Filing at a Glance

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State: Arkansas

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Company and Contact

Filing Contact Information

Kelly Smith, Manager RGA
800 King Farm Blvd.
Suite 500
Rockville, MD 20850
Kelly_Smith@uhc.com
240-632-8061 [Phone]

Filing Company Information

UnitedHealthcare of Arkansas, Inc.
Plaza West Building
415 North McKinley Street, Suite 300
Little Rock, AK 72205
(952) 992-7428 ext. [Phone]

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Product Name:	*100-6088 UHC Admin Guide 2012. Updated 1.6.2012*		
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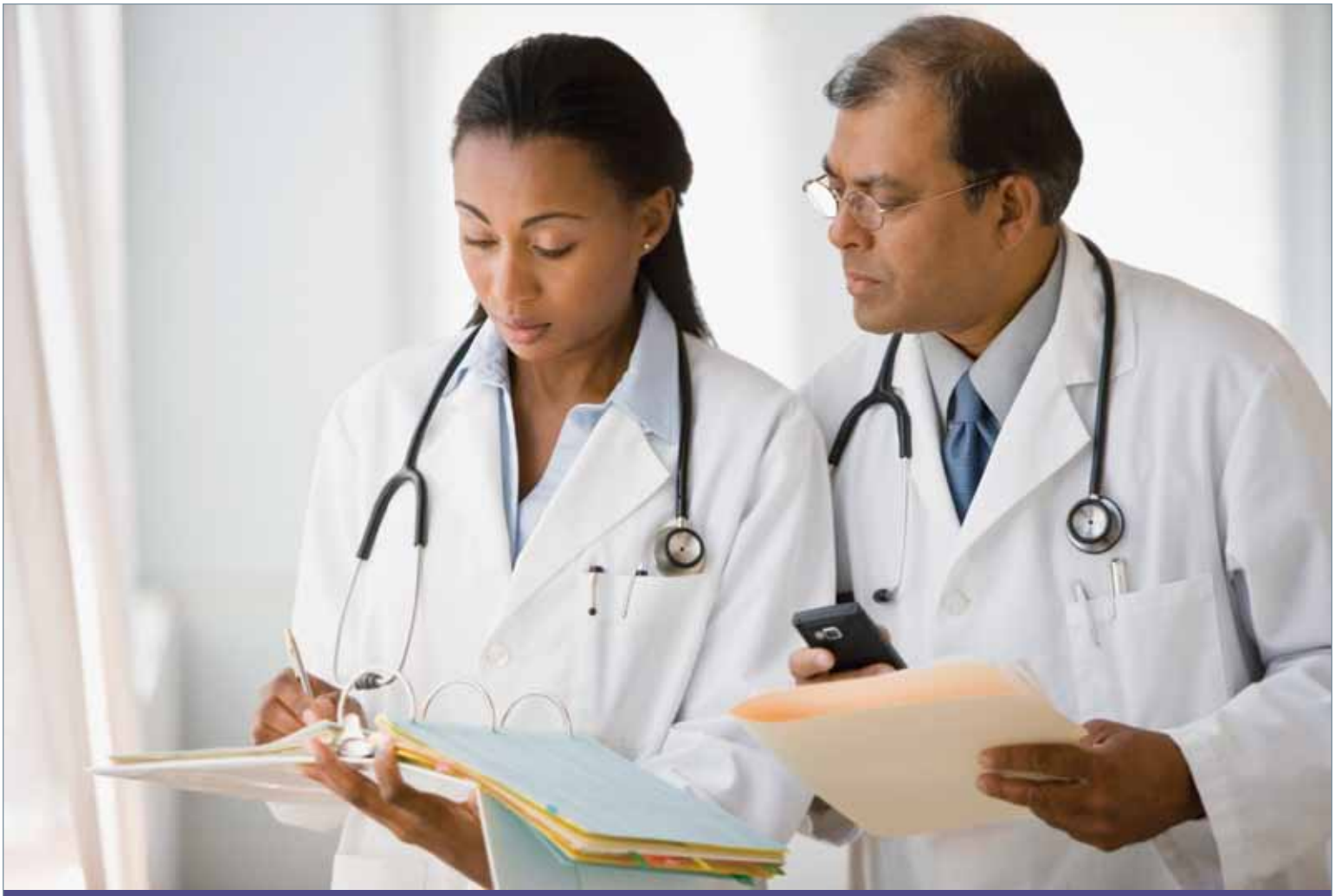
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	100-6088 UHC ADMIN GUIDE 2012. Updated 1.6.2012 Cover letter	Approved	Yes
Form	100-6088 UHC Admin Guide 2012. Updated 1.6.2012	Approved	Yes

Form Schedule

Lead Form Number: 100-6088 UHC Admin Guide 2012. Updated 1.6.2012

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/23/2012	100-6088 UHC Admin Guide 2012. Updated 1.6.2012	Other	100-6088 UHC Admin Guide 2012. Updated 1.6.2012	Revised	Replaced Form #: 100-6088 UHC Admin Guide 2012 Previous Filing #: 100-6088 UHC Admin Guide 2012	56.700	100-6088 UHC Admin Guide.Updated 1.6.2012.pdf



Physician, Health Care Professional, Facility and Ancillary Provider 2012 Administrative Guide

For Commercial and Medicare Advantage Products

UnitedHealthcare®

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Important information regarding the use of this Guide

This 2012 Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (this "Guide") applies to covered services you provide to Customers under a benefit plan insured by or receiving administrative services from UnitedHealthcare and its affiliates, unless otherwise noted.

Except when indicated, this Guide is effective on April 1, 2012 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, 2012.

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

Terms used in this Guide include, but are not limited to, the following:

- "Customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined in your agreement with us (we sometimes refer to Customers as "members");
- "Commercial" refers to all UnitedHealthcare medical products that are not Medicare, Medicaid, CHIP, workers' compensation or other governmental programs (except that "Commercial" also applies to benefit plans for government employees or students at public universities);
- "You" or "your" refers to any provider subject to this Guide, including physicians, health care professionals, facilities and ancillary providers; except when indicated 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.

Except when indicated, the Guide applies to UnitedHealthcare Medicare Advantage Customers, including Erickson Advantage Customers but excluding UnitedHealthcare Medicare Direct Customers. If a particular section does not apply to a Medicare Advantage Customers, it will be clearly indicated in this Guide. As used in this Guide, references to "Medicare Advantage Customers" only apply to those Medicare Advantage Customers enrolled in UnitedHealthcare Medicare Advantage plans offered under the AARP MedicareComplete, UnitedHealthcare Medicare Solutions, and Erickson Advantage brands.

All Medicare Advantage plans subject to this Guide are identified by the following logos on the back of the Medicare Advantage Customer health care identification (ID) card: "Medicare Solutions" and either "UHC" or "West."*

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.

In the event of a conflict or inconsistency between your agreement and this Guide, the provisions of your agreement will control (except that where your agreement provides that Protocols of certain of our affiliates will control; if those Protocols are now collected in a supplement to this Guide, those Protocols in that supplement will control with regard to services you render to a Customer subject to that supplement).

This entire Guide is subject to change.

