PDL.</del>
<del>Behavioral Health Services+</del>	<del>Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network. Therefore, it is important for you to call the number on the health care ID card when referring for any mental health or substance abuse services.</del>

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~~UnitedHealthcare [3210](http://UnitedHealthcare.com).~~

## Outpatient Radiology Notification (for Commerical Members only)

~~Except as noted below, the~~The outpatient radiology notification requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers (“Physicians/Providers”) for **Advanced Outpatient Imaging Procedures**. ~~Applicability of this Protocol to Medicare members will be implemented in the future, as communicated to Physicians/Providers at that time.~~

- ~~This Protocol applies to all physicians ordering advanced radiology imaging that have not received the UnitedHealth Premium<sup>®</sup> quality and efficiency designation. Ordering physicians who have received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation are exempt from the notification program for the period they are designated. Designation is an annual process and generally occurs during the Fall of each calendar year.~~advanced Outpatient imaging Procedures.
- ~~This Protocol is a prior notification requirement, **not**~~and we do not consider the Protocol to be a precertification, preauthorization or medical necessity determination . Notification under this Protocol is required for outpatient services only . ~~Imaging~~imaging services ordered during emergency room visits, in the observation unit or during an inpatient stay do not require notification .
- Compliance**compliance with this Protocol is required.~~Incomplete . incomplete~~ notification and/or non-notification rates will be tracked through physician data sharing reports .  
:Without completion of the entire notification process described below, a notification number will not be issued . if the imaging study requested for a member is performed and the claim is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur.  
:This Protocol is effective on the date noted in your notification letter .

### Ordering Physician/Provider:

- The Physician/Provider ordering the imaging service is responsible for obtaining a notification number prior to scheduling **Advanced**advanced Outpatient ~~Imaging~~imaging Procedures.~~Ordering . The process required by this Protocol for ordering~~ Physicians/ Providers ~~can obtain the required notification number by contacting us~~ is as follows:
  - Obtain the required notification number by contacting us via:
    - ~~Online: UnitedHealthcareOnline .com~~ Notifications Radiology Notification Submission & Status ~~Fax: (866) 889-8064~~
    - Fax: (866) 889-8061
    - Phone: (866) 889-8054

### Rendering

The information listed below may be requested at the time of the notification request

#### Member/procedure information

- Member's/enrollee's name and member's/enrollee's United Healthcare id number
- Member's/enrollee's address and telephone number
- Member's/enrollee's group number
- Member's/enrollee's date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The primary diagnosis or “rule out” with the icd-9-cM (or its successor) code(s)

Physician/Provider: information

- Ordering Physician's or health care professional's name, TiN/N Pi, specialty, address, and telephone number
- To receive payment for services rendered, prior to performing the stated **Advanced Outpatient Imaging Procedures, the rendering Physician/Provider must:** Physician/Provider to whom the member is being referred, if specified, and the address

~~—Validate with us that a notification is on file by contacting us as follows:~~

- ~~Online: UnitedHealthcareOnline.com • Notifications • Radiology Notification Submission & Status Rendering physician's or health care professional name and TiN/N Pi~~

Clinical information

- ~~Phone: (866) 889-8054 (select prompt 2 to check status of a notification request) **OR** The member's clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.~~

~~—Confirm that the ordering physician has received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation. If the ordering physician has received the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designation, the Rendering Physician/Provider must:~~

- ~~Include the UnitedHealth Premium<sup>®</sup> quality and efficiency of care designated physician's name and TIN or NPI number on the claim form when submitted for payment. dates of prior imaging studies performed.~~

**OR**

- ~~Request a notification number on behalf of the UnitedHealth Premium<sup>®</sup> quality and efficiency designated Ordering Physician/Provider. This can be done online at UnitedHealthcareOnline.com • Notifications • Radiology Notification Submission & Status • Submit on Behalf of a Quality and Efficiency Designated Physician, or by phone: (866) 889-8054 (select prompt 5 and then select option 9). any other information the ordering Physician/Provider believes would be useful in evaluating whether the service ordered meets current evidence-based guidelines, such as prior diagnostic tests and consultation reports.~~

~~—If you would like to verify the UnitedHealth Premium<sup>®</sup> designation status of a physician, visit our physician Web site at UnitedHealthcareOnline.com • Physician directory or send an email to unitedpremium@uhc.com.~~

~~If the rendering Physician/Provider determines there is no notification on file, the rendering Physician/Provider may contact UnitedHealthcare to obtain notification via the channels noted above. UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to obtain the notification from the ordering Physician/Provider prior to the rendering of services.~~

~~The process required by this Protocol for ordering Physicians/Providers who have not received the UnitedHealth Premium<sup>®</sup> quality and efficiency designation is as follows:~~

~~—Ordering Physician/Provider must contact UnitedHealthcare by phone, fax or online at UnitedHealthcareOnline.com and provide all of the member/procedure information, Physician/Provider information and required clinical information as described below.~~

- ~~If if the requested imaging study is consistent with evidence-based clinical guidelines, a notification number will be communicated to the ordering Physician/Provider at the time of the request .~~

**OR**

• ~~—If~~

.if the imaging study requested for the member is not consistent with evidence-based clinical guidelines, or if further information is needed to assess the request, the ordering Physician/Provider participates in a physician-to-physician discussion to understand the request, provide additional clinical information and to consider alternative approaches . Upon completion of the discussion, the ordering Physician/Provider will confirm the procedure ordered and a notification number will be issued . The ordering physician maintains final decision authority .

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on clinical guidelines . This discussion is not a preauthorization, precertification or medical necessity determination-

- ~~Without completion of the entire notification process described above, a notification number will not be issued and a claim reimbursement reduction will occur.~~

### **If the Ordering Physician is Non-Participating**

~~The rendering physician/provider may call (866) 889-8054 and select option 5 to speak with a Customer Care professional. The Customer Care professional will assist with obtaining a notification number on behalf of the nonparticipating ordering physician. No clinical questions will be asked.~~

~~The information listed below may be requested at the time of the notification request.~~

#### **Member/Procedure Information**

- ~~Member's UnitedHealthcare ID number~~
- ~~Member's name, address and telephone number~~
- ~~Member's group number~~
- ~~Member's date of birth~~
- ~~The examination(s) being requested, with the CPT code(s)~~
- ~~The diagnosis or "rule out" with the ICD-9-CM (or its successor) code(s)~~

#### **Physician/Provider Information**

- ~~Ordering Physician/Provider name, Tax Identification Number, specialty, address, and telephone number~~
- ~~Physician/Provider to whom the member is being referred, if specified, and the address~~
- ~~The contact person at the ordering Physician's/Provider's office~~

#### **Clinical Information**

- ~~The member's clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.~~
  - ~~Dates of prior imaging studies performed.~~
  - ~~Any other information the ordering Physician/Provider believes would be useful in evaluating whether the service ordered meets current evidence-based guidelines, such as prior diagnostic tests and consultation reports .~~
- Notification numbers will be communicated to the **Ordering** ~~ordering~~ Physician/Provider when the notification process is completed . They will be communicated by telephone, fax and/or online, consistent with how the request was initiated . To help promote proper payment, this number should be communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to perform the **Advanced Outpatient Imaging Procedures** ~~advanced outpatient imaging Procedures~~ . Please note that the receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that ~~notification was made~~ **notification was made** . Medical coverage/payment authorization is a separate process determined by the member's benefit contract and your agreement with us ~~is~~ .

### **Urgent ~~Requests~~ requests**

- Physician/Provider may request a notification number on an urgent basis if the Physician/Provider determines it to

be medically required . **A** notification number will be issued for urgent requests within three (3) hours of UnitedHealthcare receiving all required information . **I**f the Physician/Provider determines that care must be provided before a notification number can be issued on an urgent basis, the services should be performed and the notification requested retrospectively following the Retrospective Notification process described below.

### Retrospective notification

- if an advanced Outpatient imaging Procedure is required on an urgent basis, or notification cannot be obtained because it is outside of UnitedHealthcare's normal business hours, the service may be performed and notification can be requested retrospectively.
- Retrospective notification requests must be made within two (2) business days of the service.
- Ordering Physicians/Providers should follow the same notification process outlined above for a standard request.
- documentation must include an explanation as to why the procedure was required on an urgent basis or why notification could not be obtained during UnitedHealthcare's normal business hours.

### Rendering Physician/Provider

To receive payment for services rendered, prior to performing the stated advanced Outpatient imaging Procedures, the rendering Physician/Provider must validate with us that a notification is on file by contacting us as follows:

- Online: UnitedHealthcareOnline.com Notifications Radiology Notification Submission & Status
- Phone: (866) 889-8054 (select prompt 2 to check status of a notification request)

if the rendering Physician/Provider determines there is no notification on file, the rendering Physician/Provider may contact UnitedHealthcare to obtain notification via the channels noted above . UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to obtain the notification from the ordering Physician/Provider prior to the rendering of services .

### **Provision of ~~Additional Advanced Outpatient Imaging Procedures~~ additional advanced outpatient imaging procedures**

- ~~—If~~ **if**, during the provision of an ~~Advanced~~ **advanced** Outpatient ~~Imaging~~ **imaging** Procedure, the rendering Physician/Provider determines that additional services should be delivered above and beyond the service(s) for which notification has been obtained, the ~~Rendering~~ **rendering** Physician/Provider should render those service(s) and obtain retrospective notification following the Retrospective Notification process described ~~below~~ **above**.

#### **Retrospective Notification**

- ~~—If an Advanced Outpatient Imaging Procedure is required on an urgent basis, or notification cannot be obtained because it is outside of UnitedHealthcare's normal business hours, the service may be performed, and notification can be requested retrospectively.~~
- ~~—Retrospective notification requests must be made within two (2) business days of the service.~~
- ~~—Ordering Physicians/Providers should follow the same notification process outlined above for a standard request.~~
- ~~—Documentation must include an explanation as to why the procedure was required on an urgent basis or why notification could not be obtained during UnitedHealthcare's normal business hours.~~

### If the ordering physician is non-participating

The rendering Physician/Provider may call (866) 889-8054 and select option 5 to speak with a customer care professional . The customer care professional will assist with obtaining a notification number on behalf of the nonparticipating ordering physician .

### **Products ~~Included~~ included**

**Commercial** commercial benefit plans issued and administered by UnitedHealthcare or one of its affiliates, which are subject to this Guide, and for which the physician is required to provide prior notification, are subject to the Radiology

Notification Program . ~~Injn~~-scope products include such products as ~~Choice, Choice~~choice, choice Plus, Definity<sup>SM</sup> HRA/HSA, Select and Select Plus .

## **Products/~~Members Excluded~~members excluded**

Benefit plans issued or administered by ~~Definity<sup>SM</sup> Health~~, Oxford Health Plans, ~~PacifiCare, MD Individual LLC~~: Oxford Health insurance, by a subsidiary of either Pacificare Health Plan Administrators, inc . or Pacificare Health Systems, LLC, MD-individual Practice Association, ~~Inc, inc.~~ (M .D . IPA, IPA), Optimum ~~Choice, choice~~, Inc, inc. (Optimum Choice, choice), ~~MAMSI, MAMSi~~ Life and Health Insurance Company, insurance company (MLH), Neighborhood Health ~~and~~-Partnership, UnitedHealthcare Services Company, company of the River Valley, ~~Inc, inc.~~\*, UnitedHealthcare Plan of the River Valley\*, Inc, inc. or UnitedHealthcare Insurance Company, insurance company of the River Valley\*, which are subject to the administrative guide or manual of that affiliate, are excluded . Also excluded are ~~government, governmental~~ benefit plans for Medicare and Medicaid members, and benefit plans for which the member (rather than the physician) is required to provide notification, such as Options PPO and UnitedHealthcare Indemnity, indemnity .

~~Refer to UnitedHealthcareOnline.com for the latest radiology notification table.~~

~~If you would like to verify your status with the UnitedHealth Premium<sup>®</sup> designation program, visit UnitedHealthcareOnline.com or send an email to unitedpremium@uhc.com.~~

## **Physical Medicine and Rehabilitation Services**

~~Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy provider.~~

~~These excluded benefit plans may have separate Radiology notification or pre-authorization requirements . Refer to UnitedHealthcareOnline .com for the most current listing of CPT codes that require notification . \*Except Medicare Advantage benefit plans are subject to this notification requirement.~~

## **Physician Office Physical Medicine and Rehabilitation (“PM&R”) Service Prior Notification Protocol; Florida and Colorado (additional states may be added)**

- ~~This Protocol supplements the provisions of the Participation Agreement between Physicians or Medical Groups, as applicable, and UnitedHealthcare pertaining to notification of PM&R Services (physical or occupational therapy services, as more specifically articulated in the attached CPT and HCPCS Code List) for Physicians providing care. At the time of printing, this Protocol is applicable to physicians in the states of Florida and Colorado. Additional states may have been added to this Protocol since the date of printing. Refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) for a complete list of states in which this Protocol is applicable.~~
- ~~This Protocol applies to:~~
  1. ~~Physicians, and health care professionals at their direction, who perform PM&R Services in their office (for purpose of this Protocol, “in their office” includes PM&R Services performed or directed to be performed by physicians who belong to the same medical group or practice as the physicians ordering the services, even if the services are rendered in a different location than the location of the ordering physicians).~~
  2. ~~Physicians, and health care professionals at their direction, who render PM&R Services under commercial benefit plans issued or administered by UnitedHealthcare or one of its affiliates if: the Physician is subject to this Guide, and the Physician is required to comply with notification requirements described under this Guide. This includes products such as UnitedHealthcare Choice, Choice Plus, Select and Select Plus as denoted on the member’s health care identification card.~~
- ~~This Protocol does not apply to:~~
  1. ~~Physicians, and health care professionals at their direction, who:~~
    - a. ~~Order PM&R Services and have received the UnitedHealth Premium<sup>®</sup> designation for quality and efficiency of care, for as long as the Physician is so designated.~~
    - b. ~~Perform PM&R services in a state outside Florida or Colorado (or any additional state added hereafter as designated on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com)).~~
  2. ~~Products excluded: government benefit plans such as Medicare, Medicaid and CHIP; or benefit plans issued or administered by Oxford Health Plans, PacifiCare, MD Individual Practice Association, Inc. (M.D. IPA), Optimum Choice, Inc. (Optimum Choice), MAMSI Life and Health Insurance (MLH), Neighborhood Health Partnership, UnitedHealthcare Services Company of the River Valley, Inc., UnitedHealthcare Plan of the River Valley, Inc., UnitedHealthcare Insurance Company of the River Valley, Arnett Health Plans, IBA Health Plans which are subject to an administrative guide or manual of that affiliate.~~
  3. ~~Benefit plans for which the member (rather than the Physician) is required to provide notification, including, but not limited to, UnitedHealthcare’s Options PPO or Managed Indemnity products.~~
- ~~Notification is only required for the Physical Medicine & Rehabilitation Services (PM&R) identified in the CPT or HCPC Service Code List below or found on [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). Click on the Notifications tab at the top of the page.~~
- ~~Physicians or the health care professionals who perform PM&R Services at their direction must notify UnitedHealthcare prior to, or within five (5) business days after, the initial date of service and prior to scheduling additional PM&R Services. Subsequent notification of additional PM&R Services may be requested by UnitedHealthcare.~~
- ~~This is a prior notification requirement only, not a pre-certification, pre-authorization or medical necessity determination. Failure to notify in accordance with this Protocol may result in claim reimbursement reduction. Physicians can obtain the proper notification form and can review training instructions on how to complete the form by visiting [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) • Notifications • PM&R Services Notification Program.~~
- ~~Notifications must be filled out completely and accurately, and submitted by facsimile transmission to (888) 329-5183. Physicians should retain their fax confirmation sheet as proof of submission. A~~

notification number will be included in a letter response from United Healthcare and should be inserted in Box 23 of the claim form prior to submitting the claim.

On average, notifications will be processed within two (2) business days from initial date of receipt, and the submission acknowledgement response letter will be generated on the third (3<sup>rd</sup>) business day thereafter unless state regulations require otherwise, or unless additional information is requested in order to process the notification. An incomplete notification will delay processing. Tutorials on completing the NF702 notification form are available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) - Clinician Resources - Neuroscience, Orthopaedic & Spine - Physical Medicine & Rehabilitation (PM&R) Notification Program. Scroll to the bottom of the page and find the “Tools & Resources” and “For completion by Patient” sections which will include all relevant materials. You can also email us at [PM&R.Services@uhc.com](mailto:PM&R.Services@uhc.com) with any questions.

Please allow time for the notification form to be processed before checking on the status of the notification via the [UnitedHealthcareonline.com](http://UnitedHealthcareonline.com) Web site. If you provide a dedicated business fax line (not a billing number), we will fax the response letter to you after processing. If we do not have a valid fax number on file or if it fails to send, your response letter will be mailed. Expect to wait an additional five (5) to seven (7) business days for mail delivery. To expedite your receipt of the submission acknowledgement response letter, please call (800) 699-2495 to confirm the fax number on file for each of your locations where the response letter should be sent.

Submitting a notification is not a guarantee of payment. Payment is determined by the member’s benefit plan and the applicable agreement.

*If you intend to submit a claim to UnitedHealthcare for payment of one of the following Physical Medicine & Rehabilitation Service Codes rendered within a physician’s office — a notification will be required.*

Code Type	CPT Codes	Description	
Physical / Occupational Therapy	HCPC Codes	G0284	Electrical Stimulation (unattended) chronic stage III & IV ulcers etc
		G0283	Electrical Stimulation (unattended) non-wound
	CPT Codes	97001	PT Evaluation
		97002	OT Evaluation
		97003	PT Re-Evaluation
		97004	OT Re-Evaluation
		97012	Mechanical Traction
		97016	Vasopneumatic compression
		97018	Paraffin Bath
		97022	Whirlpool
		97024	Diathermy
		97026	Infrared
		97028	Ultraviolet
		97032	Electrical Stimulation — attended
		97033	Iontophoresis
		97034	Contrast Bath
97035	Ultrasound		
97036	Hubbard Tank		
97039	Unlisted modality		

	97110	Therapeutic procedure
	97112	NMR
	97113	Aquatic

Code Type	CPT Codes	Description
	97116	Gait Training
	97124	Massage
	97139	Unlisted modality
	97140	Manual Therapy
	97150	Therapeutic Group Activities
	97530	Ther functional activities
	97532	Cognitive
	97533	Sensory
	97535	Self-Management
	97537	Community and Work
	97542	Wheelchair management
	97545	Work Hardening/conditioning
	97546	Each additional hour
	97750	Physical performance test
	97755	Assistive technology assessment
	97760	Management & Training— Orthotics
	97761	Management & Training— Prosthetics
	97762	Checkout for orthotic/prosthetic use
	97799	Unlisted physical medicine/rehab

*If one of the services listed above will be used during the member's treatment plan and billed to UnitedHealthcare, print the PM&R notification form found on UnitedHealthcareOnline.com and fax it to the number listed on the form. Wait for response letter to be faxed or mailed back to you with the notification number before submitting claim. See the FAQ or*

*Notification tutorial for more information.*

## Compensation

### Additional Fees for Covered Services

You may not charge our members fees for **Covered Services** beyond copayments, coinsurance or deductible as described in their benefit plans . You may not charge our members retainer, membership, or administrative fees, voluntary or otherwise . This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide that are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies. This does not prevent you from charging our commercial members nominal fees for missed appointments or completion of camp/school forms . Please note, however, that for Medicare **Advantage** members, **CMS** does not allow the provider to charge for "missed appointments" unless the provider has previously disclosed that policy to the member .