UnitedHealthcare and its affiliates own UnitedHealthcareOnline.com, myuhc.com and the websites listed in the "Additional Manuals/Website" of the "Benefit Plans" table on pages 3-6 of this Guide. We do not own the other websites referred to in this Guide, but reference them because they may contain information that is useful or interesting to you. We do not endorse, and are not responsible for, the content and accuracy of websites operated by third parties or any of your dealings with such third parties. You are solely responsible for your dealings with such third parties, and so we encourage

* The only exception is UnitedHealthcare Senior Options, which is a benefit plan offered only in Massachusetts. For this benefit plan, the logos on the back of the Medicare Advantage Customer ID card are "Medicare Community Plan" and UHC."

you to read the terms of use and privacy policies on such third-party websites.

Note: 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 for further information.

Information regarding certain benefit plans referenced in this Guide

Some of the benefit plans that may be included under your agreement with us are subject to additional requirements of one or more additional provider manuals or supplements to this Guide and/or are not subject to certain of the requirements of this Guide. Those additional manuals and those supplements to this Guide are each referred to in this section as an "Additional Manual."

Below is a table setting forth information about how to identify the Customers covered under those benefit plans and a general guide to where those Additional Manuals are located and how they apply. You are subject to these Additional Manuals when providing covered services to a Customer covered under one of these benefit plans, to the extent provided in your contract and in the table below. United may make changes to the Additional Manuals in accordance with the provisions of your Agreement that relate to Protocol and Payment Policy changes.

Please note that UnitedHealthcare may change the location of a website, a benefit plan name, branding or the Customer identification card identifier. If and when these changes occur and apply to you, we will communicate such changes to you.

Term Used in this Guide	Definition	ID card reference	Location of most Customers subject to Additional Manuals	Additional Manual/ website	When and how does the Additional Manual apply when you are providing services to the Customer of the Benefit Plan?*
Oxford	Benefit Plans issued or administered by any of the following entities: • Oxford Health Plans, LLC • Oxford Health Insurance, Inc. • Investors Guaranty Life Insurance Company, Inc. • Oxford Health Plans (NY), Inc. • Oxford Health Plans (NJ), Inc. • Oxford Health Plans (CT), Inc.	"Oxford"	CT, NJ, NY (except upstate), some counties in PA	**For Commercial Benefit Plans:** Oxford Provider Reference Manual (for Commercial plans only) oxhp.com **For Medicare Advantage Benefit Plans:** Oxford Medicare Advantage Supplement to this Guide UnitedHealthcareOnline.com	If your agreement specifically references Oxford protocols or manuals, then the applicable Oxford Additional Manual applies, and it supersedes conflicting provisions in this Guide.
MDIPA	Benefit Plans issued or administered by MD-Individual Practice Association, Inc.	"MDIPA"	DC, DE, MD, NC, SC, VA, WV, some counties in PA	Mid-Atlantic Regional Supplement to this Guide UnitedHealthcareOnline.com	If your agreement specifically references MDIPA protocols or manuals, then the MDIPA Additional Manual applies, and it supersedes this Guide if there is a conflict.
OCI	Benefit Plans issued or administered by Optimum Choice, Inc.	"OCI"	DC, DE, MD, NC, SC, VA, WV, some counties in PA	Mid-Atlantic Regional Supplement to this Guide UnitedHealthcareOnline.com	If your agreement specifically references OCI protocols or manuals, then the OCI Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
OneNet	Benefit Plans accessing a network administered by OneNet PPO, LLC	"OneNet PPO"	DC, DE, MD, NC, PA, VA, WV	OneNet PPO Supplement to this Guide UnitedHealthcareOnline.com	If your agreement specifically references OneNet protocols or manuals, then the OneNet Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
NHP	Benefit Plans issued or administered by Neighborhood Health Partnership, Inc.	"Neighborhood HMO Access"	FL	Neighborhood Health Partnership Supplement to this Guide UnitedHealthcareOnline.com	If your agreement specifically references NHP protocols or manuals, then the NHP Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.

* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are contracted directly with the affiliate that offers that benefit plan.

Term Used in this Guide	Definition	ID card reference	Location of most Customers subject to Additional Manuals	Additional Manual/ website	When and how does the Additional Manual apply when you are providing services to the Customer of the Benefit Plan?*
UnitedHealthcare West or UHC West (Benefit plans referenced in this row were formerly known as "PacifiCare")	Benefit Plans issued or administered by any of the following entities: • PacifiCare Health Plan Administrators, Inc. • PacifiCare of Arizona, Inc. • UnitedHealthcare of California • PacifiCare of Colorado, Inc. • PacifiCare of Nevada, Inc. • UnitedHealthcare of Oklahoma, Inc. • UnitedHealthcare of Oregon, Inc. • UnitedHealthcare Benefits of Texas, Inc. • UnitedHealthcare of Washington, Inc.	"West"	AZ, CA, CO, NV, OK, OR, TX, WA	UnitedHealthcare West Non-Capitated Supplement to this Guide UnitedHealthcareOnline.com uhcwest.com	If your agreement specifically references PacifiCare or UHC West protocols or manuals, then the UHC West Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
River Valley	Certain benefit plans issued or administered by • UnitedHealthcare Services Company of the River Valley, Inc. • UnitedHealthcare Plan of the River Valley, Inc., and; • UnitedHealthcare Insurance Company of the River Valley	River Valley Customers can be identified by a reference to "uhcrivervalley.com" on the back of their ID card.	As of 1/1/12, parts of AR, GA, IA, IL TN, WI, VA Note: River Valley also offers benefit plans in OH & SC, but the River Valley Entities Supplement does not apply to those benefit plans.	The River Valley Entities Supplement to this Guide UnitedHealthcareOnline.com and uhcrivervalley.com.	The River Valley Entities Supplement applies to you, and it supersedes this Guide if there is a conflict, if all of the following are true: • Your United contract specifically references River Valley or John Deere Health protocols or manuals; and • You are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Mercer, Whiteside, Lee, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean. • You are providing services to a River Valley commercial Customer and not to River Valley Medicare Advantage, Medicaid or CHIP Customer
UnitedHealthOne or All Savers	Benefit Plans issued or administered by: a) Golden Rule Insurance Company b) All Savers Insurance Company c) PacifiCare Life and Health Insurance Company, and d) American Medical Security Life Insurance Company (AMSLIC)	a) "Golden Rule" b) "All Savers Insurance" c) "PacifiCare" d) "American Medical Security"	All markets	Golden Rule Insurance Company, All Savers, & American Medical Security Supplement to this Guide UnitedHealthcareOnline.com	Additional Manual always applies, but it ***does not supersede the rest of this Guide***.

* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are contracted directly with the affiliate that offers that benefit plan.

Term Used in this Guide	Definition	ID card reference	Location of most Customers subject to Additional Manuals	Additional Manual/ website	When and how does the Additional Manual apply when you are providing services to the Customer of the Benefit Plan?*
Sierra	Benefit Plans issued or administered by one of the following entities: • Sierra Health and Life Insurance Co., Inc. • Health Plan of Nevada, Inc. • Sierra Healthcare Options, Inc.	"UnitedHealthcare ChoicePlus Network Outside Nevada" or "UnitedHealthcare Options PPO"	NV	Benefit Plans for Sierra Health and Life Insurance Company, Inc.: sierrahealthandlife.com Benefit Plans for Health Plan of Nevada, Inc.: healthplanofnevada.com	The network for services in Nevada is the applicable Sierra network and not the UnitedHealthcare network; if you are in the applicable Sierra network, services you render in Nevada to Sierra Customers are subject to your Sierra agreement, and the applicable Additional Manual, and not to your UnitedHealthcare agreement or this Guide. Services rendered outside of Nevada to Sierra Customers with the ID card reference described in this row are subject to your UnitedHealthcare agreement and to this Guide, and not to the Additional Manuals described in this row (unless you are in Arizona or Utah and have a contract directly with Sierra).
Empire Plan	Benefit Plans insured by UnitedHealthcare Insurance Company of New York, providing physician and certain ancillary provider benefits for employees of the State of New York and local governments in New York	"The Empire Plan" and/or "NYSHIP"	NY	• Empire Plan Physician & Provider Manual • Empire Plan Home Care Provider Manual UnitedHealthcareOnline.com	The network for services rendered in New York to Empire Plan Customers is the Empire Plan network and not the UnitedHealthcare network, and such services are not subject to your UnitedHealthcare agreement or this Guide. If you are directly contracted to participate in the Empire Plan network, services you render in New York to an Empire Plan Customers are subject to your Empire Plan agreement, and the applicable Additional Manual, and not to your UnitedHealthcare agreement or this Guide. The UnitedHealthcare network is the network for services rendered in AZ, CT, DC, FL, NJ, NC and SC to Empire Plan Customers. Services rendered in those states are subject to your UnitedHealthcare agreement and to this Guide, and not to the Additional Manuals described in this row. For services rendered to Empire Plan Customers in states other than NY, AZ, CT, DC, FL, NJ, NC and SC, the Empire Plan does not use the UnitedHealthcare network; services you render in these states to an Empire Plan Customer are not subject to your UnitedHealthcare agreement or this Guide. If you are directly contracted to participate in the Empire Plan network, services you render to an Empire Plan Customer in states other than NY, AZ, CT, DC, FL, NJ, NC and SC are subject to your Empire Plan agreement, and the applicable Additional Manual.
UHC Community Plan Medicaid, CHIP and Uninsured	Benefit Plans (including Medicaid, CHIP and other non-Commercial state government programs) offered through the UnitedHealthcare Community Plan business unit	"UnitedHealthcare Community Plan" or "Evercare"	Multiple states	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured uhccommunityplan.com	If your agreement specifically references UnitedHealthcare Community Plan or Evercare Medicaid, CHIP or Uninsured protocols or manuals (including references to older brand names such as "AmeriChoice" or "APIPA"), then the UnitedHealthcare Community Plan manual applies, and it supersedes this Guide if there is a conflict.

* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are contracted directly with the affiliate that offers that benefit plan.

Term Used in this Guide	Definition	ID card reference	Location of most Customers subject to Additional Manuals	Additional Manual/ website	When and how does the Additional Manual apply when you are providing services to the Customer of the Benefit Plan?*
UHC Community Plan Medicare Advantage	Medicare Advantage Benefit Plans offered through the UnitedHealthcare Community Plan business unit	"Medicare Community Plan" on the back** of the card. **Note that, in addition to the benefit plans addressed in this row, UnitedHealthcare Community Plan also offers Medicare Advantage benefit plans where the back of the ID card has a reference to "Medicare Solutions", rather than "Medicare Community Plan". Those benefit plans are NOT included in the term "UHC Community Plan" Medicare Advantage," as defined in this row and used in this Guide, and ARE subject to this Guide rather than an Additional Manual.	Multiple states	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicare uhccommunityplan.com	If your agreement specifically references UnitedHealthcare Community Plan Medicare Advantage protocols or manuals (including references to older brand names such as "AmeriChoice" or "APIPA"), then the UnitedHealthcare Community Plan Additional Manual applies, and it supersedes this Guide if there is a conflict.

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 generally posted in the news section of UnitedHealthcareOnline.com and/or in the Network Bulletin. To register to use UnitedHealthcareOnline.com, simply select the 'New User' link in the upper right corner of the UnitedHealthcareOnline.com home page, and follow the prompts. Where required by law, updates will be provided in writing. We may also use additional channels (such as mail, internet, email, phone and fax) to communicate with you in the event a Protocol is modified. We will notify you prior to implementation of a Protocol change if specified in your agreement with us or if required by law. To the extent that some Protocols are applicable only in certain states at the time of printing, we have indicated that in this Guide. Please reference UnitedHealthcareOnline.com to view a complete list of states to which Protocols are applicable.

Network bulletin

UnitedHealthcare publishes 6 editions annually of a user-friendly online notice of updates to policies, protocols, programs and other interesting items. The Network Bulletin helps our network physicians and facilities know about changes throughout UnitedHealthcare lines of business, including, but not limited to, Commercial, Medicaid and Medicare. The Network Bulletin is posted online at UnitedHealthcareOnline.com → Quick Links → Network Bulletin. At this site, you also can sign up to receive the Network Bulletin via email. The email distribution is not limited to only one person in your office – you can have everyone sign up! Postcard announcements are mailed to all contracted providers in January and where required by applicable law to send written notice for the remainder of the year.

* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are contracted directly with the affiliate that offers that benefit plan.

In 2012, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

January 3	March 1	May 1	July 2	September 4	November 1

Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

How to contact us

Commercial & Medicare Products		
Resource	**Where to go**	**What you can do there**
UnitedHealthcare Online®	UnitedHealthcareOnline.com	• Register for UnitedHealthcare Online • Review a Customer's eligibility or benefits and current Health Reimbursement Account (HRA) balances • View Patient Personal Health Records • Submit notifications • Submit referrals or check status of referrals • View claim pre-determination and bundling logic using claim Estimator (for professional claims Commercial Customers only) • Submit professional claims (for Commercial Customers have Real-Time Adjudication capabilities) • Check status of or update existing notifications • Check claims status • Reprint an explanation of benefits (EOB) using the Single EOB Search • Enroll in Electronic Payments and Statements (EPS) for direct deposit and electronic EOBs • 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 tax identification number (TIN)) • Review the physician directory • Look up your fee schedule, 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 • View the Credentialing and Recredentialing Plan • View and register for webcast seminars
	(866) UHC-FAST (842-3278), Option 2	• Get help with UnitedHealthcare Online

Commercial & Medicare Products		
Resource	**Where to go**	**What you can do there**
Electronic Claim Submission (EDI Support Line)	(800) 842-1109, or online at UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Education for Electronic Transactions To obtain information on HIPAA transactions & code sets go to wpc-edi.com/ Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Claims & Payments → Electronic Claims Submissions, under EDI Education for Electronic Transactions	• Obtain information on submitting claims electronically • Use our payer ID 87726 Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Payer List for UnitedHealthcare Affiliates and Strategic Alliances under Electronic Claims.
United Voice Portal	(877) UHC-3210 (842-3210) For a Quick Reference Guide, go to UnitedHealthcareOnline.com → Contact Us → click on the quick reference link under Healthcare for Health care Professionals (United Voice Portal)	• Inquire about a Customer'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 • Check privacy practice information
Provider Relations	UnitedHealthcareOnline.com → Contact Us.	• Physician and Hospital Advocates assist UnitedHealthcare participating providers. Both roles are externally focused. • These advocates are local market and field representatives who are (1) navigational specialists who assist providers with services, product offerings and specific issues and (2) trusted advisors on industry best practices.
Advance Notification and Admission Notification ("Advance Notification" applies to those Customers whose benefit plans require prior authorization and those whose benefit plans do not)	UnitedHealthcareOnline.com or call the United Voice Portal at (877) UHC-3210 (842-3210). See Customer's health care ID card for Customer Care contact information	• Notify us about the procedures and services outlined in the *Notification Requirements* section of this Guide • Communicate with us regarding utilization management issues
Urgent Appeal Submission (Commercial Customers only) (Medicare – follow the directions in the Customer decision letter)	Fax: (801) 994-1083	An expedited appeal may be available to you if the Customer's medical conditions such that the time needed to complete a standard appeal could seriously jeopardize the patient's life, health or ability to regain maximum function.
Erickson Advantage® (A UnitedHealthcare Medicare Advantage product for residents of Erickson Retirement Communities)	See Customer's health care ID card for Customer Care contact information	• Inquire about benefits and services as indicated in this Guide, including Notification Requirements
Pharmacy Services (For Commercial Customers only)	UnitedHealthcareOnline.com Phone: (877) 842-1508 Fax: (877) 842-1435 Fax: (888) 327-9791	• View the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) by drug • Request a copy of the PDL • Call for medications requiring notification • Fax for easy Rx service