## Charging ~~Members~~members for ~~Non-Covered Services~~non-covered services

For commercial members, you may seek and collect payment from our member for services not covered under the applicable benefit plan, provided you first obtain the member's written consent . Such consent must be signed and dated by the member prior to rendering the specific service(s) in question . Retain a copy of this consent in the member's medical record . ~~In~~In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must: (a) include an estimate of the charges for that service; (b) include a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, include a statement that UnitedHealthcare has determined that the service is not covered and that the member, with knowledge of UnitedHealthcare's determination, agrees to be responsible for those charges .

For Medicare ~~Advantage~~advantage members, a Notice of ~~Denial~~denial of Medical ~~Coverage should~~coverage must be provided to the member advising them when a service is not covered .

You should know or have reason to know that a service may not be covered if:

- We have provided general notice through an article in a newsletter or bulletin, or information provided on our Web site (UnitedHealthcareOnline .com), including clinical protocols, medical and drug policies, either that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the member; or
- We have made a determination that planned services are not ~~Covered Services~~covered services and have communicated that determination to you on this or a previous occasion .

You must not bill our member for non-covered services if you do not comply with this Protocol .

~~If~~If you do not obtain written consent as specified above, the rendering provider must accept full financial liability for the cost of care . General agreements to pay, such as those signed by the member at any time ~~of~~(including at admission or upon the initial office visit), are not considered written consent under this Protocol .

## Financial ~~Incentives~~incentives

UnitedHealthcare notifies our members that the treatment decisions are made between physicians and members, and coverage decisions on health care services are based on the member's benefit contract .

- ~~The~~ coverage decisions are made based on the ~~appropriateness of care and services~~existence of coverage as defined within the member's benefit contract .
- The staff of UnitedHealthcare, its delegates, and the physicians and other health care professionals making these decisions are not ~~specifically~~ rewarded for issuing non-coverage decisions .
- UnitedHealthcare ~~does~~and its delegates do not offer incentives to physicians or other health care professionals to encourage underutilization of care or services .

~~In 1997, CMS created a new payment methodology for~~ **Medicare Risk Adjustment Information**

## Medicare Advantage ~~plans. The methodology uses the health status of Medicare members to determine accurate payment rates.~~ risk adjustment data

~~Physicians and other health care professionals play an important role in the model because CMS looks at physician encounter data (extracted by UnitedHealthcare from claims) to determine payment rates.~~

The ~~encounter~~risk adjustment data you submit to UnitedHealthcare must be accurate and complete .

- Remember that risk adjustment is based on ICD~~icD~~-9-CM~~cM~~ (or its successor) diagnosis codes, not CPT~~cPT~~ codes. ~~Therefore, .~~ Therefore, it is critical for your office to refer to an ICD~~icD~~-9-CM~~cM~~ (or its successor) coding manual and code accurately, specifically and completely when submitting claims to UnitedHealthcare .
- Diagnosis codes must be supported by the medical record . If it's is not documented in the medical record, then UnitedHealthcare will not recognize it as occurring. ~~Therefore, .~~ Therefore, medical records must be clear and complete .
- Never use a diagnosis code for a “probable” or “questionable” diagnosis . ~~Instead~~ instead, code only to the highest degree of certainty .
- Be sure to distinguish between acute vs . chronic conditions in the medical record and in coding . Only choose diagnosis code(s) that fully describe the member’s condition and pertinent history at the time of the visit .
- Always carry the diagnosis code all the way through to the correct digit for specificity . For example, do not use a 3- digit code if a 5-digit code more accurately describes the member’s condition.   
~~• CMS will conduct an encounter data validation study on an annual basis by reviewing a sample of physician medical records to ensure coding accuracy. UnitedHealthcare may contact you to request medical records for data validation .~~
- Be sure that the diagnosis code is appropriate for the member’s gender .

## Reimbursement ~~Policies~~policies

UnitedHealthcare reimbursement policies are available online at UnitedHealthcareOnline .com <sup>▲</sup> Tools and Resources <sup>▲</sup> Policies and Protocols link. Reimbursement policies may be referred to in your agreement with UnitedHealthcare as “payment policies .”

## Receiving ~~Reimbursement~~reimbursement

UnitedHealthcare contracts generally contain the requirement to conduct business with us electronically .

UnitedHealthcare has made Electronic Payments and Statements (EPS) the ~~standard~~ preferred method for issuing claim payments and Explanation of Benefits (EOBs) . To learn about EPS and how to enroll, go to WelcometoEPS .com .

# Quality Management

## Health Management Program Information management program information: Case and Disease Management Programs programs

Our ~~Case approach to case~~ and ~~Disease Management programs use advanced systems and claims-based predictive modeling to help find those~~ disease Management goes beyond traditional medical coverage and preventive services . We use integrated systems and proprietary software for case and disease Management that allows us to identify, stratify, assess, and intervene in order to identify gaps in care, and educate and coordinate access to services . Using medical, pharmacy and behavioral health claims data, our proprietary predictive model system helps us to identify people who are at high risk and direct them to our programs. ~~Our goal is to support the right care at the right time for the individual. Individuals~~ for outreach to facilitate the management of their care . Individuals can also be identified ~~through~~ at time of hospital discharge, ~~their~~ using results from our Health Risk ~~Assessment results, or assessment,~~ referred from our Nurse Triage line, ~~clinician direct referral, or member self-referral. Physicians may refer individuals~~ through self-referral and through direct referrals by physicians or other practitioners .

Our outbound call programs assess members with high-risk conditions for gaps in care . We then apply structured interventions to facilitate access to care . Our programs are built using evidence-based guidelines . at the core of these programs are health education and a focus on self-care and medication management . We give our members easy access to information and resources that focus on education, prevention and reminders . The programs also include medical director peer-to-peer conversations to alert practitioners to gaps in care, discuss best practices and encourage the use of evidence-based medicine in the treatment of the member .

We manage over twenty-three (23) high-risk conditions in our case and disease Management programs, where appropriate members can be referred to our transplant, kidney, cancer, neonatology and maternity resource services programs and engage with clinical specialists in these complex areas . in addition to the medical support we provide, we also screen for depression so that those with behavioral health needs are directed to the appropriate behavioral health resource . For support with lifestyle-oriented risks, we actively refer members to our online self-directed behavior modification programs for weight management, nutrition, smoking cessation, exercise, diabetes care, stress management and others . Physicians may refer members to any of the case Management or disease Management

programs by calling the physician toll free service number (877) 842-~~3210. Select the Care Notification~~ 3210, then selecting the care notification prompt to speak with a representative to initiate a referral to the appropriate program . The person member will be assessed ~~for need and triaged~~ to determine the appropriate level of intervention ~~by a program case manager through our outbound call program.~~

Members with chronic diseases who are at high-risk can benefit from the following programs .

### • High-Risk Case Management Program

~~At~~ at the core of High Risk ~~Case case~~ Management is the philosophy of identifying at-risk members with high cost, complex, ~~cases~~ high-cost conditions who can benefit from case management services. ~~Our case managers are Registered Nurses . We partner with members and their physicians or other health care professionals to facilitate health care access and decisions that can have a dramatic impact on the quality and affordability of their health care . Specifically, our programs are designed to assist members to:~~

- Receive evidenced-based care
- Have necessary self-care skills

- [Have the right equipment and supplies to perform self-care](#)
- [Have requisite access to health care delivery system](#)
- [Be compliant with medications](#)

[Our case managers are registered nurses](#) who engage the appropriate resources needed to address the **member's** health care needs, whether the resources are internal, external or community-based. ~~Case Managers. When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, behavioral health, employee assistance and disability.~~

[case managers](#) engage the member's physician, whether primary care or specialist, to **assist the member in getting help our members receive** the right care, and the right medication, at the right time. [Our medical directors are engaged in the process of case review and support the provision of evidence-based care. Our case managers utilize community-based resources to](#)

[meet the needs of members such as home health care agencies, equipment vendors, schools, churches or referrals to financial resources.](#)

[depending on a member's needs, member engagement in the High-Risk case Management program can range from a few weeks to an indefinite period of time.](#)

## • **Disease Management Programs** [programs](#)

UnitedHealthcare offers [population-based longitudinal](#) disease **management programs related to asthma, coronary artery disease, diabetes and heart failure** [Management programs that are designed to use multiple sources of information, including, but not limited, to the ingenix predictive model to identify and stratify members with these conditions into the appropriate level of intervention.](#) The programs are voluntary and at **no cost to the member. For members managed in the high intensity outbound call program, their physician is notified when the member enrolls in one of the programs.**

~~For Medicare members, UnitedHealthcare's approach aligns traditional disease management with care management concepts and evidence-based guidelines. Care Management integrates services into a seamless system of care, focuses on care that slows progression of illness and involves members, physicians and other health care professionals in the care planning process. The key process features of Care Management are: risk stratification, community and social assessment, interdisciplinary care planning, evidence-based interventions, focus on delivery of coordinated services, promotion of self-care and ongoing monitoring and evaluation. There are two disease management programs available for Medicare members, coronary artery disease and diabetes. Physicians may refer members for any of these programs by calling our toll-free physician services number (877) 842-3210.~~

## **Clinical Performance Assessment**

~~Principles for performance assessment are derived from UnitedHealthcare's philosophies and business strategies for improving the quality of clinical care and supporting physicians in their practice of evidence-based and efficient health care delivery. In general, the evaluation of physician practices is based on the comparison of observed practice patterns with the expected practice based on externally published, nationally derived standards. The physician's primary specialty, as designated by the physician, is used for the evaluation. Our goal is to improve health care quality and efficiency and reduce unintended variation in health care outcomes by promoting the practice of evidence-based medicine. UnitedHealthcare's clinical performance assessment program provides physicians with data to benchmark their performance against national standards and similar specialists in their market. UnitedHealthcare strongly supports transparency in its performance assessment criteria and methods.~~

~~We require cooperation with our performance assessment program and improvement activities (including, but not limited to, requests for telephone or face-to-face discussions, requests for additional information, and/or participation in UnitedHealthcare's notification and medical management programs). Failure to cooperate with these performance assessment programs and improvement activities will be reviewed by UnitedHealthcare and may result in appropriate action under your participation agreement (including,~~

~~but not limited to, modification to reimbursement or other terms of your agreement with us and/or termination).~~

~~The criteria supporting UnitedHealthcare's clinical performance assessment programs may be viewed at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com), or you may request a copy by contacting **UnitedHealthcare Clinical Advancement at (866) 270-5588.**~~

~~no cost to the participant . Physicians are notified when their patients participate in the high-risk program, and members participating in the moderate intensity program are provided with a letter to give to their physician about their participation .~~

~~The disease Management programs use evidence-based medicine to identify gaps in care and prevent avoidable admissions or slow the progression of the chronic condition . The outbound call program provides a series of structured calls as needed to address a member's particular gaps in care . The focus is on providing education about self- management, medication management, access to care and coordination of appropriate tests and physician visits . The participant may also call a disease Management nurse at any time during normal business hours . Programs offered may include:~~

- ~~• [coronary artery disease](#)~~
- ~~• [diabetes](#)~~
- ~~• [Heart Failure](#)~~
- ~~• [chronic Obstructive Pulmonary disease \(cOPd\)](#)~~

~~The goal of the disease Management programs is to assist members in managing their condition . Each program aims to deliver optimal clinical and financial outcomes by targeting the areas with the greatest potential for impact: the right health care provider, the right medications, the right care and the right lifestyle .~~

~~Our programs provide information and resources that members need to understand their condition and its implications, how to reduce risk factors, maintain a healthy lifestyle, adhere to physician treatment plans and medication regimens, effectively manage their condition and co-morbidities including depression, and receive the most clinically appropriate, cost-effective and timely diagnostic testing .~~

~~For some programs, members may receive comprehensive assessments by specialty-trained registered nurses to determine the appropriate level and frequency of interventions required . For many of our programs members also receive educational mailings, newsletters and tools such as the Healthlog to assist them in tracking their physician visits, health status and recommended targets or other screenings . For members in employer-based plans, disease Management programs available to members may vary .~~

## Clinical performance assessment

The UnitedHealth Premium<sup>®</sup> physician designation program ~~is designed~~ uses clinical practice information to assist physicians in their continuous practice improvement and to assist consumers in making more informed and personally appropriate choices ~~when seeking for their~~ medical care . The program uses national industry, evidence-based and medical society standards with a transparent methodology and robust data sources to evaluate physicians across twenty (20) specialties to advance safe, timely, effective, efficient, equitable and patient-centered care . The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty- specific standards for quality and local cost efficiency benchmarks . ~~For more information regarding the UnitedHealth Premium<sup>®</sup> physician designation program, go~~ in general, the evaluation of physicians for quality of care compares observed practice to expected practice, using measurements based on published scientific evidence and national standards applied to administrative data . The evaluation of physicians for cost efficiency compares observed cost for episodes of care to expected cost for episodes of care, with adjustments for the patient's severity of illness and the physician's case mix .

UnitedHealthcare strongly supports transparency in its performance assessment criteria and methods . The criteria supporting our clinical performance assessment programs may be viewed at [UnitedHealthcareOnline .com](http://UnitedHealthcareOnline.com), or you may

[request a copy by contacting UnitedHealth Premium program advisors at \(866\) 270-5588 . For more information regarding the UnitedHealth Premium physician designation program, go to \[UnitedHealthcareOnline .com . clinician Resources . UnitedHealth Premium\]\(#\), or call our toll-free number at \(866\) 270-5588 . Please note the UnitedHealth Premium physician designation program does not apply to Medicare Advantage benefit plans .](#)

## Cancer status forms

[UnitedHealthcare is collecting patient-specific clinical data from oncology/hematology providers on members with breast, colon, lung, prostate or rectal cancers as well as lymphomas, as part of a new cancer Status collection initiative .](#)

[The clinical data will be collected every six \(6\) months for these cancer patients who are UnitedHealthcare members . This data will allow us to combine patients into clinically similar groups - a sorting task we cannot do using only claims data . By combining patients into clinically similar groups, we can assess treatment approaches and make comparisons between like cases . We will then use these clinically similar groups to identify gaps in care . in the future, we will be sharing our aggregate results with participating oncology/hematology providers . Participating providers with sufficient volume will be able to receive results for UnitedHealthcare members in their practices .](#)

[Forms will be faxed directly to your office to request data . For more information regarding this program, go to \[UnitedHealthcareOnline .com\]\(#\) •\*\*Clinical Resources\*\* • \*\*UnitedHealth Premium\*\* or call our toll-free number \*\*\(866\) 270-5588\*\*, \[clinician Resources . cancer – Oncology . cancer Status Forms\]\(#\) or send an email to \[unitedoncology@uhc.com\]\(mailto:unitedoncology@uhc.com\) .](#)

## Clinical Guidelinesguidelines

UnitedHealthcare ~~has identified~~[utilizes](#) evidence-based clinical guidelines to [guide/develop](#) our quality and health management programs . The following chart lists the clinical guidelines and the Web sites where the most current version of the guideline can be found .

Topic	Name of Guideline	Web Address
<a href="#">Acute MI</a>	<a href="#">ACC/AHA Guideline for the Management of Patients with ST</a>	<a href="#">American College of Cardiology/American Heart Association</a> <a href="http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1">http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1</a>
		<b>American College of Cardiology/American Heart Association:</b>
<a href="#">Acute MI</a>	<a href="#">Acc/AHA Guideline for the Management of Patients with ST Elevation Myocardial infarction</a>  <a href="#">2007 Focused Update</a>  <a href="#">Acc/AHA 2007 Guideline for the Management of Patients with Unstable Angina and Non-ST Elevation Myocardial infarction</a>	American <a href="#">Collegecollege</a> of <a href="#">Cardiologycardiology</a> /American Heart Association <a href="http://contentacc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm">http://contentacc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm</a>  <a href="#">American college of cardiology/American Heart Association content .onlinejacc.org/cgi/content/full/j_jacc.2007.10.001</a>  <a href="#">American college of cardiology/American Heart Association content .onlinejacc.org/cgi/content/full/50/7/e1</a>
<b>Asthma</b>	National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma	National Heart, Lung and Blood <del>Institute</del> <a href="http://www.institute.nhlbi.nih.gov/guidelines/asthma/index.htm">www.institute.nhlbi.nih.gov/guidelines/asthma/index .htm</a>

<a href="#"><u>Attention Deficit Hyperactivity Disorder (ADHD)</u></a>	<a href="#"><u>Practice Parameter for the Assessment and Treatment of children, Adolescents and Adults with Attention Deficit Hyperactivity Disorder</u></a>	<a href="http://aacap.org/galleries/practiceparameters/JAAcAP_ADAH_2007">American Academy of child and Adolescent Psychiatry aacap.org/galleries/practiceparameters/JAAcAP_ADAH_2007</a>
<b>Cardiovascular Disease</b>	<b>AHA/ACC Guidelines for Secondary Prevention for Treatment of Patients With</b>	American <b>College of Cardiology/American Heart</b> <a href="#"><u>Psychiatric</u></a> Association <a href="http://content.onlinejacc.org/cgi/content/full/47/10/2130.com/pracGuide/pracGuide">psychiatryonline http://content.onlinejacc.org/cgi/content/full/47/10/2130.com/pracGuide/pracGuide</a>
<b>Cholesterol Management</b>	<b>The Third Report of the Expert Panel on</b>	<b>National Heart, Lung and Blood Institute</b> <a href="http://www.nhlbi.nih.gov/guidelines/cholesterol">http://www.nhlbi.nih.gov/guidelines/cholesterol</a>
		<b>Note July 13, 2004 Update</b>
<b>Chronic Heart Failure</b>	<b>ACC/AHA 2005 Guideline Update for the Diagnosis</b>	<b>American College of Cardiology</b> <a href="http://www.acc.org/qualityandscience/clinical/guidelines/failure/updates">http://www.acc.org/qualityandscience/clinical/guidelines/failure/updates</a>
<b>Chronic Stable Angina</b>	<b>2007 Chronic Angina Focused Update of the ACC/AHA 2002</b>	<b>American College of Cardiology/American Heart Association</b>