Commercial & Medicare Products		
Resource	**Where to go**	**What you can do there**
Pharmacy Services (For Medicare Advantage Customers only)	Go to UHCMedicareSolutions.com → Search the drug list Fax: (877) MDRXFAX (637-9329) Phone: (800) 711-4555 Fax: (800) 527-0531 Fax: (800) 853-3844 Phone: (866) 798-8780, Option 2	• View the UHC Medicare Solutions Part D (MAPD) Formulary or request a copy • Request a prior authorization • Submit request for oral medications • Submit request for injectable medications • Request information on the Medicare Medication Management Program
Behavioral Health Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's behavioral health benefits
Vision Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's vision benefits
Transplant Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's transplant benefits
Customer Care	See Customer's health care ID card for Customer Care contact information	• Obtain information for services as indicated in this Guide
Electronic Payments and Statements (EPS)	UnitedHealthcareOnline.com (866) UHC-FAST (842-3278), Option 5	• Sign up for EPS • Call for questions about EPS
Outpatient Radiology Notification & Authorization Submission and Status	UnitedHealthcareOnline.com Phone: (866) 889-8054 Fax: (866) 889-8061	• Notify us of certain radiology procedures as described in the *Outpatient Radiology Notification* and the *Outpatient Radiology Prior Authorization* section of this Guide
Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers contracted with OptumHealth Physical Health	myoptumhealthphysicalhealth.com Phone: (877) 842-3210	• Verify benefits and eligibility • Check Utilization Review process requirements
Cardiology Notification Submission & Status	UnitedHealthcareOnline.com Phone: (866) 889-8054 Fax: (866) 889-8061	Notify us of certain inpatient, outpatient, and office-based cardiology procedures as described in the *Cardiology Notification* section of this Guide

Health care identification (ID) cards

UnitedHealthcare Customers 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 (such as claims address, copayment information, phone numbers such as those for Customer Care and Advance 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 Customer's health care ID card at each visit and keep a copy of both sides of the ID card for your records.

Checking eligibility and copayment using the health care ID swipe/bar code card

We've implemented a slight change in our card standard for our medical and prescription drug cards. These cards now include prescription information (Rx Bin, PCN and Group) that is shown on the front of the cards in the bar code. This is a new feature that was not previously included on the magnetic stripe. We began issuing the new bar code card in the Fall of 2010 and will continue throughout 2012. You may continue to see cards in the old format through 2012 as we transition. The new health care ID cards are used for:

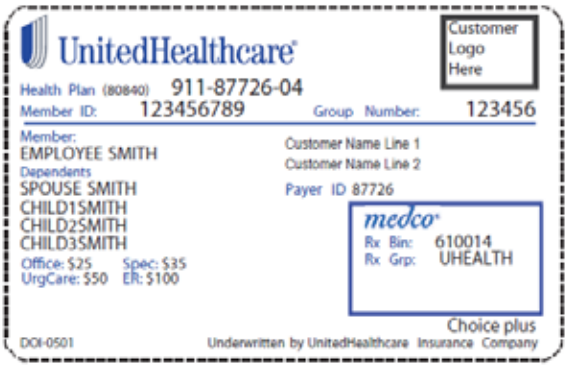
- Rebranded health plans
- New business
- Renewals with plan changes affecting ID cards
- All maintenance replacement cards
- New Customers

The bar code format allows for pharmacy information to be included and can be scanned/photocopied successfully keeping the functionality of the bar code intact. This also allows for electronic technology, such as smart phones, to include a graphic of the ID card bar code which can be read at the point of service.

A 2D bar code scanner is required to use the new cards. The scanner can be used in conjunction with UnitedHealthcareOnline.com to access the Customer'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 Customer ID cards.

In addition to the Swipe Health Care ID Cards Quick Reference, we now have information about purchasing 2D bar code scanners on UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Health Care ID Machine Readable Card 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.

Commercial health care ID card

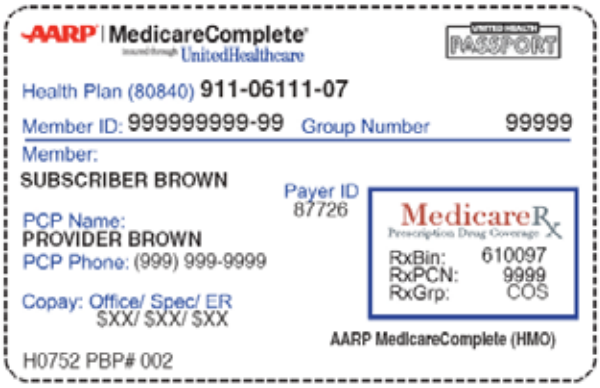


Medicare Advantage health care ID cards

In order to help identify those Customers associated with our Medicare Advantage products, please go to the following provider website for more complete information on ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → UnitedHealthcare Medicare Solutions Physician & Provider Information → Scroll to the "Benefit Plan Name Overviews" section at the bottom of the page.

MedicareComplete (HMO) (formerly SecureHorizons by UnitedHealthcare)

AARP MedicareComplete



Our products

Commercial products

This table provides information about some of the most common UnitedHealthcare products (your agreement with us may use "benefit contract types", "benefit plan types" or a 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 Customer presents an ID card with a product name with which you are not familiar, please contact Customer Care at the number on the back of the Customer's health care ID card. This product list is provided for your convenience and is subject to change over time.

Product Name	How do Customers access physicians and health care professionals?	Is the treating physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Choice and Choice Plus and CORE Choice and CORE Choice Plus	Customers can choose any network physician or health care professional without a referral and without designating a primary physician.* Choice Plus provides out-of-network benefits.** Choice does not (except for emergency).	Yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Select and Select Plus	Customers 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 benefits.** Select does not (except for emergency).	Yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Options PPO	Customers can choose any network physician or health care professional without a referral and without designating a primary physician.* Options PPO provides out-of-network benefits.**	No. Customers are responsible for notifying us at the phone number on their health care ID card, as described under the Customer's benefit plan. Please refer Customers to Customer Care for questions about their responsibilities. In Colorado, yes, on selected procedures. See guidelines in *Notification Requirements* section.
UnitedHealthcare Indemnity	Customers can choose any physician or health care professional.*	No. Customers are responsible for notifying us at the phone number on their health care ID card. Please refer Customers to Customer Care for questions about their responsibilities.
UnitedHealthcare Navigate℠, Navigate Balanced℠, Navigate Plus℠	Customers choose a Primary Physician from the network of physicians for each family member. The Primary Physician makes referrals to network specialists, (except when there is direct access without a referral to a network OB/GYN, for routine refractive eye exams with a network provider, and for mental health/substance abuse disorder services with a network behavioral health clinician). Navigate Plus provides out-of-network benefits**, Navigate and Navigate Balanced do not (except for emergency services).	Yes, on selected procedures. See guidelines *in Prior Authorization and Notification Requirements* section.

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

** The benefit level for non-emergency services from out-of-network physicians and other providers will generally be less than for services from network physicians and other providers.

Consumer-driven health plans

UnitedHealthcare offers consumer-driven health which may be identified via the health care ID card or by looking up your patient's eligibility information at UnitedHealthcareOnline.com. These 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 helpful, support resources designed to influence consumer behavior and health care choices.

UnitedHealthcare Health Reimbursement Account (HRA) fast facts

- The UnitedHealthcare Health Reimbursement Account (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 funded by the employer.
- The 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.
- 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.

UnitedHealthcare Health Savings Account (HSA) fast facts

- The UnitedHealthcare Health Savings Account (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 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 allow annual deposits that can equal the plan's deductible.
- The 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.
- 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.

Medicare Advantage products

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for individuals and employer group retirees. Visit UnitedHealthcareOnline.com; AARPMedicarePlans.com, UHCMedicareSolutions.com, uhcwest.com; or UHCCommunityPlan.com; for more information about our Medicare Advantage products in your area. If a Customer 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 Customer's health care ID card. This product list is provided for your convenience and is subject to change at any time.

This Guide does not apply to our Medicare Advantage Private Fee for Service product, UnitedHealthcare Medicare Direct. This product does not use a contracted provider network. For information about UnitedHealthcare Medicare Direct, go to: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → Private Fee For Service (PFFS).

Medicare Advantage – Products for Individuals

Product Name	Customer's Eligibility	How do Customers access physicians and health care professionals?	Does a primary physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give notice when providing certain services?
HMO and HMO-POS plans under the UnitedHealthcare or AARP brands: • MedicareComplete • MedicareComplete Essential • Medicare Complete Plus • MedicareComplete Plus Essential	Customers who are Medicare eligible	Customers choose a primary physician from the network of physicians to coordinate their care. Medicare Complete 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.	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.	Yes. See guidelines in the *Notification Requirements* section.
Local PPO and Regional PPO (RPPO) plans under the UnitedHealthcare or AARP brands: • MedicareComplete Choice • MedicareComplete Choice Essential	Customers who are Medicare eligible	In most plans, Customers choose a primary physician from the network of physicians to coordinate their care. MedicareComplete Choice PPO plans provide out-of-network coverage for all benefits also covered in-network.**	No. A referral is not needed.	Yes. See guidelines in the *Notification Requirements* section.
Institutional Special Needs Plans (HMO, HMO-POS, PPO, Regional PPO) • UnitedHealthcare Nursing Home Plan	Customers who are Medicare eligible and reside in a contracted institutional setting.	Customers choose a primary physician from the network of physicians, to coordinate their care. PPO and HMO-POS plans provides out-of-network coverage.** HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	No. A referral is not needed.	Yes. See guidelines in the *Notification Requirements* section.
Dual Special Needs Plans (HMO, HMO-POS, PPO and Regional PPO) Plans under the UnitedHealthcare brand	Customers who are Medicare and Medicaid eligible.	In most plans, Customers choose a primary physician from the network of physicians, to coordinate their care. POS and PPO plans provide out-of-network coverage.** HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	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 card and your Tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.	Yes. See guidelines in the *Notification Requirements* section.
Erickson Advantage Plans	Customers who are Medicare eligible and who reside in an Erickson Retirement Community.	Customers are assigned a primary physician from the Erickson Health Medical Group network of physicians. The primary physician coordinates their care. Erickson Advantage provides out-of-network coverage.**	No. A referral is not needed.	Yes. See guidelines in the *Notification Requirements* section.

* Physicians in both the St. Louis, MO market and the South Florida (Miami-Dade, Broward and Palm Beach) 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 other providers will generally be less than that for services from network physicians and other providers.

Medicare Advantage – Products for Groups

Product Name	Customer's Eligibility	How do Customers access physicians and health care professionals?	Does a primary physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give notice when providing certain services?
UnitedHealthcare Group Medicare Advantage (HMO/MCO and HMO-POS)	Customers who are Medicare eligible and meet employer's requirements.	Customers choose a primary physician from the network of physicians. The primary physician coordinates their care. HMO-POS plans provide out-of-network coverage for some covered benefits. ** HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	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.	Yes. See guidelines in the *Notification Requirements* section.
UnitedHealthcare Group Medicare Advantage Plans (Regional PPO)	Customers who are Medicare eligible and meet employer's requirements.	Customers may choose a primary physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care. Regional PPO plans provide out-of-network coverage.**	No. A referral is not needed.	Yes. See guidelines in the *Notification Requirements* section.
UnitedHealthcare Group Medicare Advantage Plans (PPO and National PPO)	Customers who are Medicare eligible and meet employer's requirements.	Customers are not required to choose a primary physician from the network of physicians.	No. A referral is not needed.	. Yes. See guidelines in the *Notification Requirements* section.

* Physicians in both the St. Louis, MO market and the South Florida (Miami-Dade Broward and Palm Beach) market may be required to obtain referral through either a contracted Physician Hospital Organization or other contracted entity, dependent upon contractual arrangement.

** Other than for the UnitedHealthcare Group Medicare Advantage National PPO Plan, the benefit level for non-emergency services from non-network physicians and other providers will generally be less than that for services from network physicians and other providers.

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 that participates in our Medicare Select network. It is a lower cost alternative to standardized Medicare Supplement coverage.

Responsibilities of Medicare Select Customers

To offer the plan at a lower premium, we require that Medicare Select Customers use a participating hospital for all inpatient and outpatient hospital services (except emergency care and services provided when Customers are outside of their service area). If Medicare Select Customers do not use a participating hospital for inpatient or outpatient hospital services, the services will not be covered unless required by law.

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 Customers in the form of lower premium cost.

To submit a Medicare Part A or Part B Intermediary claim for a Medicare Select Customer, mail a copy of the standard Centers for Medicare and Medicaid Services (CMS) billing form along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

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 insured AARP membership number on the standard CMS billing form.