<u>Topic</u>	<u>Name of guideline</u>	<u>Web address</u>
<u>Bipolar Disorder – Children &amp; Adolescents</u>	<u>Practice Parameter for the Assessment and Treatment of children and Adolescents With Bipolar Disorder</u>	<u>American Academy of child and Adolescent Psychiatry</u> <a href="http://aacap.org/page_wv?section=Practice+Parameters&amp;name=Practice+Parameters">aacap.org/page_wv?section=Practice+Parameters&amp;name=Practice+Parameters</a>
<u>Cardio-vascular Disease</u>	<u>AHA/Acc Guidelines for Secondary Prevention for Patients With coronary and Other Atherosclerotic Vascular Disease: 2006 Update</u>	<u>American college of cardiology/American Heart Association</u> <a href="http://content.onlinejacc.org/cgi/content/full/47/10/2130">content_onlinejacc.org/cgi/content/full/47/10/2130</a>
<u>Cardio-vascular Disease - Women</u>	<u>Evidenced-based Guidelines for cardiovascular Disease Prevention in Women; 2007 update</u>	<u>American college of cardiology/American Health Association</u> <a href="http://acc.org/qualityandscience/clinical/pdfs/cvdinwomen.pdf">acc.org/qualityandscience/clinical/pdfs/cvdinwomen.pdf</a>
<u>Cholesterol Management</u>	<u>The Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood cholesterol in Adults (Adult Treatment Panel iii)</u>	<u>National Heart, Lung and Blood institute</u> <a href="http://nhlbi.nih.gov/guidelines/cholesterol/index.htm">nhlbi.nih.gov/guidelines/cholesterol/index.htm</a>
<u>Chronic Heart Failure</u>	<u>2009 Focused Update incorporated into the Acc/AHA 2005 Guideline Update for the Diagnosis and Management of chronic Heart Failure in the Adult</u>	<u>American college of cardiology</u> <a href="http://content.onlinejacc.org/cgi/reprint/j.jacc.2008.11.013v1.pdf">content_onlinejacc.org/cgi/reprint/j.jacc.2008.11.013v1.pdf</a>
<u>Chronic Obstructive Pulmonary Disease</u>	<u>Global initiative for chronic Obstructive Lung Disease</u>	<a href="http://goldcopd.com">goldcopd.com</a>
<u>Chronic Stable Angina</u>	<u>2007 chronic Angina Focused Update of the Acc/AHA 2002 Guidelines for the Management of Patients with chronic Stable Angina</u>	<u>American college of cardiology/American Heart Association</u> <a href="http://content.onlinejacc.org/cgi/content/full/j.jacc.2007.08.002">content_onlinejacc.org/cgi/content/full/j.jacc.2007.08.002</a>
<u>Depression</u>	<u>Treatment of Patients with Major Depressive Disorder (Second Edition)</u>	<u>American Psychiatric Association</u> <a href="http://psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx">psychiatryonline.com/pracGuide/pracGuideTopic_7.aspx</a>
<u>Diabetes</u>	<u>Standards of Medical care for Patients with Diabetes 2009</u>	<u>American Diabetes Association</u> <a href="http://care.diabetesjournals.org/content/vol32/Supplement_1">care.diabetesjournals.org/content/vol32/Supplement_1</a>
<u>Hemophilia and von Willebrand Disease</u>	<u>Guidelines for the Management of Hemophilia</u> <u>National Heart Lung and Blood institute - von Willebrand Disease</u>	<a href="http://wfh.org/2/docs/Publications/Diagnosis_and_Treatment/Guidelines_Mng_Hemophilia.pdf">wfh.org/2/docs/Publications/Diagnosis_and_Treatment/Guidelines_Mng_Hemophilia.pdf</a>  <a href="http://nhlbi.nih.gov/guidelines/vwd/index.htm">nhlbi.nih.gov/guidelines/vwd/index.htm</a>
<u>Human Immuno-deficiency Virus Guideline</u>	<u>A guide to care of patients with HIV/AiDS</u>	<u>Primary care Guidelines for the Management of Persons infected with Human immunodeficiency Virus: Recommendations of the HiV Medicine Association of the infectious Diseases Society of America, 2004</u> <a href="http://guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=5625&amp;nbr=3793">guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=5625&amp;nbr=3793</a>  <u>A Guide to Primary care for People with HIV/AiDS, 2005 . U .S Department of Health and Human Services, Health Resources and Service Administration .</u> <a href="http://ftp.hrsa.gov/hab/PcARE04.pdf">ftp://ftp.hrsa.gov/hab/PcARE04.pdf</a>  <u>Guidelines for the Use of Antiretroviral Agents in HIV-1 - infected Adults and Adolescents U .S . Department of Health and Human Services, January 29, 2008</u>

Topic	Name of <del>Guideline</del> <u>guideline</u>	Web Address <u>address</u>
	of	<del>American Diabetes Association</del> <del><a href="http://www.diabetes.org/for-health-professionals-1">http://www.diabetes.org/for-health-professionals-1</a></del>
<del>Diabetes</del> <u>Hyp</u> <del>erbili-</del> <del>rubinemia in</del> <del>the Newborn</del>	<del>Standards</del> <u>Management</u> of <del>Medical Care for Patients with</del> <del>Diabetes Mellitus 2007</del> <u>Hyperbilirubinemia in the Newborn infant</u> <u>35 or more weeks in gestation</u>	<del>American Academy of Pediatrics</del> <del><a href="http://aappolicy.aappublications.org/cgi/reprint/pediatrics;1">aappolicy.aappublications.org/cgi/reprint/pediatrics;1</a></del> <del>information for families can be accessed at</del> <del><a href="http://aap.org/families">aap.org/families</a></del> <del>.htm</del>
Hypertension	The Seventh Report on the Joint National <del>Committee</del> <u>committee</u> on Detection, Evaluation and Treatment of High Blood Pressure	National Heart, Lung and Blood <del>Institute</del> <del><a href="http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm">http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm</a></del>
<del>Hyperbili-</del> <del>rubinemia in the newborn</del>	<del>Management of</del> <del>Hyperbilirubinemia</del> <del>in the Newborn</del>	<del>American Academy of Pediatrics</del> <del><a href="http://aappolicy.aappublications.org/cgi/reprint/pediatrics;1">http://aappolicy.aappublications.org/cgi/reprint/pediatrics;1</a></del> <del>information for families can be</del> <del>accessed at</del>
<del>Major Depression</del>	<del>Treatment</del> <del>of</del> <del>Patients</del> <del>with</del> <del>Major Depressive</del>	<del>American Psychiatric Association</del> <del><a href="http://www.psychiatryonline.com/pracGuide/pracGuide.htm">http://www.psychiatryonline.com/pracGuide/pracGuide.htm</a></del> <del>Note Guideline Watch (9/2005)</del>
<del>Attention Deficit Hyperactivity Disorder</del> <del>(ADHD)</del>	<del>Practice</del> <del>Parameter for the</del>	<del>American Academy of Child and Adolescent Psychiatry</del> <del><a href="http://www.aacap.org/galleries/PracticeParameter">http://www.aacap.org/galleries/PracticeParameter</a></del>
<del>Preventive Services Guidelines</del>	Guide to <del>Clinical</del> <u>clinical</u> Preventive Services - US Preventive Services Task Force (USPSTF)	Agency for <del>Healthcare</del> <u>Health care</u> Research and Quality <del><a href="http://www.ahrq.gov/clinic/uspstfix.htm">http://www.ahrq.gov/clinic/uspstfix.htm</a></del> <del>pocketgd00</del>
<del>Seizure Disorders (Epilepsy) with Antiepileptic Medications</del>	<del>Multiple names now for use in initial diagnosis, recurring seizures, etc.</del>	<del>Multiple guidelines exist at</del> <del><a href="https://aan.com/practice/guidelines">https://aan.com/practice/guidelines</a></del> <del>initial monotherapy guideline at</del> <del><a href="http://ilae-epilepsy.org/VisitingDocuments/Guidelines.pdf">ilae-epilepsy.org/VisitingDocuments/Guidelines.pdf</a></del>
<del>Schizophrenia Guideline</del>	<del>Practice guideline for the treatment of patients with schizophrenia (Second Edition)</del>	<del><a href="http://www.guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=17&amp;nbr=3572">guideline.gov/summary/summary.aspx?ss=15&amp;doc_id=17&amp;nbr=3572</a></del>
Spinal Stenosis	Evidence-Based <del>Clinical</del> <u>clinical</u> Guidelines for Multidisciplinary Spine <del>Care</del> <u>care</u>	North American Spine Society <del><a href="http://www.nass-spine.org/Pages/PracticePolicy/ClinicalCare/ClinicalGuidelines">http://www.nass-spine.org/Pages/PracticePolicy/ClinicalCare/ClinicalGuidelines</a></del>

If you do not have internet access and would like a copy of any of the guidelines, please call our National **Clinical** **clinical** Excellence Manager at (954) 447-8818 or our Medicare National **Clinical Excellence** Manager of **Accreditation and clinical Quality** at (866) 934-~~5747-5717~~.

This information is provided to you for general reference and is not intended to address every aspect of a clinical situation that may exist now, or in the future. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual **members** **patients**. We hope you will consider this information and use it, when it is appropriate for eligible members.

## Important **Behavioral Health Information** **behavioral health information**

(References to United Behavioral Health also include ~~its~~ our affiliates PacifiCare Behavioral Health and PacifiCare Behavioral Health California.)

### Screening for **Depression** **depression**

United Behavioral Health (UBH) is responsible for managing the behavioral health care benefits for most UnitedHealthcare members. UBH is committed to supporting primary care physicians in identifying and treating mental health disorders. The U.S. Preventive Services Task Force (USPSTF) recommends screening patients for depression in primary care. ~~If~~ left untreated, depression can adversely affect patient quality of life and clinical outcomes. ~~Screening for depression is key to treatment as it can contribute to readiness to change an accurate diagnosis. You can help by screening all patients, including adolescents, for depression. To assist, UBH has identified a sensitive and specific screen which is accurate and easy to use. The screen is the Whooley Depression Screen (Whooley et al., 1997). To obtain a copy of the screen, email your request to [BHInfo@uhc.com](mailto:BHInfo@uhc.com).~~

For more information on depression, you and your patients may access the liveandworkwell.com Web site of UBH. To refer a patient to a participating UBH clinician for assessment and/or treatment, call UBH at the toll-free number on the back of the patient's health care **ID** **ID** card.

## Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

UBH has developed an online Preventive Health Program which offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse/dependence and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes: a dedicated section

for physicians and other health care professionals with articles addressing aspects of each condition; information about co-morbid conditions; links to nationally recognized practice guidelines from the American Psychiatric Association; a self-appraisal that you can print, use or refer your patients to; and a listing of support resources for you, your patients and their families . Physicians and other health care professionals may access the program via [www.UnitedHealthcareOnline .com](http://www.UnitedHealthcareOnline.com) **•** [Clinician](#) [clinician](#) Resources **•** Patient Safety **•** [Resources](#) Behavioral Health or at [www.liveandworkwell .com/prevention](http://www.liveandworkwell.com/prevention) .

## **The ~~Importance~~[importance](#) of ~~Collaboration between Primary Physicians and Behavioral Health Clinicians~~[collaboration](#) ~~between primary physicians and behavioral health clinicians~~**

A substantial number of patients who have serious illnesses also have behavioral health conditions. ~~For example,~~ [Approximately](#) 20% of patients who have had a heart attack are likely to develop depression within twelve (~~12~~[12](#)) months of the event. ~~Between 20% and 27;~~ [likewise greater than 20%](#) of patients with diabetes also have depression .

~~It~~[It](#) is important to determine if a behavioral health clinician is treating a patient with these and other illnesses . ~~If~~[If](#) so, it is helpful to coordinate care with the behavioral health clinician. ~~Coordination~~ [coordination](#) of care takes on greater importance for enrollees with severe and persistent mental health and/or substance abuse problems . This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when patients have been hospitalized for a medical or psychiatric condition .

~~Communication~~[communication](#) between clinicians can also maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions for patients being prescribed psychotropic medication . ~~It~~[It](#) can also help reduce the risk of relapse for patients with substance abuse disorders or psychiatric conditions .

Please discuss with your patients the benefits of sharing essential clinical information . We encourage you to obtain a signed release from each UnitedHealthcare patient that allows you to share appropriate treatment information with the patient's behavioral health clinician .

## **UBH**

### **Psychiatric ~~Information Line for Network Primary Care Physicians~~**

~~UBH is focused on improving the continuity and coordination of care between behavioral health and medical care practitioners. UBH recognizes that all behavioral health care services and medical care services must be carefully coordinated along the health care continuum to provide for the optimum outcome to the enrollee. UBH works closely with relevant medical delivery systems and medical practitioners to ensure the appropriate management of these enrollees. The end result of this is the assurance of timely, effective, and integrated health care.~~

~~In order to improve such continuity and coordination, UBH has implemented dedicated, toll-free Psychiatric information lines available to physicians practicing in the states listed below. The queue lines are open from 8:00 a.m. to 5:00 p.m. in local time zones Monday through Friday. This service allows medical providers easy access to UBH staff psychiatrists for purposes of reviewing psychotropic medication and/or treatment as part of their patient's care. This program identifies and monitors activities in five general categories related to the coordination of behavioral health services with general medical care:~~

- ~~1 Exchange of information between behavioral health care practitioners, providers and primary care physicians (PCPs)~~
- ~~2 Identification and treatment of behavioral health disorders commonly seen in primary care~~
- ~~3 Appropriate utilization of psychopharmacological medications~~
- ~~4 Coordination of care for co-existing medical and behavioral health disorders~~
- ~~5 Coordination of preventive health activities with medical delivery systems~~

You can access psychiatric information by dialing the toll-free telephone number listed for your coverage area below:

- ~~(800) 720-4128 for providers in the following states: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina~~
- ~~(877) 772-6414 for providers in the following states: Kansas, Kentucky, Missouri, Nebraska, Ohio, Tennessee, Arkansas~~
- ~~(877) 633-7824 for providers in the following states: Colorado, Connecticut, Iowa, Illinois, New York, New Jersey, Michigan, New Mexico, Nevada, Rhode Island, Utah, Wisconsin, Virginia~~
- ~~(800) 292-2922 for providers in the following states: California, Oregon, Washington~~
- ~~(800) 547-1413 for providers in the following states:~~

~~Texas, Oklahoma~~ **Psychiatric Consults for Medical**

### **Patients** [consults for medical patients](#)

~~If~~ [Please contact UBH if](#) you would like to arrange a psychiatric consultation for a patient in a medical bed, are unclear whether a consultation is warranted, or need assistance with any needed authorization, ~~please contact UBH.~~ [We can be reached](#) by calling the telephone number on the back of the patient's medical ~~insurance~~ [id](#) card .

### **Cooperation with** ~~Quality Improvement Activities~~ [quality improvement activities](#)

All participating physicians and providers must cooperate with all quality improvement activities . These include, but are not limited to, the following:

- Timely provision of medical records upon request by UnitedHealthcare [or its contracted business associates](#); **and**
- [cooperation with quality of care investigations](#);
- Participation in quality audits, including site visits and ~~on-site~~ medical record ~~review~~ [standards review, and annual Health care Effectiveness data and information Set \(HEDIS\) record review](#);

### **Criteria for Determining Coverage**

~~You can obtain copies of the medical policies which UnitedHealthcare uses to determine whether a particular medical procedure or treatment is covered, by contacting your local Care Management Center. In addition, our medical directors are available to discuss these policies and their decisions with you. Contact the Care Management Center at the telephone number listed on the member's UnitedHealthcare health care ID card and ask to speak to one of our medical directors. Medical policies are also available online at [UnitedHealthcareOnline.com](#) • Tools & Resources • Policies and Protocols.~~

- [if medical records are requested by UnitedHealthcare, provision of copies of such records free of charge during site visits or via mail, secure email, or secure fax.](#)

### **Hospital** ~~Audit Services~~ [audit services](#)

The agreement between UnitedHealthcare and the hospital establishes UnitedHealthcare's right to audit submitted claims . ~~In~~ [in](#) order to assure that audits performed by UnitedHealthcare's Hospital Audit Services [unit](#) are conducted in a fair and reasonable manner, UnitedHealthcare utilizes appropriate nationally recognized billing or coding guidelines, such as those ~~promulgated~~ [set forth](#) by ~~CMS~~ [CMS](#) Billing Guidelines, as stated in the Medicare Provider Reimbursement Manual, or the National Uniform Billing ~~Commission~~ [commission](#), as the criteria for audit .

UnitedHealthcare may have other claim audit programs, and claim audits under such programs will be conducted in accordance with the provisions of such programs . Audits may occur on a pre-payment or post-payment basis,

depending on the circumstances and the terms of the agreement .

The following provisions, ~~"Hospital Requirements and Access"~~, ~~"Audit Findings & Exit Conference"~~ and ~~"Post Audit Procedures"~~ are specific to the Standard Hospital Bill ~~Audit~~ [audit](#), in accordance with the National Hospital Billing

**Audit Guidelines** ~~audit Guidelines~~ . UnitedHealthcare may conduct other audits, or make other records requests, in addition to Standard Hospital Bill audits .

The scope of audit for UnitedHealthcare's Standard Hospital Bill ~~Audit~~audit is to review the ~~Medical Record~~medical record to substantiate charges billed . ~~As~~as more fully described below, when, during the course of audit, a UnitedHealthcare Nurse Reviewer identifies a charge billed to UnitedHealthcare that appears to have been unbundled from the more general charge in which it is commonly included or that is not supported by the medical record, the UnitedHealthcare Nurse Reviewer is expected to report his/her findings to the hospital representative and disallow the charges . Written notification of disallowed charges will be provided at the conclusion of the audit . Post-audit claim reconsideration will reconcile any ~~over-overpayments~~ or underpayments identified as a result of the audit process, in accordance with applicable law and the agreement with us .

**Hospital Requirements and Access**

- UnitedHealthcare's Hospital ~~Audit~~audit Services ~~Department~~department will notify the hospital of the intent to audit a claim . This notification will be provided utilizing a ~~Communication~~communication Form, and will be addressed to the hospital ~~CFO~~FO, his/her designee or the hospital auditing representative .
- The hospital will provide one of the following:
  - ~~:-~~A copy of the itemized bill to UnitedHealthcare's Hospital ~~Audit~~audit Services ~~Department~~department within thirty (30) calendar days of the date requested .
  - ~~:-~~A copy of the bill breakdown to UnitedHealthcare's Nurse Reviewer at the time of the audit . (The ~~Hospital~~hospital will notify the UnitedHealthcare Hospital ~~Audit~~audit Services ~~Department~~department within thirty (30) calendar days of notification of intent to audit if bill breakdown will be provided .)
- The hospital will cooperate in a timely manner, so ~~as to enable~~the UnitedHealthcare Nurse Reviewer can complete the audit scheduling process ~~to be completed~~ within thirty (30) calendar days of the scheduling request ~~by the UnitedHealthcare Nurse Reviewer~~.
- ~~If~~if there is a hospital requirement for a member release of medical information, it is the hospital's responsibility to obtain this release, or to waive the requirement if permitted by applicable law . Most standard hospital release forms, signed by the member at the time of admission, authorize release of UnitedHealthcare member information to ~~UnitedHealthcare~~United Healthcare for purposes of claims review. ~~Additionally~~ . additionally, per ~~HIPAA~~HiPaa, protected health information may be disclosed to UnitedHealthcare for "...treatment, payment, or health care operations..." .
- ~~If~~if there is a hospital-imposed fee to audit the medical record, or a copy fee, said fee will be waived unless specified in the hospital's network participation agreement .
- Standard Hospital Bill ~~Audits~~audits will be conducted at the hospital in cooperation with the hospital representative .
- ~~At~~at the time of the audit, the hospital will provide the UnitedHealthcare Nurse Reviewer with access to the medical record, all applicable department charge sheets and, if requested, any applicable hospital policy and procedure .
- The hospital will give UnitedHealthcare's audit vendors the same level of access as UnitedHealthcare employee auditors, when those vendors are acting at the direction and on behalf of ~~UnitedHealthcare~~ . ~~Any~~United Healthcare any vendor authorized by UnitedHealthcare to conduct an audit on UnitedHealthcare's behalf will be bound by UnitedHealthcare's obligations under the agreement, including any confidentiality requirements ~~with regard to~~regarding the hospital audit and ~~HIPAA~~HiPaa requirements with regard to ~~Protected Health Information~~protected health information .
- The hospital will not impose any time limitation on UnitedHealthcare's right or ability to audit, except to the extent

such a limit is imposed by the agreement or by applicable state law .