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

Select Plans C & F

- 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 3 pints of unreplaced blood furnished in a calendar year
- Foreign Travel Emergency
- Hospice - the Medicare copayments and coinsurance for Hospice Care and Respite Care

Select Plan F only

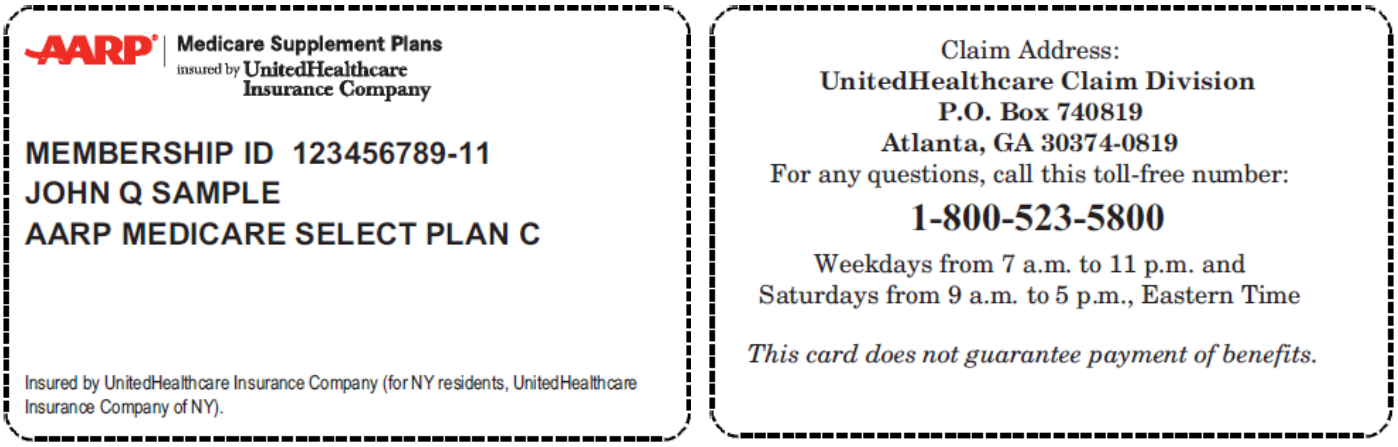
- Medicare Part B Excess Charges for Medicare approved services

What advantages does Medicare Select give to participating hospitals?

- Participating in Medicare Select will likely increase the hospital's access to insured members of AARP because to get the most out of their coverage, Medicare Select Customers must go to a participating hospital. Only participating hospitals will be included in AARP Medicare Select Plan marketing materials within their service area.
- By participating in Medicare Select, the hospital will be limiting its financial exposure to non-payment of the Medicare deductible and coinsurance amounts for inpatient and outpatient hospital services. Under the AARP Medicare Select Plans C and F, neither inpatient hospital stays nor outpatient hospital services, will be covered unless they are received at a participating hospital. The participating 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. If a non-participating hospital provides inpatient or outpatient services to a Medicare Select insured member, the services will not be covered.
- Hospitals can expect to receive claim payment in a timely fashion, as more than 90% of all claims are processed within 10 business days, which reduces hospital collection efforts.
- This product meets "Safe Harbor" requirements under Federal Anti-Kickback legislation.

For more information on Medicare Select and other AARP Medicare Supplement product offerings, contact Customer Service at (800) 523-5800 (para Español (800) 822-0246). For hearing impaired members (TTY), call 711.

Sample AARP Medicare Select Plan ID card



Notification requirements

Notification requirements at a glance

- Physicians, health care professionals and ancillary providers are responsible for Advance Notification for services listed in the *Advance Notification List* section of this Guide, page 19.
- Facilities are responsible for confirming the coverage approval is on file resulting from the *Advance Notifications* (above) prior to the date of services. Please see pages 19-29, below.
- Facilities are responsible for *Admission Notification* for inpatient services even if the coverage approval is on file. Please see page 28.
- Failure to comply with the requirements described in greater detail below may result in claims being denied in whole or in part and, as required under your contract, the Customer being held harmless.

Standard advance notification requirements for physicians, health care professionals and ancillary providers

Why is Advance Notification Required?

- Information gathered about planned customer care supports the care coordination process and, for certain Customers, the pre-service clinical coverage review process.

Why Does Advance Notification Support Different Processes for Different Customers?

- Some Customers have benefit plans that provide for pre-service clinical coverage reviews, while other Customers do not.
- You do not need to determine whether a coverage review is required in a given case or for a given Customer because, for services on the *Advance Notification List*, the process for you to initiate Advance Notification is exactly the same for both types of benefit plans.
- Once you inform us of a service on the *Advance Notification List*, we will tell you whether a clinical coverage review is required and we will inform you what information is necessary to complete the notification or coverage review.
- Once a coverage determination is rendered, you will be informed of the decision.
- It is important that you and the Customer are fully aware of coverage decisions before services are rendered.
- If you provide the service before a coverage decision is rendered, and if we ultimately determine that the service was not covered, we may deny the claim and you must not bill the Customer; this is because your not waiting for the coverage determination made it impossible for the Customer to decide, with knowledge of the non-coverage determination, whether to receive and pay for the services.

- After you inform us of the planned service, we will inform you what information is necessary to complete the notification or coverage review. Once a coverage determination is rendered, you will be informed of the decision.

Who is responsible for Advance Notification?

- Physicians, health care professionals and ancillary providers are responsible for Advance Notification for the services on the list below. Notification is required only for those planned services on the *Advance Notification List*.

What services require Advance Notification?

- Notification is required only for those services on the *Advance Notification List*. In some cases the Customer's benefit documents also require a clinical coverage review.
- Certain services may not be covered within an individual Customer's benefit plan, regardless of whether Advance Notification is required.
- The Advance Notification protocols outlined in this section do not apply to the required notification for certain advanced radiology procedures for specified Commercial plans or to the required notification for certain cardiology procedures for certain Commercial and Medicare plans. Instead of Notification Requirements, our Medicare Advantage Plans require Prior Authorization for certain advanced radiology procedures. The requirements and protocols for those procedures and the plans to which they apply are addressed in the sections entitled, *Outpatient Radiology Notification for Commercial Customers, Radiology Prior Authorization Program for Medicare Advantage Customers and Cardiology Notification Program.*

When is Advance Notification Required?

- Notification should be submitted as far in advance of the planned service as possible to allow for coverage review. Notification is required at least 5 business days prior to the planned service date (unless otherwise specified within the *Advance Notification List*). Note that Notification for home health services is required within 48 hours after the physician's order.
- For a claim involving urgent care, please call the telephone number on the Customer's health ID card (unless specified differently below). You must state that the case is clinically urgent and explain the clinical urgency. Urgent requests for benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize the Customer's life or health, or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Customer's medical condition, could cause severe pain.

How Do You provide Advance Notification?

- Notify us at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification Submission. We will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (also see fax numbers in the *Advance Notification* section). If you do not have electronic access, please call us at the number on the back of the Customer's health care ID card.
- Advance Notifications must contain the following information about the planned service
  - Customer name and Customer health care ID number
  - Ordering physician or health care professional name and TIN or National Provider Identification (NPI)
  - Rendering physician or health care professional name and TIN or NPI
  - ICD-9-CM (or its successor) diagnosis code for the diagnosis for which the service is requested
  - Anticipated date(s) of service
  - Type of service (primary and secondary) procedure code(s) and volume of service (when applicable)
  - Service Setting (outpatient, inpatient, physician office, home or other)
  - Facility name and TIN or NPI where service will be performed (when applicable)
  - Original start date of dialysis (End Stage Renal Disease (ESRD) only)

Please refer to the individual services listed in the *Advance Notification List* below for specific, additional required information. Where a clinical coverage review is provided for in the Customer's benefit plan, we may request additional information in order to make the necessary determination, as described in more detail below in the *Clinical Coverage Review: Clinical Information* section.

- **Note:** Certain services may not be covered within an individual Customer's benefit plan, regardless of whether Advance Notification is required.
- In the event of a conflict or inconsistency between applicable regulations and the notification requirements in this Guide, the notification process will be administered in accordance with applicable regulations.

Clinical coverage review: Clinical information

- You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, providing 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 our care management team and/or medical director. You must provide complete clinical information as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the 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 UnitedHealthcare uses for Commercial products and the UnitedHealthcare Medicare Coverage Summaries Manual used for Medicare Advantage products online at UnitedHealthcareOnline.com → Tools & Resources → Policies and Protocols.
- UnitedHealthcare also may use tools developed by third parties, such as the Milliman Care Guidelines®, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. For Medicare Advantage Customers, we use CMS coverage documents to determine coverage. If Milliman Care Guidelines or any other Medical Policies or CDGs contradict CMS guidance, including National Coverage Determinations and Local Coverage Determinations, then UnitedHealthcare will follow CMS guidance. You may request a copy of the clinical criteria from your Case Reviewer or by calling the Voice Portal at (877) 842-3210.

Advance Notification list

The following list of Advance Notification requirements for physicians, other healthcare professionals and ancillary providers does not indicate or imply coverage. Coverage is determined in accordance with the Customer's benefit plan. In some cases the Customer's benefit documents require a clinical coverage review based on medical necessity; for certain services, the advance notification process will lead to a request for clinical information, a clinical coverage review, and result in a benefit determination.

This table provides information about some of the most common UnitedHealthcare products that have an advance notification requirement. For additional product information in your area, visit UnitedHealthcareOnline.com or refer to the *Our Products* section of this Administrative Guide. Medicare and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in these products. This product list is provided for your convenience and is subject to change over time.

If a Customer presents an ID card with a product name with which you are not familiar, please contact Customer Care at the number on the back of the Customer's health care ID card.

Excluded Plans (benefit plans not subject to the following Advance Notification requirements)*	
• Benefit plans for which the Customer (rather than the physician) is required to provide notification, such as UnitedHealthcare Options PPO and UnitedHealthcare Indemnity • UnitedHealthOne or All Savers MDIPA, OCI, or OneNet • NHP • Oxford • Benefit Plans subject to the River Valley Entities Supplement (as further described on page 4)	• UnitedHealthcare West or UHC West • Sierra • UHC Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described on page 6). As explained on Page 6, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Notification Program • Other benefit plans, such as Medicaid, CHIP and Uninsured, that are neither Commercial nor Medicare Advantage.

* The Advance Notification requirements below will not apply to the listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Advance notification submission methods		
UnitedHealthcare Online	UnitedHealthcareOnline.com	
Phone	See Customer's health care ID card for the phone number unless specified differently below.	
Fax	Commercial Customers:	(866) 756-9733
Fax	Medicare Complete Customers:	(800) 676-4798
Fax	MedicareAdvantage Special Needs Plans Customers (Except Erickson Advantage):	(800) 538-1339
Phone	Erickson Advantage	Call Erickson Campus Customer Service number on the Customer's ID card

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Dental Services due to Accident	• Commercial • Medicare Advantage	• Erickson Advantage	Dental services that meet the following criteria may be eligible for medical coverage depending on the Customer's benefit plan: • Date of initial contact for dental evaluation is within plan limits following the accident. • Initiation of definitive treatment services within guidelines. • Estimated completion date of treatment services, if known. • Certification that the injured tooth was a sound natural tooth. This does not apply to dental services that are excluded under the Customer's benefit plan. Dental implants are not covered under most plans.
Ambulance Transportation (non urgent)	• Commercial • Medicare Advantage	• No applicable exclusions	Non-urgent ambulance transportation (by air, land, other) between specified locations. For Medicare Advantage Customers, non-emergency ambulance transportation must follow Medicare coverage guidelines. Non-emergency transportation by ambulance is covered only if it is documented that the Customer's condition is such that other means of transportation could endanger the person's health (regardless of whether another form of transportation is actually available) and that transportation by ambulance is medically required.
Bariatric Surgery	• Commercial • Medicare Advantage	• Erickson Advantage	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. CPT is a registered trademark of the American Medical Association. ICD-9-CM (or its successor): 44.31, 44.38, 44.39, 44.68, 44.95, 44.96, 44.98 CPT: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999 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. Medicare coverage is based on the guidelines outlined by the CMS. For additional information, consult the CMS National Coverage Determination Database.
Behavioral Health Services	• Commercial • Medicare Advantage	• Erickson Advantage	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 Customer's health care ID card when referring for any mental health or substance abuse/substance use services.

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
BRCA Genetic Testing Program	• Commercial	• Medicare Advantage	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. BRCA testing requires an Advance Notification prior to performing the DNA sequencing. The ordering provider provides notice to the laboratory which would conduct the test, and the laboratory in turn provides notice to UnitedHealthcare. HCPCS: S3818-S3820, S3822-S3823 Genetic counseling is a service that Customers 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 lab, Customers will receive a letter outlining the available genetic counseling service and how to access that service. As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans. Please note: Medicare coverage for genetic testing is based on the guidelines outlined by CMS. For additional information, consult the CMS National Coverage Determination database. For services listed in this section, fax to (866) 756-9733.
Cardiology Notification Program **(See additional requirements in the Cardiology Notification section of this Guide)**	• Commercial • Medicare Advantage	• Erickson Advantage	Notification required for participating physicians for inpatient, outpatient, and office-based diagnostic catheterizations and electrophysiology implants prior to performance. Physician-to-physician review may be required, based on the Cardiology Notification Program Clinical Criteria, to help support physicians in their decision-making process. Notification may be submitted by the rendering physician in one of three ways: 1. Online: Via UnitedHealthcareOnline.com → Notifications → Cardiology Notification Submission and Status 2. Phone: (866) 889-8054 3. Fax: (866) 889-8061 For additional details, including a list of the CPT codes for which notification is required, please visit UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program.
Capsule Endoscopy	• Commercial	• Medicare Advantage	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.
Chiropractic Services	• Commercial • Medicare Advantage	• Erickson Advantage	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 Customer's health care ID card when referring for any chiropractic services.
Cochlear Implants	• Commercial	• Medicare Advantage	Surgically-placed devices used to improve sound recognition.
Congenital Heart Disease	• Commercial • Medicare Advantage	• No Applicable Exclusions	Congenital Heart Disease-related services 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. ICD-9-CM (or its successor): 745.0 through 747.81 CPT: 33251, 33254, 33255, 33256, 33257, 33258, 33259, 33261, 33404, 33414, 33415, 33416, 33417, 33476, 33478, 33500, 33501, 33502, 33503, 33504, 33505, 33506, 33507, 33600, 33602, 33606, 33608, 33610, 33611, 33612, 33615, 33617, 33619, 33641, 33645, 33647, 33660, 33665, 33670, 33675, 33676, 33677, 33681, 33684, 33688, 33690, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33735, 33736, 33737, 33750, 33755, 33762, 33764, 33766, 33767, 33768, 33770, 33771, 33774, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33786, 33788, 33802, 33803, 33820, 33822, 33840, 33845, 33851, 33852, 33853, 33917, 33920, 33924, 93501, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, 93580, 93581

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Durable Medical Equipment (DME) – greater than $1,000	• Commercial • Medicare Advantage	• No Applicable Exclusions	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* in this grid) for Medicare Advantage Customers. Some Home Health Care services may qualify under the DME requirement but is not subject to the $1000 retail purchase or cumulative retail rental cost threshold (see separate Home Health Care Services requirement in this grid). Some payer groups may have different DME notification requirements imposed upon Customers through their benefit plans.
End Stage Renal Disease/ Dialysis Services	• Commercial • Medicare Advantage	• Erickson Advantage	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 Customer travels outside of the service area. CPT: 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 – Non routine 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 UnitedHealthcareOnline.com or call us at (877) 842-3210. In an effort to maximize Customer 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 Customers outside the UnitedHealthcare network.
Home Health Care Services	• Commercial • Medicare Advantage	• No Applicable Exclusions	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) • Speech Therapy (ST)
Hospice (Inpatient)	• Commercial	• Medicare Advantage	Inpatient Hospice services only.
Hyperbaric Oxygen Treatment (Outpatient)	• Commercial	• Medicare Advantage	Non-emergent hyperbaric oxygen treatments require advance notification and benefit review.