## **Audit Findings** ~~findings~~ and **Exit Conference** ~~exit conference~~

- ~~After~~ after completing ~~his/hers~~ the review, the UnitedHealthcare Nurse Reviewer will provide the facility representative with a copy of the findings of the review . This document will list all discrepancies noted during the course of the audit, including item, unit cost, number charged, number documented, discrepancy, overcharge, undercharge, unbilled charge or disallowed/unbundled charge . ~~If~~ if the audit occurs at the hospital, a copy of the documented audit findings will be provided to the hospital at the time of the exit conference . ~~If~~ if the audit occurs at a location other than the hospital, a copy of the findings will be supplied promptly .
- ~~At~~ at the completion of each audit, the UnitedHealthcare Nurse Reviewer will participate in an exit conference with the hospital representative . The purpose of the exit conference is to notify the hospital of **UnitedHealthcare** United Healthcare's audit findings, including overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed . UnitedHealthcare's Nurse Reviewer will provide the hospital representative with a copy of the document findings .
- ~~During~~ during this conference, the hospital representative will have the opportunity to present any conflicting audit findings . When additionally required by the agreement ~~stipulation~~ or by applicable state regulation, hospital representative sign-off will be obtained .

## **Post-Audit Procedures** ~~audit procedures~~

- **Refund Remittance** – ~~In~~ in the event there is an undisputed overpayment, the hospital will remit the amount of the overpayment within thirty (30) calendar days of receipt of the ~~Refund Request~~ refund request, or as required by law .
- **Disputed Audit Findings** – ~~In~~ in the event the hospital wishes to dispute any audit findings, the hospital will submit notification of its intent to dispute the audit findings to UnitedHealthcare's Hospital **Audit** audit Services ~~Department~~ department within thirty (30) calendar days of receipt of the audit findings . The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items .
- **Dispute Resolution** – UnitedHealthcare's Hospital **Audit** audit Services ~~Department~~ department will respond to notification of disputed audit findings in writing within sixty (60) calendar days of receipt .
- **Escalated Dispute Resolution** – ~~In~~ in the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare's Hospital **Audit** audit Services ~~Department~~ department as well as Network Management . Escalated dispute resolution will cause suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties .
- **Unresolved Dispute** – ~~The hospital has the right to~~ Either party may further pursue dispute resolution as outlined in the agreement ~~with~~ between us .
- **Offsets** – When a refund request has been issued, UnitedHealthcare will recoup or offset the identified overpayment, underpayment, and/or disallowed charge amounts after the expiration of thirty-five (35) calendar days from the date of the refund request provided by UnitedHealthcare's Hospital **Audit** audit Services ~~Department~~ department, except under the following circumstances: (1) the hospital has remitted the amount due within the thirty-five (35) calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the thirty-five (35) calendar day repayment period .

~~UnitedHealthcare appreciates that the audit of hospital claims can be an administrative burden to both parties. Therefore, UnitedHealthcare has included in this Protocol a provision that allows for~~

~~UnitedHealthcare's hospital bill audit activity to reflect the previous results at the hospital.~~

## Imaging Accreditation

~~Effective fourth quarter 2009~~, if you perform outpatient imaging studies and bill on a ~~CMS/HICF~~~~cMS/HicF~~-1 500 or the electronic equivalent, you must obtain accreditation for the following procedures: ~~CTcT~~, ~~MRI~~~~MRi~~, Nuclear Medicine/~~Cardiology~~~~cardiology~~, PET and Echocardiography . This ~~Ac~~~~creditation~~~~accreditation~~ requirement applies to global and technical service claims . The accreditation process takes approximately six (6) to nine (9) months to ~~obtain full accreditation.~~ ~~Failure~~~~complete~~ . ~~This accreditation Protocol promotes compliance with nationally recognized quality and safety standards .~~

~~Upon notice from UnitedHealthcare, failure~~ to obtain accreditation ~~by fourth quarter 2009~~ will affect your right to be reimbursed for procedures rendered using these modalities. ~~This accreditation Protocol is to ensure that equipment, technologists and physicians are in compliance with nationally recognized quality and safety standards for these procedures . As a result, an administrative claim reimbursement reduction, in part or in whole, will occur .~~

~~In the following scenarios, upon~~ ~~Upon~~ completion and submission of an accreditation application ~~if you are:~~

- ~~1 . an existing participating provider adding any of the above modalities and/or expanding to a new site, or~~
- ~~2 . a newly participating provider with UnitedHealthcare,~~ you will be placed in a pending accreditation status for the modalities in the application . ~~The pending status will continue~~ for twelve (~~12~~~~1~~~~2~~) months from the date of submission, or until you have received a decision on your accreditation application, whichever occurs first . During this pending status, your claims will not be denied under this Protocol solely for the reason of your pending status.

- ~~• You are an existing participating provider and have not obtained accreditation by fourth quarter 2009;~~ ~~or~~
- ~~• You are an existing participating provider adding any of the above modalities and/or expanding to a new site;~~ ~~or~~
- ~~• You are a newly participating provider with UnitedHealthcare .~~

Accreditation is obtained by submitting an application and fulfilling accreditation standards with one of the following accreditation agencies:

- American ~~College~~~~college~~ of Radiology (~~ACR~~~~AcR~~) at ~~acr~~ .org
- ~~Intersocietal Commission~~~~intersocietal commission~~ Accreditation of ~~CTcT~~ Labs (~~ICAGTL~~~~icAcTL~~) at ~~icactl~~ .org
- ~~Intersocietal Commission~~~~intersocietal commission~~ Accreditation ~~Commission (IAC)~~~~commission (iAc)~~ at ~~intersocietal~~ .org
- ~~Intersocietal Commission~~~~intersocietal commission~~ Accreditation of Magnetic Resonance Labs (~~ICAMRL~~~~icAMRL~~) at ~~icamrl~~ .org
- ~~Intersocietal Commission~~~~intersocietal commission~~ Accreditation of Echocardiography Labs (~~ICAEL~~~~icAEL~~) at ~~icael~~ .org
- ~~Intersocietal Commission~~~~intersocietal commission~~ Accreditation of Nuclear Medicine Labs (~~ICANL~~~~icANL~~) at ~~icanl~~ .org

Additional details regarding this accreditation requirement, including a list of the ~~CPT~~~~cPT~~ codes for which accreditation is required, are available on UnitedHealthcareOnline .com ~~• Clinician~~~~clinician~~ Resources ~~• Radiology~~~~imaging~~ ~~imaging~~ Accreditation .

## Provide Access to Your Facility

~~In support of UnitedHealthcare's clinical and quality initiatives, including HEDIS, notification and concurrent review activities, you will provide us access to: (1) your facilities, including the emergency room; (2) our members and their medical records; and (3) your hospital and medical staff for purposes of obtaining necessary clinical information regarding our member's condition or treatment plan. In addition, you will participate in discharge planning activities. This Protocol also applies when providing continued care to our members following termination of your agreement.~~

## Return Calls from the Care Management Team and/or Medical Director

~~You must provide complete clinical information as required within four (4) hours if request is received before 1:00 p.m. local time, or make best efforts to provide within the same business day if request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).~~

# Additional ~~Requirements~~requirements

## Access to ~~Records~~records

UnitedHealthcare may request copies of medical records from you in connection with UnitedHealthcare's utilization management/care management, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of the network participation agreement and appropriate billing practice. ~~If~~ if medical records are requested by UnitedHealthcare, you will provide copies of such records free of charge.

in addition, you must provide access to any medical, financial or administrative records related to the services you provide to UnitedHealthcare members within fourteen (14) calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Such records must be maintained for six (6) years, or longer if required by applicable statutes or regulations. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

## ~~After-Hours Care~~hours care

The emergency department is an appropriate venue for emergencies, but in non-emergent circumstances, use of the emergency department needlessly overwhelms hospital resources and contributes to the delivery of more fragmented and costly care. Overuse of emergency department services may result from a variety of factors, including perceived difficulty in accessing the primary care physician's office, limited availability of urgent appointment times, member preferences and other factors. We ask that you and your practice have a mechanism in place for after-hours access, and influence some of these factors by implementing advanced or open access scheduling, establishing relationships with local urgent care and emergency rooms, and providing ~~your~~ members with information such as:

- ~~Alternative~~alternative resources the member may access if care by you is not available or not appropriate. This may include a listing of local urgent care centers, convenience care centers, or after hour triage services.
- ~~Directions~~directions regarding after hours follow-up with you or another care setting if they experience certain changes in their condition.

## Arrange ~~Substitute Coverage~~substitute coverage

~~If~~ if you are unable to provide care and are arranging for a substitute, we ask that you ~~try to~~ arrange for care from other physicians and health care professionals who participate with UnitedHealthcare. ~~For the most current listing of network physicians and health care professionals, review our physician and health care professional directory at UnitedHealthcareOnline.com. In order for services to so that services may~~ be covered under the member's in-network benefit, ~~a non-network physician or health care professional will need to join our network by applying for participation and, if accepted, signing a participation agreement. We encourage you to go to UnitedHealthcareOnline.com to find the most current directory of our network physicians and health care professionals.~~

## Comply with ~~Protocols~~protocols

Your agreement with us ~~provides~~states that you will cooperate with, and be bound by, UnitedHealthcare's and Payer's Protocols, including those Protocols contained in this Guide. Failure to comply with such Protocols will be reviewed by UnitedHealthcare and may result in appropriate action under your agreement with us, which may include, but is not limited to, change to or reduction in payment, financial offsets, ~~modifications to reimbursement or other~~

~~terms of your agreement with us~~, ineligibility to participate in designation and/ or recognition programs, other measures as identified in connection with a specific Protocol, or termination of your agreement with us . You must not bill our members for any amounts not paid due to your failure to comply with the Protocols . [A](#) complete list of UnitedHealthcare Protocols can be viewed at [UnitedHealthcareOnline .com](#) [Tools & Resources](#) [Policies & Protocols](#) .

## Credentialing and ~~Recredentialing~~recredentialing

We are dedicated to providing our members with access to effective health care and, as such, we periodically review the credentials of participating physicians and other health care professionals in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though, fully compliant with) the National ~~Committee~~committee on Quality ~~Assurance (NCQA)~~assurance (NcQa) requirements.

We are a member of the ~~Council~~council for ~~Affordable~~affordable Quality ~~Healthcare (CAQH)~~Health care (caQH), and we utilize the ~~CAQH~~caQH Universal Provider DataSource (~~UPDU~~PD) for gathering credentialing data for physicians and other health care professionals. The ~~CAQH~~caQH process is available to physicians and other health care professionals at no charge. The ~~CAQH~~caQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, ~~reduces~~reducing the need for costly credentialing software, and ~~minimizes~~minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the ~~CAQH~~caQH process as our single source credentialing application nationally, unless otherwise required in designated states. ~~All~~all physicians and other health care professionals applying to begin participating in our network and those scheduled for recredentialing are instructed on the proper method for accessing the ~~CAQH UPD. For additional information on our credentialing and recredentialing process, please refer to~~ UnitedHealthcareOnline.com~~caQH UPD.~~

## Rights ~~Related~~related to the ~~Credentialing Process~~credentialing process

Physicians and other health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at (877) 842-~~3210~~3210.

While current board certification is not a requirement for network participation, it is a requirement for the ~~UnitedHealthcare~~UnitedHealth Premium<sup>®</sup> designation program. Providing updated board certification is part of the credentialing application.

## Delay in Service

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to provide ~~Covered~~ Services~~covered services to~~ our members in a timely manner. ~~A~~a Delay in Service is defined as a failure to execute a physician order in a timely manner that results in a longer length of stay.

~~A~~a Delay in Service may result for any of the following reasons:

- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- ~~A~~a facility resource needed to execute a physician's order is not available
- Facility does not discharge the member on the day the physician's discharge order is written

## Inform ~~Members~~members of Advance Directives

The federal Patient Self-Determination ~~Act~~act (~~PSDA~~PSDa) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to members on state law about advance treatment directives, about members' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform members of state laws on advance directives through our member handbooks and other communications. We

encourage these discussions with our members .

## Important ~~News~~news and ~~Updates~~updates

Our preferred method to communicate with you is electronically, ~~however we will~~and any news or updates regarding policy, product or reimbursement changes are posted in the news section of UnitedHealthcareOnline.com. We also use multiple channels (mail, ~~Internet~~internet, email, telephone, facsimile) to communicate with you. ~~In~~in the event a ~~protocol~~Protocol changes or is modified, we will notify you prior to implementation in accordance with your agreement with us. To the extent that some ~~protocols~~Protocols are applicable only in certain states at the time of printing, we have indicated that in this Guide. ~~If~~if your agreement with us is effective after the date of printing, please reference UnitedHealthcareOnline.com to view a complete list of states to which such ~~protocols are applicable~~Protocols are applicable. To register on UnitedHealthcareOnline.com, simply select the 'New User' link in the upper right corner of the UnitedHealthcareOnline.com home page, and follow the prompts.

## Continuity of ~~Member Care Following Termination of Your Participation~~member care following termination of your participation

~~If~~if your network participation terminates for any reason, you are required to assist in the transition of your ~~member~~patient's care to another physician or health care professional who participates in the ~~UnitedHealthcare~~United Healthcare network to the extent provided in your agreement. This may include providing service(s) for a reasonable time, at our contracted rate during the continuation period. ~~Member Care~~customer care is available to help you and our members with the transition. ~~At~~at least thirty (30) ~~calendar~~calendar days prior to the effective date of your departure from the ~~Network~~network, UnitedHealthcare will send, via regular mail, notification to affected members. ~~If~~if applicable state law requires earlier notification, the state law will prevail.

## Medical ~~Record Standards~~record standards

Medical records will contain all information necessary and appropriate for quality improvement activities and to support claims for services submitted by you.

~~In~~in providing care for UnitedHealthcare members, we expect that you have signed, written policies to address the following (critical elements appear in bold text in this section):

1. Maintain a single, permanent medical record that is current, detailed, organized and comprehensive for each member ~~that~~and is available at each visit.
2. **Protect member records, whether in paper or electronic form, against loss, destruction, tampering or unauthorized use.** For electronic medical records, you must establish security safeguards in order to prevent unauthorized access or alteration of records without leaving an audit trail to identify the breach. Such safeguards must be programmed so that they cannot be overridden or turned off.
3. **Maintain medical records in a confidential manner and provide periodic training to office staff regarding confidentiality processes. Records storage must allow for easy retrieval, be secure and allow access only by authorized personnel.**
4. Maintain a mechanism for monitoring and handling missed appointments.
5. **demonstrate the office does not discriminate in the delivery of health care.**

## General ~~Documentation Guidelines~~documentation guidelines

We also expect you to follow these commonly accepted guidelines for medical record information and documentation:

- ~~Date~~date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and

their credentials . it should be apparent from the documentation which individual performed a given service .

- clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change . The provider must also maintain a copy of the original entry .
  - Generate documentation at the time of service or shortly thereafter .
  - Make entries legible .
-

Cite medical conditions and significant illnesses on a problem list and document clinical findings and evaluation for each visit.

documentation that is not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the function of a malformed body member (over documentation) should not be considered when selecting the appropriate level of an E&M service. Only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate E&M level.

- Give prominence to notes on medication allergies and adverse reactions . Also, note if the member has no known allergies or adverse reactions .
- Make it easy to identify the medical history, and include chronic illnesses, accidents and operations .
- For medication ~~record~~records, include name of medication and dosages . Also, list over the counter drugs taken by the member .
- Records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the physician/health care professional .

clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.

~~Document~~document these important items:

- Tobacco habits, including advice to quit, alcohol use and substance abuse for members age eleven (11) and older
- **Immunization record**
- Family and social history
- Preventive screenings/services and risk screenings
- Screening for depression and evidence of coordination with behavioral health providers
- Blood pressure, height and weight, body mass index

## Goals

- 90% of medical records will contain documentation of critical elements . ~~Critical~~critical elements appear in bold text in this section .
- 80% of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record audits.
- ~~Documentation~~documentation of allergies and adverse reactions must be documented in 100% of the records .  
**Demographic Information**

## Demographic information

The medical record for each member should include:

- Member name and ~~or~~ date of birth, or member name and health care ~~ID~~id number, on every page
- Gender
- ~~Age~~age or date of birth
- ~~Address~~address
- Marital status
- Occupational history
- Home and/or work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- ~~Insurance~~insurance information

## Member ~~Encounters~~encounters

When you see one of our members, document the visit by noting:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- ~~Diagnosis~~diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric members
- ~~Developmental~~developmental assessment for pediatric members
- Member education, counseling or coordination of care with other providers
- ~~Date~~date of return visit or other follow-up care
- Review by the primary physician (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- ~~inpatient records~~
- ~~Consultation~~consultation and abnormal studies are initialed and include follow-up plans ~~Clinical Decision and Safety Support Tools~~

## Clinical decision and safety support tools

Examples of evidence-based care tools include the following:

- ~~ALT/AST laboratory test done if Member taking Statins~~
- ~~Immunization~~immunization tracking sheet
- Flow sheet for chronic diseases (e.g., diabetes, asthma)
- Member reminder system
- Electronic medical records
- Eprescribing
- Epocrates<sup>®</sup>

## Additional Medicare Advantage Requirements~~requirements~~

If you participate in the network for UnitedHealthcare's Medicare Advantage products, you are required to ~~follow a number of Medicare laws, regulations and Centers for Medicare & Medicaid Services (CMS) instructions. Some of these requirements are stated in your agreement with us; other significant requirements are listed here. This Guide does not apply to SecureHorizons MedicareDirect, a Private Fee-For-Service Medicare Advantage product. For information on SecureHorizons MedicareDirect, visit [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) comply with the following additional requirements.~~

- You may not discriminate against members in any way based on health status .
- You must allow members to directly access screening mammography and influenza vaccination services .
- You may not impose cost-sharing on members for influenza vaccine or pneumococcal vaccine .
- You must provide ~~women~~female members with direct access to a women's health specialist for routine and preventive health care services .
- You must ensure that members have adequate access to covered health services .
- ~~Each of us must provide the other at least sixty (60) calendar days written notice if electing to terminate our agreement without cause, or as described in our agreement if greater than sixty (60) calendar days.~~
- ~~You must ensure that your hours of operation are convenient to members and do not discriminate against members and that medically necessary services are available to members twenty-four (24) hours a day, seven (7) days a week . Primary Carecare Physicians must have backup for absences .~~
- You may not distribute marketing materials or forms to members without ~~CMS~~CMS approval of the materials or forms .

- You must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- ~~You must make a best effort attempt to ensure that each new member has an initial health assessment within ninety (90) calendar days of enrollment .~~
- You must cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care .
- You must document in a prominent part of the member's medical record whether the member has executed an advance directive .
- You must provide covered health services in a manner consistent with professionally recognized standards of health care .

•

- You must ensure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with **CMS standards**.
- ~~You understand that you are subject to laws applicable to persons or entities receiving federal funds and you must notify all subcontractors that they are also subject to these laws, applicable CMS standards.~~
- You must cooperate with our processes to disclose to **CMS** all information necessary for **CMS** to administer and evaluate the Medicare **Advantage** Program, and all information **determined by CMS to be** necessary ~~for CMS~~ to **assist** members **in making** an informed choice about Medicare coverage .
- You must cooperate with our processes for notifying members of provider agreement terminations .
- You must comply with our medical policies, quality improvement programs and medical management procedures .
- You **will** cooperate with us in fulfilling our responsibility to disclose to **CMS** quality, performance and other indicators, as specified by **CMS**.
- ~~You will comply with all applicable laws and regulations.~~
- ~~You must not employ or contract with an individual or entity who is excluded from participation with Medicare or other federal health care programs for the provision of health care or administrative services.~~
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals .
- You must provide full disclosure to members before providing a health service, if you feel that such service will not be covered by the member's benefit plan, ~~if the~~ **The** member may assume additional responsibility in accordance with the member's benefit plan and the contract language . **A** document similar to the Medicare **Advanced** Beneficiary Notice (**ABN**) must be signed by the **beneficiary** before liability ~~of~~ payment can be passed to the member . **If** the service is performed and there is not signed advance notice on record, the claim will be denied with provider liability .

## Fraud, waste and abuse prevention & training

if you identify potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately . Please see the *How to Contact Us* section of this guide for contact information . Please note UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

- ~~You must follow CMS marketing guidelines found in the CMS Managed Care Manual if you are marketing a Medicare Advantage plan to your Medicare eligible members.~~ Fraud is a false statement, made or submitted by an individual or entity, who knows that the statement is false, and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity . These false statements could be verbal or written .
- ~~You must follow National Coverage Determination (NCD) rules when providing care to Medicare Advantage members.~~ Waste Generally means over-use of services, or other practices that result in unnecessary costs . in most cases, waste is not considered caused by reckless actions but rather the misuse of resources .
- ~~You must follow the Standard Notification Requirements, with the exception of those areas identified where notification varies from commercial standard.~~ Abuse Generally refers to provider, contractor or member practices that are inconsistent with sound business, financial or medical practices; and that cause unnecessary costs to the health care system .

Effective January 1, 2009, the centers for Medicare & Medicaid Services ("CMS") modified certain rules and regulations of the Medicare advantage and the Part d programs . The rules state that a compliance plan must include training, education, and effective lines of communication between the compliance officer and the organization's

employees, managers, directors, as well as first tier, downstream and related entities . This change clarified that plan sponsors, such as UnitedHealthcare, need to apply these training and communication requirements to all entities they are partnering with to provide services in Medicare advantage or Part d programs .

as a contracted provider for United Healthcare's Medicare advantage programs, you are considered a first tier or downstream entity and are subject to this CMS requirement . it is our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors . To facilitate that, we will be providing your organization with training materials, which will be made available on UnitedHealthcareOnline .com .

annually, your organization must administer the training materials to your employees and applicable subcontractors . This annual training can be done using our materials or you may use your existing training program and/or materials provided by another health plan as long as that training meets the CMS requirements . Please maintain records of the training (i .e . sign-in sheets, materials, etc) . documentation of the training may be requested by UnitedHealthcare, CMS, or an agent of CMS to verify the training was completed .

## Protocol for Notice of Medicare Non-Coverage (NOMNC)

~~Beginning January 1, 2004, you~~ You must deliver required notice to members at least two (2) calendar days prior to termination of ~~services in~~ skilled nursing care, home health care or comprehensive rehabilitation ~~facilities.~~ ~~If facility services . if~~ the member's services are expected to be fewer than two (2) calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a ~~noninstitutional~~ non-institutional setting . ~~If in a noninstitutional~~ non-institutional setting, if the span of time between service exceeds two (2) calendar days, the notice should be given no later than the next to last time services are furnished. ~~Delivery of notice is valid only upon signature and date of member or member's authorized representative .~~

Delivery of notice is valid only upon signature and date of member or member's authorized representative . The notice must be written in ~~CMS~~ CMS required language and is entitled, "Notice of Medicare Non-~~Coverage~~ coverage" (~~NOMNC~~) NOMNC). The text may be found ~~at on~~ the ~~CMS web~~ CMS Web site or you may contact your regional Quality Improvement improvement Organization (QIO) ~~by referring to~~ http://www.medqic.org/content/qio/qio.jsp?pageID+4 QIO for information . ~~Any appeals of such service terminations are called "fast track" appeals and are reviewed by the CMS-approved independent quality review and improvement organization (QIO); and~~

~~Any appeals of such service terminations are called "fast track" appeals and are reviewed by the QIO .~~ You must provide requested records and documentation to ~~our Notification Unit~~ our Notification Unit or ~~QIO~~ the QIO, as requested, no later than by close of business of the day that you are notified by the plan or ~~QIO~~ the QIO if the member has requested a fast track appeal .

## **Medicare Hospital Discharge Appeal Rights Protocol**

### Medicare hospital discharge appeal rights protocol

Medicare Advantage members have the statutory right to appeal their hospital discharge to a Quality Improvement improvement Organization (QIO QIO) for immediate review .

The QIO QIO notifies the facility and UnitedHealthcare of an appeal .

- When UnitedHealthcare completes the Detailed Notice of Discharge (DNOD), UnitedHealthcare will deliver it to the facility . The facility will deliver the DNOD to the Medicare Advantage member, or his or her representative, as soon as possible but ~~not no~~ later than 1212:00 p .m. local time of the day after the QIO QIO notification of the appeal . The facility will fax a copy of the DNOD to the QIO QIO .
- When the facility completes the DNOD, the facility will deliver the DNOD to the Medicare Advantage member, or his or her representative, as soon as possible but ~~not no~~ later than 1212:00 p .m. local time of the day after the QIO QIO notification of the appeal . The facility will fax a copy of the DNOD to the QIO QIO and UnitedHealthcare .

## Medicare Advantage protocol for Evercare Institutional Plan

Applicability – This Protocol is only applicable to Primary care Physicians, Nurse Practitioners and Physicians Assistants who participate in the network for Evercare institutional customers .

Definitions – capitalized terms used herein but not otherwise defined will have the meanings ascribed to them in the applicable participation agreement .

Evercare Institutional Customer: A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and who is enrolled in a Medicare Advantage institutional special needs benefit contract that: (a) exclusively enrolls special needs individuals who are institutionalized (as such term is defined in 42 CFR 422 .2); (b) is issued by UnitedHealthcare insurance company or by one of UnitedHealthcare's Affiliates; and (c) is administered by

UnitedHealthcare's business unit Evercare, as indicated by a reference to Evercare or Erickson Advantage on the face of the valid identification card of any Evercare institutional customer eligible for and enrolled in such Benefit Plan.

Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the commission on Accreditation of Allied Health Education Programs.

Primary Care Physician: defined as (a) a doctor of Medicine or a doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable Benefit Plan to admit or refer patients to Skilled Nursing Facility for covered services; (b) who has been selected by or assigned to an Evercare institutional customer to provide and/or coordinate the Evercare institutional customer's covered services; (c) whose practice predominantly includes internal medicine, family or general practice; and (d) who participates in UnitedHealthcare's network.

Primary Care Team: a team comprised of a care manager, a Primary care Physician, and a Nurse Practitioner or Physician assistant.

Skilled Nursing Facility: a Medicare-certified nursing facility that (a) provides Skilled Nursing Services and (b) is licensed and operated as required by applicable law.

## Primary Care Physician Protocols

if these Primary care Physician Protocols differ from or conflict with other Protocols in connection with any matter pertaining to Evercare institutional customers, these Primary care Physician Protocols will govern unless statutes and regulations dictate otherwise.

The Primary care Physician will cooperate with and be bound by these additional protocols:

1. attend Primary care Physician orientation session and annual Primary care Physician meetings thereafter.

2. conduct face-to-face initial and ongoing assessments of the medical needs of Evercare institutional customers, including all assessments mandated by regulatory requirements.

3. deliver health care to Evercare institutional customers at their place of residence in collaboration with the Primary care Team.

4. Family care conferences - Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare institutional customer to discuss the Evercare institutional customer's condition, care needs, overall plan of care and goals of care, including advance care planning.

5. Primary care Team collaboration and coordination - collaborate with other members of the Primary care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services to Evercare institutional customers. This includes, but is not limited to, making joint visits with other Primary care Team members to Evercare institutional customers and participating in formal and informal conferences with Primary care Team members and/or other treating professionals following a scheduled Evercare institutional customer reassessment, significant change in plan of care and/or condition.

6. collaborate with Evercare when a change in the Primary care Team is necessary.

7. Provide Evercare a minimum of forty-five (45) calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare institutional customers reside.

8. When admitting an Evercare institutional customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.

## Nurse Practitioner and Physician Assistant Protocols

if these Nurse Practitioner and Physician Assistant Protocols differ from or conflict with other Protocols in connection with any matter pertaining to Evercare institutional customers, these Nurse Practitioner and Physician Assistant Protocols will govern unless statutes and regulations dictate otherwise.

The Nurse Practitioner and Physician Assistant will cooperate with and be bound by these additional protocols:

1. Attend training and orientation meetings as scheduled by Evercare.
2. Deliver health care to Evercare institutional customers at their place of residence in collaboration with a Primary care Physician, including making joint visits to Evercare institutional customers in the facility on a regular basis.
3. Family care conferences - communicate with the Evercare institutional customer's responsible parties, family and/or legal guardian on a regular basis. Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the Evercare institutional customer to discuss the Evercare institutional customer's condition, care needs, overall plan of care and goals of care, including advance care planning.
4. Primary care Team collaboration and coordination - collaborate with other members of the Primary care Team designated by Evercare and any other treating professionals to provide and arrange for the provision of covered services for Evercare institutional customers. This includes, but is not limited to, making joint visits with other Primary care Team members to Evercare institutional customers and participating in formal and informal conferences with Primary care Team members and/or other treating professionals following a scheduled Evercare institutional customer reassessment, significant change in plan of care and/or condition.
5. collaborate and communicate with Evercare's designated Director of Health Services to coordinate all inpatient, outpatient and facility care delivered to Evercare institutional customers. Forward copies of required documentation to Evercare's office. Work with the Director to develop a network of providers cognizant of the special needs of the frail elderly.
6. initial Assessment - conduct a comprehensive initial assessment for all Evercare institutional customers within thirty (30) calendar days of enrollment that includes:
  - a) History and physical examination, including mini-mental status (MMS) and functional assessment.
  - b) Review previous medical records.
  - c) Prepare problem list.
  - d) Review medications and treatments.
  - e) Review lab and x-ray procedures.
  - f) Review current therapies (PT, OT, ST).
  - g) Update treatment plan.
  - h) Review advance directive documentation including DNR/DNI and use of other life-sustaining techniques.
  - i) contact the family/responsible party within thirty (30) calendar days of enrollment to:
    - schedule a meeting at the facility, if possible;
    - obtain further history;
    - agree on type and frequency of future contacts; and
    - discuss advance directives.
  - j) Perform clinical and quality initiative documentation as directed.

7. Provide care management services to coordinate the full range of covered services outlined in the

Evercare institutional customer's benefit contract including, but not limited to:

- a) all medically necessary and appropriate facility services.
- b) Outpatient procedures and consultations.
- c) inpatient care management.
- d) Podiatry, audiology, vision care and mental health care provided in the facility.

8. When admitting an Evercare institutional customer to a hospital, notify Evercare or Payer immediately if the admission is for an emergency or for observation.

9. Provide Evercare a minimum of forty-five (45) calendar days prior notice when discontinuing delivery of covered services at any facility where Evercare institutional customers reside.

## Non-Discrimination

You will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a member of UnitedHealthcare or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence

### ~~Provide Access to Your Records~~

~~You must provide access to any medical, financial or administrative records related to the services you provide to UnitedHealthcare members within fourteen (14) calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Such records must be maintained for six (6) years, or longer if required by applicable statutes or regulations. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.~~

### ~~Provide Official Notice~~

~~of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any members in need of the services you provide.~~

## Physical Medicine and Rehabilitation Services

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy provider.

## Provide official notice

~~You must notify us at~~Notification should be sent to the address noted in your participation agreement ~~with us of the following events, in writing~~ and delivered via the method required ~~by your agreement~~, within ten (10) calendar days of your knowledge of ~~their~~the occurrence of any of the following:

- 1 Material changes to, cancellation or termination of, liability insurance;
- 2 Bankruptcy or insolvency;
- 3 ~~Any, any~~ indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- 4 ~~Any, any~~ suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
- 5 ~~Loss, loss~~ or suspension of your license to practice; or
- 6 Transfer of member records to another physician/facility due to relocation or closing of your practice.

## **Provide ~~Timely Notice of Demographic Changes~~ timely notice of demographic changes**

### **~~Physician/Health Care Professional Verification Outreach~~**

#### **Physician/health care professional verification outreach**

UnitedHealthcare is committed to providing our members with the most accurate and up to date information about our network . We are currently undertaking an initiative to improve our data quality . This initiative is called Professional Verification Outreach (PVO) . Your office may receive a call from a member of our staff asking to verify your data that is currently on file in our provider database . Please be assured that this information is confidential and will be immediately updated in our database . ~~By requesting this information annually, UnitedHealthcare will be able to display the most accurate provider demographic information in its directories, which are utilized by many of our members.~~

## **Proactive ~~Notification~~notification of ~~Changes~~changes**

You must notify us of changes to the demographic information that ~~differs from the information you~~ reported with the executed agreement, ~~including, but~~ within ten (10) calendar days prior to the effective date of the change, changes which must be reported include, but are not limited to, ~~TIN~~TiN changes, address changes, additions or departures of health care providers from your practice and new service locations ~~within ten (10) calendar days of the change. These updates can be submitted.~~

### **To change an existing TIN or to add a physician or health care provider**

You must include the physician's or health care provider's W-9 form to make a TiN change or to add a physician or health care provider to your practice. To submit the change, please complete and fax the Physician/provider demographic update fax form and the W-9 form to the appropriate fax number listed on the bottom of the fax form

The W-9 form and the Physician/provider demographic update fax form are available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) contact Us Service & Support Forms.

### **To update your practice or facility information**

You can make all other updates to your practice information by submitting the change directly through [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) ~~viaby using~~ the Practice/Facility **Profile**profile function found on the global navigation at the top of any [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) page, ~~or by~~ You can also submit your change by: (a) completing the Physician/provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our United Voice Portal at (877) 842-3210-3210.

## **Use of Non-Participating Laboratory Services**

### **Use of non-participating laboratory services**

- This Protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals .
- This Protocol does not apply where the physician bears financial risk for laboratory services .
- This Protocol does not apply to laboratory services provided by physicians in their offices . **Requirement to Use Participating Laboratories**

### **Requirement to use participating laboratories**

[UnitedHealthcare](http://UnitedHealthcare.com) maintains a robust network of more than 1,500 national, regional and local providers of laboratory services . These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the **UnitedHealthcare**United Healthcare network . Participating laboratories also provide clinical data and related information to support **UnitedHealthcare's**the UnitedHealth Premium® Designationdesignation program and other clinical quality improvement activities. it is important to note that in many benefit plans, members receiving services in non- network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

**You are required to refer laboratory services to a participating provider in our network, except as otherwise authorized by UnitedHealthcare or a Payer .** Participating laboratory providers can be found in the [UnitedHealthcare](http://UnitedHealthcare.com) directory online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) . **If** you need assistance in locating or using a participating laboratory provider, please contact UnitedHealthcare Network Management . We are **eager**here to support your efforts to direct laboratory services to participating laboratories .

We are aware of the vital importance of laboratory services to our members, and we are committed to maintaining a laboratory network that is both reliable and affordable . Given the size of this network, we are confident that you will have no difficulty locating and using a participating laboratory .

**In** the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact ~~UnitedHealthcare Optum Care~~[United Healthcare Network](#) Management to confirm that the specific laboratory test is covered . ~~Optum~~[We](#) will work with you to assure that those covered proven tests are performed, even if that means the use of a non-participating laboratory .

## **Administrative ~~Actions for Non-Network Laboratory Services Referrals~~ actions for non-network laboratory services referrals**

UnitedHealthcare network physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that virtually all participating physicians will be able to easily find a participating laboratory that will meet their needs.

**If** UnitedHealthcare determines an ongoing and material practice of referrals to non-network laboratory service providers, UnitedHealthcare will inform the responsible physicians of the issue and remind them of their contractual requirements. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to **nonparticipating non-participating** laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with Protocols:

- a change in eligibility for the Practice Rewards programs;
- a decreased fee schedule; or
- termination of network participation, as provided in your agreement with us.

Please refer to UnitedHealthcareOnline.com **Tools & Resources** Policies & Protocols Protocols for state-specific variations of this Protocol.

## **Use of ~~Specialty Pharmacies for Certain Drugs (applies only to specialty pharmacies for certain drugs (for commercial Members members)~~**

### **Synagis<sup>®</sup> (palivizumab)-**

#### **Acquisition for ~~Administration in the Health Care Setting by Physicians and other Health Care Professionals~~ administration in the health care setting by physicians and other health care professionals**

- This Protocol applies to the acquisition, including prescription ordering, clinical coverage review, and purchase of Synagis by physicians and other health care professionals.
- This Protocol applies to **Commercial commercial** members only. **~~Requirement to Use a Participating Specialty Pharmacy Provider for Synagis Procurement~~**

#### **Requirement to use a participating specialty pharmacy provider for Synagis procurement**

UnitedHealthcare has contracted for the national distribution of Synagis. Our participating specialty pharmacy provider(s) provide(s) Synagis fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy provider(s) also provide(s) reviews consistent with UnitedHealthcare's **Drug drug** Policy for Synagis and work(s) directly with the **Clinical Coverage clinical coverage** Review unit in UnitedHealthcare's **Care care** Management **Center center** which determines whether Synagis treatment is covered. The UnitedHealthcare **Drug drug** Policy for Synagis is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics **Committee committee**, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities.

**You must acquire Synagis from a participating network specialty pharmacy provider ~~in our specialty pharmacy network~~, except as otherwise authorized by UnitedHealthcare.**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services. Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for our members meeting the criteria for coverage. [Requests for prescriptions of Synagis should be submitted to our participating specialty pharmacy using the Synagis enrollment request form that is available at UnitedHealthcareOnline.com Tools & Resources Policies & Protocols Protocols. The specialty pharmacy will dispense Synagis in compliance with the UnitedHealthcare Synagis drug Policy and the member's](#)

benefit plan . The specialty pharmacy will bill UnitedHealthcare for the medication . Physicians will only need to bill UnitedHealthcare the appropriate code for administration of the medication and should not bill UnitedHealthcare for the Synagis medication itself . The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Synagis to the physician office .

[For a listing of the participating specialty pharmacy provider\(s\) by drug, please refer to UnitedHealthcareOnline.com Tools & Resources Policies & Protocols Protocols UnitedHealthcare Participating Specialty Pharmacy Provider list for the 2010 UnitedHealthcare administrative Guide Protocols.](#)

### **Administrative ~~Actions for Non-Network Acquisition~~ [actions for non-network acquisition](#) of Synagis**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies. For the member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Synagis from a participating specialty pharmacy. ~~\*For a listing of the participating specialty pharmacy provider(s) by drug please refer to UnitedHealthcareOnline.com • Tools & Resources • Policies & Protocols • Protocols .~~

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of Synagis, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part .

~~It~~ [it](#) is the intent of ~~UnitedHealthcare~~ [United Healthcare](#) to work with participating physicians and other health care professionals to promote the specialty pharmacy network ~~viability~~ and to maximize the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network .

### **Xolair<sup>®</sup> (omalizumab)–**

#### **Acquisition for ~~Administration in the Health Care Setting by Physicians and other Health Care Professionals~~ [administration in the health care setting by physicians and other health care professionals](#)**

- This Protocol applies to the acquisition including prescription ordering, clinical coverage review, and purchase of Xolair by physicians and other health care providers .
- This Protocol applies to ~~Commercial~~ [commercial](#) members only . ~~Requirement to Use a Participating Specialty Pharmacy Provider for Xolair Procurement~~

#### **[Requirement to use a participating specialty pharmacy provider for Xolair procurement](#)**

UnitedHealthcare has contracted for the national distribution of Xolair . Our participating specialty pharmacy provider(s) provide(s) Xolair fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network . Our participating specialty pharmacy provider(s) also provide(s) reviews consistent with UnitedHealthcare's ~~Drug~~ [drug](#) Policy for Xolair and work(s) directly with the ~~Clinical Coverage~~ [clinical coverage](#) Review unit in UnitedHealthcare's ~~Care~~ [care](#) Management ~~Center which determines~~ [center to determine](#) whether Xolair treatment is covered . The UnitedHealthcare ~~Drug~~ [drug](#) Policy for Xolair is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics ~~Committee~~ [committee](#), consistent with published clinical evidence and professional specialty society guidance . Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities .

#### **You must acquire Xolair from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare .**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services . Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for ~~our~~ [United](#) members ~~meeting~~ [that meet](#) the criteria for coverage. [Requests for](#)

prescriptions of Xolair should be submitted to our participating specialty pharmacy using the Xolair enrollment request form that is available at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) Tools & Resources Policies & Protocols Protocols . The specialty pharmacy will dispense Xolair in compliance with the UnitedHealthcare Xolair drug Policy, and the member's benefit and eligibility and bill UnitedHealthcare for the medication . Physicians will only need to bill UnitedHealthcare for the administration code for Xolair when the injection is given and will not bill UnitedHealthcare for the Xolair medication .

The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Xolair to the physician office.

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com Tools & Resources Policies & Protocols Protocols UnitedHealthcare Participating Specialty Pharmacy Provider list for the 2010 UnitedHealthcare administrative Guide Protocols](#).

#### **Administrative ~~Actions for Non-Network Acquisition~~ actions for non-network acquisition of Xolair**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies. For member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Xolair from a participating specialty pharmacy. ~~\*For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com • Tools & Resources • Policies & Protocols • Protocols](#).~~

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of Xolair, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part.

#### **Administration in a ~~Health Care Setting~~ health care setting**

Effective July 2007, the prescribing information for Xolair was updated to include a black box warning on the risk of anaphylaxis that has been reported to occur after as early as the first dose of Xolair but also has occurred beyond one (1) year of regularly administered Xolair treatment. The labeling advises that patients should be closely observed for an appropriate period of time after Xolair administration and Xolair should only be administered in a health care setting by physicians or other health care professionals. Physicians and other health care professionals administering Xolair should be prepared to manage anaphylaxis and members should be informed of the signs and symptoms of anaphylaxis and instructed to seek immediate medical care should symptoms occur.

UnitedHealthcare's ~~Drugdrug~~ Policy on Xolair includes this updated warning and administration information. The participating specialty pharmacy provider(s) will assist in dissemination of this information as part of the clinical review of Xolair utilization.

~~It~~ is the intent of ~~UnitedHealthcare~~ United Healthcare to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

#### **Botox<sup>®</sup> (~~Botulinum Toxin Type A~~) botulinum toxin type A, Dysport<sup>®</sup> (botulinum toxin type A), and Myobloc<sup>®</sup> (~~Botulinum Toxin Type B~~) - botulinum toxin type B**

#### **Acquisition for ~~Administration in the Health Care Setting by Physicians and other Health Care Professionals~~ administration in the health care setting by physicians and other health care professionals**

- This protocol applies to the acquisition (including prescription ordering, clinical coverage review, and purchase), of Botox, dysport, and Myobloc by participating physicians and other health care professionals.
- This protocol applies to ~~Commercial~~ commercial members only.

**Requirement to ~~Use a Participating Specialty Pharmacy Provider~~ use a participating specialty pharmacy provider for Botox, Dysport, and Myobloc ~~Procurement~~ procurement**

UnitedHealthcare has contracted for the national distribution of Botox, [dysport](#), and Myobloc . Our participating specialty pharmacy provider(s) provide(s) Botox, [dysport](#), and Myobloc fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network . Our participating specialty pharmacy provider(s) also provides reviews consistent with UnitedHealthcare's [Drugdrug](#) Policy for Botox, [dysport](#), and Myobloc and work(s) directly with the [Clinical Coverageclinical coverage](#) Review unit in UnitedHealthcare's [Carecare](#) Management [Centercenter](#) to determine whether Botox, [dysport](#), and Myobloc

treatment is covered . The UnitedHealthcare [Drugdrug](#) Policy for Botox, [dysport](#), and Myobloc is reviewed and updated or revised periodically by the UnitedHealthcare National Pharmacy & Therapeutics [Committeecommittee](#), consistent with published clinical evidence and professional specialty society guidance . Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support UnitedHealthcare's clinical and quality improvement activities .

**You must acquire Botox, [Dysport](#), and Myobloc from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare .**

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable and also offers low contracted rates and superior clinical and member services . Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring this drug for our member enrollee(s) meeting the criteria for coverage.

[Requests for prescriptions of Botox, dysport, and Myobloc should be submitted to our participating specialty pharmacy using the applicable enrollment request forms that are available at UnitedHealthcareOnline .com Tools & Resources Policies & Protocols Protocols . The specialty pharmacy will dispense Botox, dysport, and Myobloc in compliance with the UnitedHealthcare Botox, dysport, and Myobloc drug Policy and the member's benefit and eligibility and bill UnitedHealthcare for the medication . Physicians will only need to bill UnitedHealthcare for the administration code for Botox, dysport, and Myobloc when the injection is administered, and should not bill UnitedHealthcare for the Botox, dysport, or Myobloc medication itself . The specialty pharmacy will advise the member of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing Botox, dysport, or Myobloc to the physician office .](#)

[For a listing of the participating specialty pharmacy provider\(s\) by drug, please refer to UnitedHealthcareOnline .com Tools & Resources Policies & Protocols Protocols . UnitedHealthcare Participating Specialty Pharmacy Provider list for the 201 0 UnitedHealthcare administrative Guide .](#)

### **Administrative Actions for Non-Network Acquisition of Botox, [Dysport](#), and Myobloc**

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and compliance with medication policies . For member(s) meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Botox, [dysport](#), and Myobloc from a participating specialty pharmacy provider .

**\* For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](#) • [Tools & Resources](#) • [Policies & Protocols](#) • [Protocols](#).**

**Effective May 1, 2009**, continued use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers ~~of Botox or Myobloc~~, without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

- Payment of claim may be adjusted in whole or in part .

**It** is our intent to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize the clinical and quality improvement activities . Please contact UnitedHealth

Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network .

## **Use of Designated Specialty Pharmacy or Home Infusion Providers for Specialty Medications**

### **Use of designated specialty pharmacy or home infusion providers for specialty medications**

- This ~~protocol~~[Protocol](#) applies to the provision and billing of specific specialty pharmacy medications covered under the medical benefit .
- This ~~protocol~~[Protocol](#) prohibits specialty pharmacy or home infusion providers from providing non-contracted services, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, for a therapeutic category and billing UnitedHealthcare as a non-participating or non-contracted specialty pharmacy or home infusion provider .
- This ~~protocol~~[Protocol](#) does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional, who then procures and bills directly to UnitedHealthcare for the specific specialty medications .
- This ~~protocol~~[Protocol](#) applies to ~~Commercial~~[commercial](#) members only . **Requirement of**

### **Specialty Pharmacy and Home Infusion Provider(s) to be a Network**

#### **Provider specialty pharmacy and home infusion provider(s) to be a network provider**

UnitedHealthcare has contracted with a network of specialty pharmacy and home infusion providers by therapeutic category to distribute specialty medications covered under the medical benefit . The contracted specialty pharmacy and home infusion providers have been selected by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and member services . This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our members and the UnitedHealthcare network . Full program participation requirements are identified in the contracted specialty pharmacy or home infusion provider's participation agreement . Specialty pharmacy and home infusion providers are prohibited, even if they are contracted for other medical benefit medications and services, from providing non-contracted services in a therapeutic category, and billing UnitedHealthcare as a non-participating or non-contracted provider .

We are aware of the importance of drug procurement for our members, and we are committed to maintaining specialty pharmacy and home infusion distribution channels that are reliable and also offer low, contracted rates and superior clinical and member services .

### **Coverage of ~~Self-Infused/Injectable Medications~~[self-infused/injectable medications](#) under the**

#### **Pharmacy Benefit[pharmacy benefit](#)**

- This ~~protocol~~[Protocol](#) applies to the provision and billing of self-infused/injectable medications, such as Hemophilia Factor products, under the pharmacy benefit .

Under most UnitedHealthcare products, self-infused/injectable medications are generally excluded from coverage under the medical benefit, and coverage for a self-infused/injectable medication is provided through the pharmacy rider . This exclusion from the medical benefit does not apply to self-infused/injectable medications necessary to treat diabetes or to medications, which due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified physician or licensed/certified health care professional in an outpatient setting .

~~Effective May 1, 2009, any participating physician or other participating~~[Participating physicians](#), health care ~~professional~~[professionals](#), home infusion ~~provider~~[providers](#), hemophilia treatment ~~center~~[centers](#) or ~~pharmacy~~[pharmacies](#) fulfilling, distributing, and billing for the provision of self-infused/injectable medications to members ~~and~~ subject to the exclusion described above ~~will-beare~~ required to submit claims for reimbursement under

the member's pharmacy benefit .

## Use of specialty pharmacies for certain drugs (for commercial members)

### Sodium Hyaluronate Preparations (Hyalgan<sup>®</sup> and Supartz<sup>®</sup>) (Effective on and after April 1, 2010)

#### Acquisition for Administration in the Health Care Setting by Physicians and other Health Care Professionals .

- This Protocol applies to the acquisition, including prescription ordering and purchase of sodium hyaluronate and hyaluronan cross-linked preparations (Hyalgan and Supartz) by physicians and other health care professionals . For consistency in this document, these preparations will be referred to as sodium hyaluronate preparations .
- Euflexxa<sup>®</sup>, Orthovisc<sup>®</sup>, Synvisc<sup>®</sup> and Synvisc-One<sup>®</sup> may continue to be purchased and directly billed to [UnitedHealthcare](#) . Health care providers may continue to “buy and bill” Euflexxa, Orthovisc, Synvisc and Synvisc-One .
- This Protocol applies to commercial members only .

#### Requirement to Use a Participating Specialty Pharmacy Provider for the Procurement of Sodium Hyaluronate Preparations (Hyalgan and Supartz)

UnitedHealthcare has contracted for the national distribution of sodium hyaluronate preparations (Hyalgan and Supartz) . Our participating specialty pharmacy provider(s) provide(s) sodium hyaluronate preparations (Hyalgan and Supartz) fulfillment and distribution services on a timely basis to meet the needs of our members and the physicians and other health care professionals participating in the UnitedHealthcare network . Our participating specialty pharmacy provider(s) report(s) clinical data and related information and is/are audited on an ongoing basis to support United Healthcare’s clinical and quality improvement activities .

You must acquire the sodium hyaluronate preparations (Hyalgan and Supartz) from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare .

We are aware of the importance of drug procurement for our members, and we are committed to maintaining a specialty pharmacy distribution channel that is reliable, cost effective, and also superior clinical and member services . Given the capabilities of our participating specialty pharmacy provider(s), you should have no difficulty procuring these drugs for our members meeting the criteria for coverage .

Requests for impacted sodium hyaluronate preparations (Hyalgan and Supartz) are submitted to the specialty pharmacy using the applicable request form available at [UnitedHealthcareOnline.com](#) . Tools & Resources . Policies & Protocols . Protocols . The specialty pharmacy will dispense the requested medication in compliance with the [UnitedHealthcare Medical Policy Sodium Hyaluronate for the Treatment of arthritis](#), and the member’s benefit and eligibility and bill UnitedHealthcare for the medication . Physicians will only need to bill UnitedHealthcare for the administration of the sodium hyaluronate preparation The specialty pharmacy will advise the member of any cost share responsibility for the medication and advise of any amount due prior to dispensing product to the physician office .

For a listing of the participating specialty pharmacy provider(s) by drug, please refer to [UnitedHealthcareOnline.com](#) . Tools & Resources . Policies & Protocols . Protocols [UnitedHealthcare Participating Specialty Pharmacy Provider list for the 2010 UnitedHealthcare administrative Guide](#) .

#### Administrative actions for non-network acquisition of the sodium hyaluronate preparations (Hyalgan and Supartz)

UnitedHealthcare network physicians and other health care professionals have long demonstrated their commitment to affordable and quality, evidence-based health care by using pharmacies or distribution channels with optimal contracted rates and through compliance with medication policies.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturer of sodium hyaluronate preparations (Hyalgan and Supartz) without prior approval from UnitedHealthcare, will subject the physician or other health care professional to the following administrative actions, as provided in your agreement:

• Payment of claim may be adjusted in whole or in part.

it is the intent of United Healthcare to work with participating physicians and other health care professionals to promote the specialty pharmacy network viability and to maximize effectiveness of the clinical and quality improvement activities. Please contact UnitedHealth Pharmaceutical Solutions if you have any questions about making effective use of the specialty pharmacy network.

# Other **Information**information

## Member **Rights**rights and **Responsibilities**responsibilities

We tell our members they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you .

### Your patient's rights as a UnitedHealthcare member:

- Be treated with respect and dignity by UnitedHealthcare personnel, network physicians and other health care professionals .
- Be assured of privacy and confidentiality for treatments, tests and procedures you receive .
- Voice concerns about the service and care you receive .
- Register complaints and appeals concerning your health plan or the care provided to you .
- Receive timely responses to your concerns .
- Participate in a candid discussion with your physician about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage .
- Be provided with access to health care, physicians, health care professionals and other health care facilities .
- Participate with your physician and other health care professionals in decisions about your care .
- **Make**Receive and make recommendations regarding ~~the organization's member's~~UnitedHealthcare's members' rights and responsibilities policies .
- Receive information about UnitedHealthcare, our services, network physicians and other health care professionals .
- Be informed of, and refuse to participate in, any experimental treatment .
- Have coverage decisions and claims processed according to regulatory standards, when applicable .
- **Choose**choose an advance directive to designate the kind of care you wish to receive should you be unable to express your wishes .

### Your patient's responsibilities as a UnitedHealthcare member:

- Know and confirm your benefits before receiving treatment .
- **Contact**contact an appropriate health care professional when you have a medical need or concern .
- Show your health care **ID**ID card before receiving health care services .
- Pay any necessary copayment at the time you receive treatment .
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health .
- Keep scheduled appointments .
- Provide information needed for your care .
- Follow agreed-upon instructions and guidelines of physicians and health care professionals .
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals .
- Notify your employer's human resource department of changes in your address or family status .
- Visit our Web site myuhc .com<sup>®</sup> or call the phone number on the back of your health care **ID**ID card when you have a question about your eligibility, benefits, claims and more .
- Access our Web site myuhc .com<sup>®</sup> or call the phone number on the back of your health care **ID**ID card to verify that your physician or health care professional is participating in the UnitedHealthcare network before receiving services .

## Member Rights and Responsibilities – Medicare Advantage

We tell our members they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you .

### Medicare Advantage members have the right:

- To be treated with respect and in a manner that recognizes their need for privacy and dignity .
- To receive assistance in a prompt, courteous, responsible and culturally competent manner .
- To be provided with information about their health care benefits and any limitations and exclusions associated with their coverage .
- To be informed by their physician or other health care professional of their diagnosis, prognosis and plan of treatment in terms they understand .
- To participate in decisions with their physician regarding their care .
- To expect UnitedHealthcare not to interfere with any contracted physician or health care professional's discussion with them about their treatment options whether covered or not .
- To have **UnitedHealthcare**[United Healthcare](#) refer them to another contracted physician or health care professional if their physician or health care professional objects to a treatment based on moral or religious grounds .
- To be provided with information about the network of contracted physicians and health care professionals in their service area .
- To be informed by their physician or other health care professional about any treatment they may receive .
- To have their physician or health care professional request their consent for all treatment, unless there is an emergency and they are unable to sign a consent form and their health is in serious danger .
- To refuse treatment, including any experimental treatment, and be advised of the probable consequences of their decision .
- To choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes .
- To select [without interference](#), a primary care physician of their choice from within UnitedHealthcare's network of contracted physicians .
- To express a complaint about UnitedHealthcare .
- To make recommendations regarding the organization's member's rights and responsibilities policies .
- To express a complaint about the care they have received and to receive a response in a timely manner .
- To initiate the grievance procedure if they are not satisfied with UnitedHealthcare's decision regarding their complaint .
- To receive "timely access" to the records and information that **pertain**[pertains](#) to them .

## Medicare Advantage members have the responsibility:

- To know and confirm your benefits prior to receiving treatment .
- To show your Medicare Advantage **ID** card before receiving services and to protect against the wrongful use of your **ID** card by another person .
- To verify that the physician or health care professional you receive services from is participating in the Medicare network .
- To keep scheduled appointments and pay any necessary copayments/coinsurance at the time you receive treatment .
- To ask questions and seek clarification until you understand the care you are receiving .
- To follow the advice of your physician or health care professional and be aware of the possible consequences if you do not .
- To express your opinions, concerns and complaints to us .
- To provide information as necessary to UnitedHealthcare and contracted physicians and health care professionals that would help enhance your health status .
- To use emergency room services only for an injury or illness that appears to pose a serious threat to your life or health if not treated immediately .
- To follow the treatment plan agreed upon by you and your physician .
- To treat all UnitedHealthcare personnel respectfully and courteously .
- To notify us of any change in address .

• [A copy of this statement is also available on AARPMedicarecomplete .com .](#)

## Guide supplement section

### Important information regarding the use of this section

The following documents are supplements to this 201 0 UnitedHealthcare Physician, Health care Professional, Facility and Ancillary Provider Administrative Guide (“Guide”): American Medical Security & Golden Rule Supplement, leased Network Supplement, and Mid-Atlantic Regional Supplement .

in the event of any inconsistency between the Guide and any of these supplements, the supplement and the member’s benefit plan will prevail for those members subject to the supplement . in the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your participation agreement and any of these supplements, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope

of that Regulatory Requirements Appendix . Additionally, in the event of a conflict or inconsistency between your participation agreement and any of these supplements, the provisions of your participation agreement will control, unless your agreement provides otherwise . These supplements are subject to change .

# American Medical Security & Golden Rule Supplement

## Important information regarding the use of this supplement

The American Medical Security & Golden Rule Supplement applies to services provided to members enrolled in American Medical Security or Golden Rule benefit plans . in the event of any inconsistency between the Guide and the American Medical Security & Golden Rule Supplement or the member's benefit plan, the American Medical Security & Golden Rule Supplement and the member's benefit plan will prevail for American Medical Security and Golden Rule members .

You may request a printed copy of this or other Protocols and Payment Policies by contacting the United Voice Portal at (877) 842-3210 .

## How to contact us

### American Medical Security

<u>RESOURCE</u>	<u>WHERE TO GO</u>	<u>WHAT YOU CAN DO THERE</u>
<u>Notification</u>	<u>call the number on the back of the member's health care iD card or (800) 232-5432</u>	<u>To notify of hospitalizations exceeding three (3) days or transplant services outlined in the notification requirements section of this Supplement .</u>
<u>Benefits and Eligibility</u>	<u>call the number on the back of the member's health care iD card or (800) 232-5432</u>	<u>To inquire about a member's plan benefits or eligibility .</u>
<u>Pharmacy Services (Prescription Solutions)</u>	<u>call the pharmacy number on the back of the member's health care iD card or (800) 797-9791</u>	<u>To request a copy of the Prescription Drug List .</u>

### Golden Rule

<u>RESOURCE</u>	<u>WHERE TO GO</u>	<u>WHAT YOU CAN DO THERE</u>
<u>Notification</u>	<u>call the number on the back of the member's health care iD card or (800) 999-3404</u>	<u>To notify of hospitalizations exceeding three (3) days or transplant services outlined in the notification requirements section of this Supplement .</u>
<u>Benefits and Eligibility</u>	<u>call the number on the back of the member's health care iD card or (800) 657-8205</u>	<u>To inquire about a member's plan benefits or eligibility .</u>
<u>Pharmacy Services (Medco)</u>	<u>GoldenRule .com</u>	<u>To review the Prescription Drug List .</u>
	<u>call the pharmacy number on the back of the member's health care iD card (877) 884-3256</u>	<u>To request a copy of the Prescription Drug List .</u>

## Our claims process

We know that you want to be paid promptly for the services you provide. Here's what you can do to help promote prompt payment:

1. Notify American Medical Security or Golden Rule on or before the 4th day of hospitalizations that are expected to exceed three (3) days.
2. Notify American Medical Security or Golden Rule as soon as possible of proposed transplant procedures.
3. Prepare a complete and accurate claim form (see *Complete claims* section of this Supplement).
4. For American Medical Security members - submit electronic claims using Payor ID # 81400. This is the electronic claims routing number for American Medical Security members. Submit paper claims to the address on the member's health care ID card.
5. For Golden Rule members - submit electronic claims using Payor ID # 37602. This is the electronic claims routing number for Golden Rule members. Submit paper claims to the address on the member's health care ID card.

## Complete claims

Whether you submit your CMS-1 500 form or UB-04 form electronically or via paper form, a complete claim includes the following information. Additional information may be required by us for particular types of services, or based on particular circumstances or state requirements.

- Patient's name, address, sex, date of birth
- Primary member's name and ID number
- Name, signature, 'remit to' address, and phone number of the physician or health care provider performing the service, as described in the participation agreement
- Physician's or health care provider's National Provider identifier (N Pi) and federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- current CPT-4 and HCPCS procedure codes with modifiers where appropriate
- current ICD-9-cM (or its successor) diagnostic codes by specific service code to the highest level of specificity
- Referring physician's name and tax ID number (if applicable)
- charges per service and total charges
- information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby)
- Attach an anesthesia report for claims submitted with a 23, QS, G8 or G9 modifier
- Attach nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services
- Purchase price for DME rental claims exceeding \$500
- Medical records for growth hormone, co-surgeries, dental care resulting from an accident or injury to the teeth, maternity (except routine)
- For bone marrow/stem cell or organ transplant claims: transplant evaluation and transplant treatment protocols
- For reconstructive and/or cosmetic procedures regarding the cranio-facial region, breast, nose, eyes or abdomen: treatment plan, medical records for the last two (2) years regarding the condition, operative notes

- For experimental and/or investigational treatments (including Phase i or ii clinical trials): consent forms signed by the patient, medical records for the last two (2) years regarding the condition, admission and discharge summaries, treatment protocols
- For medical claims involving self-inflicted injuries or illnesses: admission and discharge summaries and progress notes during the confinement
- For HiV-related diseases and AiDS: onset information (first date diagnosed) and admission and discharge summaries for inpatient claims
- For accident and injury claims: summary of accident and injury (including date, place, and circumstances)
- Electronic claims must be HIPAA-compliant in order to be considered clean claims, using the applicable format that complies with all federal laws related to electronic health care claims, including any applicable implementation guides, companion guides, and trading partner agreements

## Additional information needed for a complete UB-04 form

- Date and hour of admission and discharge as well as member status-at-discharge code
- Type of bill code
- Type of admission (e .g . emergency, urgent, elective, newborn)
- current four-digit revenue code(s)
- current principal diagnosis code (highest level of specificity) with the applicable Present of Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
- current icD-9-cM (or its successor) procedure codes for inpatient procedures
- Attending physician iD
- Bill all outpatient surgeries with the appropriate revenue and cPT or HcPcS codes
- Provide specific cPT or HcPcS codes and appropriate revenue code(s) (e .g . laboratory, radiology, diagnostic or therapeutic) for outpatient services
- complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB04
- Attach an itemized statement if submitting a claim that will reach the contracted stop loss
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement)
- On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status
- if charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount (\$.01 or \$1.00) must be reported on all other surgical revenue code lines to assure appropriate adjudication

## Claim correction/resubmit

if you need to correct and resubmit a claim, submit a new CMS-1 500 or UB-04 indicating the correction being made . When correcting or submitting late charges on a UB-04 or 837 institutional claim, resubmit all original lines and charges as well as the corrected or additional information using bill type xx7, Replacement of Prior claim . Do not submit corrected or additional charges using bill type xx5, Late charge claim . Hand-corrected resubmissions will not be accepted .

## Submission of unlisted medical surgical codes

include a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical cPT or “other” revenue codes as well as experimental or reconstructive services.

## Submission of CMS-1500 form drug codes

include a current National Drug code (NDC) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1 500 form or the LiNo3 segment of the HIPAA 837 electronic form.

if you have questions about submitting claims, please contact American Medical Security or Golden Rule at the phone number listed on the member’s health care ID card.

## Reporting requirements for anesthesia services

- One of the CMS required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV1 04 with a “Mi” qualifier in loop 2400 SV1 03. For CMS-1 500 paper claims, report the actual number of minutes in Box 24G with qualifier Mi in Box 24H.
- When medically directing residents for anesthesia services, the modifier Gc must be reported in conjunction with the AA or QK modifier.
- When reporting obstetrical anesthesia minutes, use add-on codes 01 968 or 01969, as applicable, on the same claim as the primary procedure 01 967.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

## Claim adjustments

if you believe you were underpaid, please call American Medical Security at (800) 232-5432 or Golden Rule at (800) 657-8205 and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. if you or our staff identify a claim where you were overpaid, we ask that you send us the overpayment within thirty (30) calendar days from the date of your identification of the overpayment or of our request.

if you disagree with a claim adjustment, you can appeal the determination (see *Claims appeals*).

## Claims appeals

if you disagree with a claim payment determination, send a letter of appeal to the following address:

### American Medical Security Members

American Medical Security – Appeals Review, P.O. Box 13597, Green Bay, WI 54307-3597. Your appeal must be submitted to American Medical Security within 180 days from the date of payment shown on the EOB, unless your participation agreement or applicable law provide otherwise.

### Golden Rule Members

Golden Rule – Appeals Department, 7440 Woodland Drive, Indianapolis, IN 46278. Your appeal must be submitted to Golden Rule within twelve (12) months from the date of payment shown on the EOB, unless your participation agreement or applicable law provide otherwise.

if you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your participation agreement.



## Notification requirements

Notification, in order to be effective, must contain all necessary information including, but not limited to, member's name, member's health care id number, hospital name, hospital tax identification number, primary diagnosis description, anticipated dates of service, type of service and volume of service when applicable . in addition, such notifications must be made to the appropriate place as described on the member's health care id card .

Notify American Medical Security or Golden Rule at the number listed on the member's health care id card for any inpatient facility admission that will exceed three (3) days and for proposed transplant services .

Notify us prior to:

<u>Procedures and services</u>	<u>Explanation</u>
<u>Inpatient facility admissions</u>	<u>inpatient admissions expected to exceed three (3) days including: Acute hospitalizations (includes long term acute care), rehabilitation facilities, and skilled nursing facilities (includes subacute and hospice) that will exceed three (3) days . Notify on or before 4th inpatient day .</u>
<u>Transplant services</u>	<u>Proposed transplant services including evaluations .</u>

American Medical Security and Golden Rule use Milliman<sup>®</sup> care Guidelines<sup>®</sup>, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings, including acute and subacute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities .

As affiliates of UnitedHealthcare, American Medical Security and Golden Rule may also utilize the medical policies available online at UnitedHealthcareOnline .com . Tools & Resources . Policies and Protocols .

Notification does not guarantee coverage or payment (unless mandated by the state) . The member's eligibility for coverage is determined by the health benefit plan . For benefit or coverage information, please contact American Medical Security or Golden Rule at the number on the back of the member's health care id card .

# Leased Network Supplement

(May apply to providers in HI, ID, KY, ME, MI, MN, ND, SD, USVI, WI; reference your agreement for applicability)

## Important information regarding the use of this supplement

UnitedHealthcare's Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the "Guide") is supplemented by this Leased Network Supplement (the "leased Supplement") for physicians, health care professionals, facilities and ancillary providers who participate with UnitedHealthcare through a leased network accessed by UnitedHealthcare in an area UnitedHealthcare does not have a direct network.

Physicians, health care professionals, facilities and ancillary providers participating in UnitedHealthcare's network through a leased network are subject to both the Guide and the leased Supplement in their respective entirety; however, in the event of any inconsistency between the Guide and this leased Supplement, the leased Supplement will prevail for providers participating in a leased network arrangement.

## Leased supplement

any reference in the Guide to a physician's, health care professional's, facility's, or ancillary provider's "agreement with us" are to be considered simply an "agreement" for purposes of this leased Supplement and refer to your participation agreement with the entity operating the leased network (your "Master contract Holder").

Several items that appear in the Guide are covered by your agreement with your Master contract Holder, not the provisions stated in the Guide. any reference to updating demographic information, submitting National Provider identification information, credentialing or recredentialing processes and appeal guidelines should follow the processes as indicated in your agreement with your Master contract Holder.

# Mid-Atlantic Regional Supplement

(May apply to providers in DE, DC, MD, NC, PA, VA, WV; reference your agreement for applicability)

## Important information regarding the use of this Supplement

This Mid-Atlantic Regional Supplement applies to services provided to members enrolled in MD-individual Practice Association, inc. (“M.D. IPA”), Optimum choice, inc. (“Optimum choice”), MAMSi Life and Health insurance company (“MLH”) Benefits Plans or any Benefit Plan serviced or administered by OneNet PPO, LLC (“OneNet”) (collectively “MAHP members”). In the event of any inconsistency between the Guide and this Mid-Atlantic Regional Supplement, the Mid-Atlantic Regional Supplement and all Protocols and Payment Policies found on MAMSiUnitedHealthcare.com will prevail for MAHP members. You may request a printed copy of said Protocols and Payment Policies by contacting the Professional Services Department at (800) 342-3289.

## Product Summary

This table provides information about M.D. IPA, Optimum choice and MAMSi Life and Health insurance company (MLH) products for the Mid-Atlantic region.

<u>Attributes</u>	<u>M.D. IPA and Optimum Choice</u>	<u>M.D. IPA Preferred and Optimum Choice</u>	<u>MAMSI Life and Health Insurance Company</u>
<u>How do members access physicians and health care professionals?</u>	<u>Members' care must be arranged or coordinated by their primary care physician, except OB/GYN and routine eye refraction care.</u>	<u>in-network benefits: Members' care must be arranged or coordinated by their primary care physician, except OB/GYN and routine eye refraction care.</u>  <u>Out-of-network benefits: Members' care is not required to be arranged or coordinated by their primary care physician.</u>	<u>Members can choose to access any network physician or health care professional. MAMSi Life and Health insurance company members have out-of-network benefits.</u>
<u>Does a primary care physician have to make a referral to a specialist?</u>	<u>Yes, except routine annual visits to an OB/GYN and routine eye refraction care.</u>	<u>in-network benefits: Yes, except routine annual visits to an OB/ GYN and routine eye refraction care.</u>  <u>Out-of-network benefits: No referral needed.</u>	<u>No, a referral is not needed.</u>
<u>Is the treating physician required to obtain pre-certification for some procedures?</u>	<u>Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional Supplement.</u>	<u>Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional</u>	<u>Yes, for selected procedures; reference the Preauthorization and Precertification Requirements section of this Mid-Atlantic Regional Supplement.</u>

## OneNet PPO

OneNet PPO, llc (OneNet) maintains a large network of physicians, health care practitioners and facilities offering medical, behavioral health and workers' compensation services in the Mid-Atlantic region . OneNet customers accessing the OneNet network include:

- [insurance carriers](#)
- [Third party administrators](#)
- [Union health and welfare funds](#)
- [Workers' compensation administrators](#)
- [And others](#)

OneNet offers a variety of services to assist its customers in managing health care services . The OneNet network is constantly growing as more physicians, health care practitioners, and facilities are contracted each year to give our participants access to quality health care from a large network throughout our service area .

Due to the nature of the OneNet network, OneNet claims policies and administrative guidelines can differ from M.D., IPA, Optimum choice and MIH . Please refer to the [OneNet Physician, Health care Practitioner, Hospital and Facility Manual](#) available from your network representative, our Professional Services Department at (800) 342-3289, or in the [provider publications section of the OneNet Web site, onenetppo .com](#), for information about OneNet's protocols, policies and procedures . You may also use [onenetppo .com](#) to check claim re-pricing and find other participating physicians, health care practitioners, hospitals and facilities in the OneNet network . A secure login specific to the OneNet website is available by calling our Professional Services Department at (800) 342-3289, and is required to access the [OneNet Physician, Health care Practitioner, Hospital and Facility Manual](#) and the [claim pricing sheets](#) .

The [OneNet Physician, Health care Practitioner, Hospital and Facility Manual](#) is also available at [UnitedHealthcareOnline .com](#) through secure login .

if you need assistance or have any questions about OneNet PPO, please call our Professional Services Department at (800) 342-3289 .

## Health care ID cards

Effective October 1, 2006, we began to introduce updated M.D. iPA and Optimum choice benefit plans. Medical services for these plans will be administered and adjudicated on different technology systems, including different claims systems. It is important to check your patient's health care ID card as these will be different for those enrolled in an updated plan.

Members enrolled in M.D. iPA and Optimum choice updated benefit plans will present with a plastic health care ID card. For Optimum choice updated benefits plans, the health care ID card will display the UnitedHealthcare logo and will indicate "Optimum choice, inc." For M.D. iPA updated benefit plans, the health care ID card will display the M.D. iPA logo. All M.D. iPA and Optimum choice members enrolled in updated benefit plans will have a member number without an asterisk. Be sure to use the telephone numbers and addresses noted on these health care ID cards.

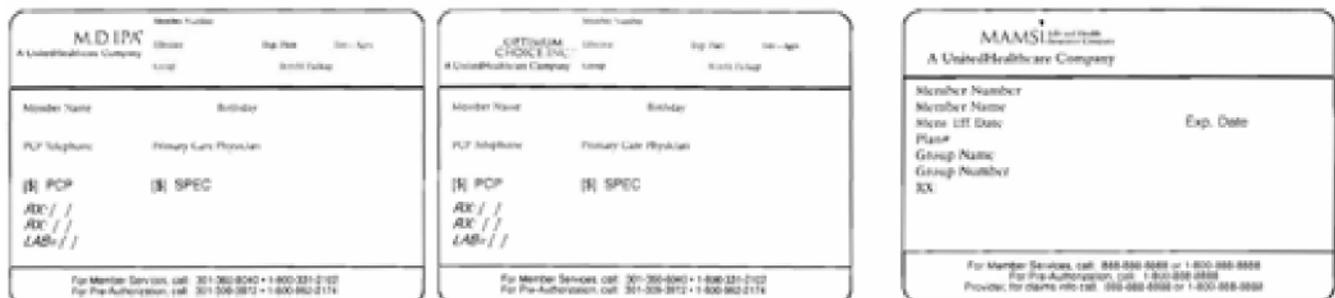
Sample health care ID cards for M.D. iPA and Optimum choice updated benefit plans:



Members enrolled in M.D. iPA and Optimum choice current (non-updated) benefit plans will present with a paper health care ID card; they will have a member number that includes an asterisk. Be sure to use the telephone numbers and addresses noted on these health care ID cards.

Sample health care ID cards for non-updated M.D. iPA and Optimum choice benefit plans:

Sample health care ID card for MAMSi Life and Health insurance company products:



## How to contact us

<u>RESOURCE</u>	<u>WHERE TO GO</u>	<u>WHAT YOU CAN DO THERE</u>
<u>Online services</u>	<p><u>Use UnitedHealthcareOnline .com for members enrolled in updated M .D . iPA and Optimum choice benefit plans .</u></p> <p><u>Use MAMSiUnitedHealthcare .com for members enrolled in non-updated M .D . iPA and Optimum choice benefit plans, and for members enrolled in MAMSi Life and Health insurance company products .</u></p>	<p><u>Real-time enrollee eligibility and benefit information</u></p> <p><u>Payment Policies, Protocols and Guides</u></p> <p><u>check claim status</u></p> <p><u>Electronic claims submission-</u></p> <p><u>UnitedHealthcareOnline .com only (Use Payer iD 87726; see Guide for more detail)</u></p> <p><u>Electronic Referral System</u></p>
<u>Voice Activated Telephone System</u>	<p><u>For members enrolled in updated M .D . iPA and Optimum choice benefit plans, call (877) 842-3210 .</u></p> <p><u>For members enrolled in non-updated M .D . iPA and Optimum choice benefit plans, and MAMSi Life and Health insurance company products, call (800) 582-3377 .</u></p>	<p><u>To inquire about a member's eligibility or benefits, check claim status, check to see if a procedure requires pre-certification, verify copayment information and more .</u></p> <p><u>You will need your provider and tax identification numbers .</u></p>

## Our claims process

Please refer to the Guide for information about our claims process for members enrolled in updated benefit plans (members with numbers without an asterisk) . Be sure to send paper claims for M .D . iPA and Optimum choice members enrolled in non-updated benefit plans (members with numbers that include an asterisk) to the following address:

claims Department  
P .O . Box 930  
Frederick, MD 21 705-0930

if you submit your claims electronically, please refer to the Payer Numbers listed on MAMSiUnitedHealthcare .com for M .D . iPA and Optimum choice members enrolled in non-updated benefit plans (members with numbers that include an asterisk) . For claims appeals for Oci, M .D . iPA or MLH, please send your letter of appeal to the address on the member's health care iD card or per the instructions on the Provider Remittance Advice (PRA) .

## Health services

This section applies to all MAMSi Life and Health insurance company, M .D . iPA and Optimum choice members and includes both the updated and non-updated Oci/M .D . iPA products .

To notify us of the procedures and services outlined in the Preauthorization, Precertification section of this Mid-Atlantic Regional Supplement, call:

- inpatient Preauthorization or Precertification call (800) 962-21 74;
- Outpatient Preauthorization or Precertification call (800) 738-1837;
- The Health Services staff is available during the business hours of 8:30 a .m . to 5:30 p .m . EST .

## Inpatient admission notification

All participating facilities are required to notify the health plan of an admission of a member within twenty-four (24) hours or the next business day following a weekend or federal holiday, whichever comes first . The health plan will initiate a case review upon receipt of your notification . if notification is not provided in a timely manner, the health plan may still review the case and request additional medical information . if you fail to notify in a timely manner, the health plan may retroactively deny one (1) or more days based upon its case review . if the patient is eligible for benefits on the date of admission, the health plan will not deny the first day of the admission if the treating provider previously received pre-authorization of the scheduled admission . Provide admission notification to Health Services via phone at (800) 962-21 74 or via fax at (800) 352-0049 .

in the event a member receiving outpatient services needs an inpatient admission, the facility must notify the health plan as noted above . Emergency room services that culminate in a covered admission will be payable as part of the inpatient stay provided the facility has notified the health plan of the admission as noted above .

## Delay in service

Facilities that provide inpatient services must maintain appropriate staff, resources and equipment to ensure that covered services are provided to members in a timely manner . a clinical delay in Service is defined as any delay in medical decision-making, test, procedure, transfer, or discharge that is not caused by the clinical condition of the member . Services should be scheduled the same day as the physician's order . However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day, unless emergent treatment was required . a delay may result in sanction of the facility by the health plan and non-reimbursement for the delay day(s), if permissible under State law .

a delay in Service will be assessed for any of the following reasons:

- a failure to execute a physician order in a timely manner that will result in a longer length of stay
- Equipment needed to execute a physician's order is not available
- Staff needed to execute a physician's order is not available
- a facility resource needed to execute a physician's order is not available
- Facility does not discharge the patient on the day the physician's discharge order is written

## Concurrent review

Review is conducted on-site at the facility or telephonically for each day of the stay using nationally-accepted criteria . You must cooperate with all requests for information, documents or discussions from the health plan for purposes of concurrent review including, but not limited to, clinical information on patient status and discharge planning . When criteria are not met, the case is referred to a medical director for determination . The health plan will deny payment for hospital days that do not have a documented need for acute care services . The health plan requires that physicians' progress notes be charted for each day of the stay . Failure to document will result in denial of payment to the hospital and the physician .

## Hospital post-discharge review

When a member has been discharged before notification to the health plan can occur or before information is available for certification of all the days, a post-discharge review will be conducted . a health plan representative will request

the member's records from the Medical Records department or via a telephonic review and review each non-certified day for appropriateness and acuity . inpatient days that do not meet acuity criteria will be referred to a medical director for determination and may be retrospectively denied . delays in service or days that do not meet criteria for intensity of service may be denied for payment .

## Hospital-to-hospital transfers

The hospital must notify the health plan of a request for hospital-to-hospital transfer . in general, transfers are approved when there is a service available at the receiving hospital that is not available at the sending hospital; the patient would receive a medically appropriate change in the level of care at the receiving facility; or the receiving facility is in-network and has appropriate services for the member . if any of the conditions above are not met, coverage for the transfer will be denied . Services at the receiving hospital would be approved if medical necessity criteria for admission were met at the receiving hospital, and there is no delay in providing services at the receiving hospital .

## Preauthorization and precertification requirements

Preauthorization is required for all non-emergency, planned admissions for all MAMSi Life and Health insurance company, M.D. iPA and Optimum choice members.

### Services requiring preauthorization or precertification

certain services require preauthorization or precertification for M.D. iPA, Optimum choice and MAMSi Life and Health insurance company members. These requirements vary for M.D. iPA and Optimum choice members enrolled in updated and non-updated benefit plans.

Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon member eligibility, benefits and applicable state law.

### Procedures requiring precertification

The following list applies to M.D. iPA and Optimum choice Members in updated and non-updated plans, and M.D. iPA Preferred and Optimum choice Preferred Members in updated benefit plans.

Be sure to submit your request at least two (2) business days prior to the provision of services. Also, please keep in mind some procedures and services listed here may not be covered under the member's benefit plan. If you have any questions, please contact the Professional Services Department at the number on the back of the member's health care ID card.

<u>Procedures and services requiring preauthorization or precertification: written request</u>	
<ul style="list-style-type: none"> <li>* <u>Acupuncture<sup>1</sup></u></li> <li>• <u>Angiomas/hemangioma (with pictures)</u></li> <li>• <u>Biofeedback</u></li> <li>• <u>Blepharoplasty (with pictures/visual fields)</u></li> <li>• <u>Breast implant Removal</u></li> <li>• <u>Breast Reconstruction (non-cancer diagnoses only)</u></li> <li>* <u>chiropractic Services<sup>1</sup></u> <u>(if not subject to a maximum dollar amount)</u></li> <li>• <u>clinical Trials</u></li> <li>• <u>cochlear implants</u></li> <li>• <u>congenital Anomaly Repair (with pictures if indicated)</u></li> <li>• <u>cosmetic and Reconstructive Surgery (with pictures if indicated)</u></li> <li>• <u>Dental Procedures in a Facility</u></li> <li>• <u>Dental Services</u> <u>(except removal of cysts/tumors and fracture care)</u></li> <li>• <u>Discectomy/Fusion (inpatient or outpatient)</u></li> <li>• <u>Durable Medical Equipment (for a complete list of DME items which do not require preauthorization, visit <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>)</u></li> <li>• <u>Elective inpatient procedures and admissions must be preauthorized Precertification also required for:</u> <ul style="list-style-type: none"> <li>- <u>Joint replacement (hip, knee, ankle, shoulder)</u></li> <li>- <u>Morbid Obesity surgery</u></li> </ul> </li> <li>• <u>Experimental Services/New Technologies</u></li> <li>• <u>General Anesthesia for Dental Procedures</u></li> <li>• <u>Gynecomastia Surgery (with pictures)</u></li> <li>• <u>Home care</u></li> <li>• <u>Hysterectomy (inpatient or outpatient)</u></li> <li>* <u>infertility Services<sup>1</sup></u></li> </ul>	<ul style="list-style-type: none"> <li>• <u>Joint Replacement (hip, knee, ankle, shoulder)</u></li> <li>• <u>Laminectomy/Fusion (inpatient or outpatient)</u></li> <li>• <u>Occupational Therapy<sup>2,3</sup> (after eight visits)</u></li> <li>• <u>Morbid Obesity (surgery/procedures)</u></li> <li>• <u>Pelvic Laparoscopy</u></li> <li>• <u>Physical Therapy<sup>2,3</sup> (after eight visits)</u></li> <li>• <u>Prosthetic devices except for prosthetic contact lenses</u></li> <li>* <u>Psychiatric Therapies including, but not limited to:<sup>4</sup></u> <ul style="list-style-type: none"> <li>- <u>Electroconvulsive Therapy (ECT)</u></li> <li>- <u>Psychological Testing including Psychological and Neuropsychological testing and extended developmental testing</u></li> <li>- <u>Substance Abuse Treatment (Outpatient, detoxification, intensive Outpatient Services, Routine Outpatient Services with a Primary Diagnosis of Substance Abuse)</u></li> </ul> </li> <li>• <u>Pulmonary Rehabilitation</u></li> <li>• <u>Radiology</u> <ul style="list-style-type: none"> <li>- <u>capsule Endoscopy</u></li> <li>- <u>cT's- Brain, chest, Musculoskeletal, colonography</u></li> <li>- <u>MRI of Brain, Heart, chest, Musculoskeletal</u></li> <li>- <u>PET Scans (non-cancer diagnoses)</u></li> <li>- <u>Virtual procedures</u></li> </ul> </li> <li>• <u>Reduction Mammoplasty (with pictures)</u></li> <li>• <u>Rhinoplasty/Septo-rhinoplasty (with pictures)</u></li> <li>• <u>Sclerotherapy (with pictures)</u></li> <li>• <u>Sleep Apnea (oral appliances and surgery)</u></li> <li>• <u>Speech Therapy<sup>2</sup> (after eight visits)</u></li> <li>• <u>Temporomandibular Disorder (TMD) or related Myofascial Pain Dysfunction Syndrome (MPD) Treatment</u></li> <li>• <u>Transplants (and evaluations)</u></li> <li>• <u>Vagal Nerve Stimulator</u></li> </ul>

1 initial preauthorization/precertification request must be submitted by the member's Primary care Physician (PcP). However, the treating physician or health care practitioner may submit the initial request for Oci Direct members.

2 All Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.

3 For Oci Direct members, precertification required from fist visit and may be requested by telephone.

4 Precertify these services through the Behavioral Health Department.

**Procedures and services requiring preauthorization or precertification: telephone or written request**

- [ambulance Services \(non-emergency\)](#)
- [cardiac angioplastic \(inpatient or outpatient\)](#)
- [coronary artery Bypass Graft](#)
- [Psychiatric Therapies \(pre-precertifications can be made by telephone\)<sup>4</sup>](#)
  - [inpatient Services \(non-emergency\)](#)
  - [Psychiatric Partial Hospitalization and intensive Outpatient Treatment](#)
  - [Substance abuse Treatment \(inpatient Rehabilitation, Partial Hospitalization\)](#)
- [Radiation Therapy<sup>1</sup>](#)

**Exception Requests**

all exceptions to the health plan's policies and procedures must be preauthorized. The most common, but not a comprehensive list of, exception requests are:

- [immunizations \(outside the scope of health plan guidelines\)](#)
- [lower level ambulatory surgery procedures rendered in Montgomery and Prince George's counties in Maryland in a hospital \(Medicare levels one to four\)](#)
- [Refer a member out-of-network to a non-participating physician, health care practitioner or facility](#)

The following list of services requiring pre-certification applies to all MAMSI Life and Health Insurance Company and M.D. IPA Preferred and Optimum Choice Preferred members in non-updated plans using their out-of-network benefits.

Be sure to submit your request at least two (2) business days prior to the provision of services. Please keep in mind some procedures and services listed here may not be covered under the member's health plan policy. If you have any questions, please contact the Professional Services department at [maprofessionalservices@uhc.com](mailto:maprofessionalservices@uhc.com), or call (800) 342-6141.

- [acupuncture \(if covered\)](#)
- [angioma/Hemangioma Treatment](#)
- [Biofeedback](#)
- [Blepharoplasty](#)
- [Breast impact Removal](#)
- [Breast Reconstruction](#)
- [cataract Surgery](#)
- [chiropractic services \(if no dollar limit\)](#)
- [cholecystectomy by laparoscopy](#)
- [cochlear implants](#)
- [congenital anomaly Repair](#)
- [cosmetic and Reconstructive Surgery](#)
- [durable Medical Equipment \(for a complete list of dME items which do not require preauthorization, visit \[UnitedHealthcareOnline.com\]\(http://UnitedHealthcareOnline.com\)\)](#)
- [Elective inpatient Procedures and admissions must be preauthorized](#)
- [Endoscopic Transthoracic Sympathectomy \(ETS\)](#)
- [Enhanced External counterpulsation](#)
- [General anesthesia for dental Procedures](#)
- [Growth Hormone Treatment](#)
- [Gynecomastia Surgery](#)
- [infertility Services \(if covered\)](#)
- [Occupational](#)
- [Pelvic laparoscopy](#)
- [Physical Therapy](#)
- [Prometheus laboratory Tests for inflammatory Bowel disease](#)
- [Psychiatric Outpatient Therapies, including but not limited to: — Eye Movement desensitization and Reprocessing \(EMdR\)](#)
  - [Psychiatric day Treatment and/or intensive Outpatient Treatment Programs \(programs providing more than one treatment session/day\)](#)
  - [Psychological Testing including Psychological and Neuropsychological Testing, Extended development Testing, neuro-Behavioral Status Exams or assessment of aphasia](#)
  - [Reduction Mammoplasty if covered](#)
- [Rhinoplasty](#)
- [Speech Therapy \(under age 10\)](#)
- [Substance abuse Treatment](#)
- [Temporomandibular disorder \(TMd\) and/or related Myofascial Pain dysfunction Syndrome \(MPdS\) Treatment](#)
- [Transplants Evaluation](#)
- [Uvulopalatoharyngoplasty](#)

1 initial preauthorization/precertification request must be submitted by the member's Primary care Physician (PcP). However, the treating physician or health care practitioner may submit the initial request for Oci direct members.

2 all Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.

3 For Oci direct members, precertification required from fist visit and may be requested by telephone.

4 Precertify these services through the Behavioral Health department.

## Obtaining Select, Provider-Administered Injectable Medications

Following are key drugs requiring use of a particular vendor and pre-authorization:

- [Botox \(Botulinum Toxin Type A\)](#)
- [Myobloc \(Botulinum Toxin Type B\)](#)
- [Synagis \(palivizumab\)](#)
- [Xolair \(omalizumab\)](#)

Following are key drugs requiring pre-authorization:

- [Amevieve \(alfacept\)](#)
- [Erythrocyte Stimulating Agents](#)
- [Hyaluronic Acid injection Agents](#)
- [Remicade \(infliximab\)](#)
- [Rituxan \(rituximab\)](#)
- [Tysabri \(natalizumab\)](#)

**Note:** The list above is valid as of May 12, 2009. Medications not included above may require inclusion of a specific diagnosis for payment. For current listings, go to [UnitedHealthcareOnline.com](#) or call contact numbers below.

information on our medical evidence-based policies is available at: [UnitedHealthcareOnline.com Tools & Resources Policies & Protocols Policies Medical Policies](#). For additional policies and information, call (800) 355-8530.

Specialty pharmaceutical vendor information available at: [UnitedHealthcareOnline.com Tools & Resources Policies & Protocols Protocols](#), or call (866) 429-81 77. All drugs are appropriate for office-based administration. (call to request an exception to office-based administration.)

Requests for pre-authorization must be faxed to (800) 787-5325. include clinical notes and name of specialty pharmacy vendor. For questions, call (800) 355-8530.

if authorized, Pharmacy Services will provide a written authorization number and coverage dates. This authorization should be submitted to the specialty pharmacy vendor along with the medication order. UnitedHealthcare will call provider's office within three (3) business days if conditions are not met for providing the drug.

### Procurement of Synagis

M.D. iPA and Optimum choice, inc. contract with Pharmicare/cVS caremark® as a specialty pharmacy for Synagis. Synagis treatment requires prior authorization which can be obtained by faxing the RSV Enrollment form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain the RSV fax enrollment form at [UnitedHealthcareOnline.com Tools & Resources Pharmacy Resources](#). You can reach Pharmicare/cVS caremark at (800) 952-4065.

if you have questions about obtaining Synagis from Pharmicare/cVS caremark, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-81 77.

### Procurement of Botox/Myobloc and Xolair

M.D. iPA and Optimum choice, inc. contract with Prescription Solutions as a specialty pharmacy for Botox/Myobloc and Xolair. Botox/Myobloc and Xolair require prior authorization which can be obtained by faxing the prior authorization request form or equivalent information to Pharmacy Services at (800) 787-5325. You may contact Pharmacy Services with questions about the prior authorization process at (800) 355-8530. You can obtain the prior authorization request forms at [PrescriptionSolutions.com Prior Authorizations Prior Authorization Request Forms](#), under the Specialty Pharmacy heading. You can reach Prescription Solutions High Touch team at (888) 293-9309.

if you have questions about obtaining Botox/Myobloc or Xolair from Prescription Solutions, please call the UnitedHealthcare Specialty Referral Pharmacy Line at (866) 429-81 77.

## Clinical appeals

To appeal an adverse decision (a decision by us not to preauthorize or precertify a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter or PRA will provide you with the filing deadlines and the address listed on the member's health care ID card to use to submit the appeal.

## Member rights and responsibilities

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

These rights and responsibilities can be found on:

- [myuhc.com](http://myuhc.com) for M.D. iPA and Optimum choice members enrolled in updated benefit plans; or
- [mamsiUnitedHealthcare.com](http://mamsiUnitedHealthcare.com) for MAMSi Health and Health insurance company members as well as M.D. iPA and Optimum choice members enrolled in non-updated benefit plans.

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February 01, 2010

Arkansas Insurance Department  
1200 West 3rd Street  
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas Inc.

NAIC No. 95446 United Healthcare of Arkansas, Inc. ®  
Group Health Form 100-6088 12/09

Dear Ms. Minor:

On behalf of UnitedHealthcare of Arkansas Inc., I am submitting the enclosed UHC Provider Administrative Guide for your Department's review and approval. Enclosed within this filing is a copy of the current version and a redlined version of the form which outlines the recent changes to the form.

This submission has been submitted electronically via SERFF and UnitedHealthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at [Ebony\\_N\\_Terry@uhc.com](mailto:Ebony_N_Terry@uhc.com).

Sincerely,

Ebony N. Terry  
Regulatory Compliance Analyst