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Intensity Modulated Radiation Therapy (IMRT)	• Commercial	• Medicare Advantage	IMRT services require advance notification. CPT: 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 collection form and all supporting information to (866) 756-9733. The UnitedHealthcare IMRT Data collection form can be found at UnitedHealthcareOnline.com.
Joint Replacement (Hip, knee and other)	• Commercial	• Medicare Advantage	Outpatient and inpatient joint replacement procedures in addition to total hip and knee.
MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroid	• Commercial • Medicare Advantage	• No Applicable Exclusions	MR-guided focused ultrasound procedures and treatments, as defined by but not limited to: CPT: 0071T and 0072T MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those benefit plans, which generally are as follows: • The physician and/or facility must confirm coverage of the service for the Customer. • The hospital and/or facility must be contracted with UnitedHealthcare. UnitedHealthcare Customers have no out-of-network benefits for MRgFUS. • The Customer 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 Customer must agree in writing to hold UnitedHealthcare harmless if he or she 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.
Orthopaedic and Spine Surgeries	• Commercial • Medicare Advantage	• No Applicable Exclusions	Inpatient and outpatient spinal surgeries, total knee replacements and total hip replacements. Advance Notification can be submitted online at UnitedHealthcareOnline.com.
Part B Occupational Therapy (OT), Speech Therapy (ST) or Physical Therapy (PT) **(Part B OT, ST or PT provided in a SNF.)**	• Medicare Advantage • Erickson Advantage Customers/ members residing in a long-term care facility.	• Commercial • UnitedHealthcare Nursing Home Plans	
Physical Therapy/ Occupational Therapy (PT/OT)	• Commercial	• Medicare Advantage	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 Customer's health care ID card before referring for any PT/OT services.
Prosthetic and Orthotic Services Greater than $1,000	• Medicare Advantage • Commercial	• No applicable exclusions	Prosthetic and orthotic services with a retail purchase cost or cumulative retail rental cost exceeding $1,000.

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Radiology Notification (See additional requirements in the *Outpatient Radiology Notification* section of this Guide)	• Commercial	• Medicare Advantage	For Commercial benefit plans, we require advance notification for the following defined set of Advanced Outpatient Imaging Procedures: CT , MRI, MRA, PET scan, 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 Advanced Outpatient Imaging Procedures. Ordering physicians/health care professionals must obtain the required notification number by contacting UnitedHealthcare through any of the following: Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status Phone: (866) 889-8054 (Direct line) Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization → Radiology Notification → Notification Resources: Modality-specific Fax Forms) 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 & Authorization → Radiology Notification → Notification Resources: Reference Materials
Radiology Prior Authorization (See additional requirements in the *Radiology Prior Authorization Program (for Medicare Advantage Customers)* section of this Guide)	• Medicare Advantage	• Commercial • Erickson Advantage	For Medicare Advantage benefit plans, UnitedHealthcare requires prior authorization for the following defined set of Advanced Outpatient Imaging Procedures: CT scan, MRI, MRA, PET scan, Nuclear Medicine and Nuclear Cardiology. The physician/health care professional ordering the imaging service is responsible for obtaining an authorization number prior to scheduling the outpatient imaging procedures. Ordering physicians/health care professionals must obtain the required authorization number by contacting UnitedHealthcare through any of the following: Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization – Submission & Status Phone: (866) 889-8054 (Direct line), Fax: (866) 889-8061 (A fax form is available to download at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Modality-specific Fax Forms) Additional details regarding this prior authorization requirement, including a list of the CPT codes for which prior authorization is required are available online at: UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Reference Material

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Reconstructive/ Potentially Cosmetic Procedures	• Commercial • Medicare Advantage	• No Applicable Exclusions	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. To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to: • 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 • Blepharoplasty, upper lid – reconstructive procedures including repair of brow ptosis • Breast Reconstruction – reconstruction of the breast other than following mastectomy • Breast Reduction – removal of breast tissue in men or women other than mastectomy for cancer • Cranial remolding helmet – for treatment of congenital musculoskeletal deformities • Genioplasty - sliding, augmentation with interpositional bone grafts • Mastectomy for gynecomastia • Orthognathic Surgery – treatment of maxillofacial functional impairment • Panniculectomy or Abdominoplasty– Excision, excessive skin and subcutaneous tissue (includes lipectomy) • Septoplasty – treatment of nasal functional impairment and septal deviation • Thoracoscopy – sympathectomy for treatment of hyperhidrosis
Referral for Out-of-Network Services	• Commercial • Medicare Advantage	• No Applicable Exclusions	Please note that your agreement with UnitedHealthcare may include restrictions on directing Customers outside the UnitedHealthcare network. Your patients who use non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses or no coverage. **For Commercial Customers:** Notification is required when a network physician or health care professional directs a Customer to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a Customer's benefit plan has benefits for out-of-network services. **For Medicare Advantage Customers:** Notification is required for Medicare Advantage members when: 1. A network physician or health care professional directs a Customer to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a Customer's benefit plan does not have benefits for out-of-network services. 2. A network physician or health care professional directs a Customer to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a Customer's benefit plan does have benefits for out-of-network services, but there are no network providers available for the type of specialty services needed by the Customer. Notification is not required for Medicare Advantage Customers whose plans have out-of-network benefits, if the Customer is choosing an out-of-network provider even though an in-network provider is available. Notification is not required for Medicare Advantage National PPO Customers, regardless of whether an in-network provider is available.
Sleep Apnea Procedures and Surgeries	• Commercial	• Medicare Advantage	Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea. To confirm coverage, we require notification for such services whether scheduled as inpatient or outpatient, including but not limited to: Palatopharyngoplasty - oral pharangeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup)

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Specialty Drug Prior Authorization (See additional requirements in the *Specialty Drug Prior Authorization Program (for Medicare Advantage Customers)* section of this Guide)	• Medicare Advantage	• Commercial	For Medicare Advantage benefit plans, UnitedHealthcare requires prior authorization for the medical use of certain specialty drugs. A complete list of the specialty drugs requiring prior authorization is available online at: UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug. All physicians who provide medical use of certain specialty drugs are required to obtain a prior authorization prior to the administration of the specialty drug being rendered in an office or an outpatient setting. Physicians and facilities who render specialty drugs within the scope of this protocol must confirm that prior authorization has been obtained, or payment for their services may be denied. Ordering Providers must obtain authorization. Servicing Providers must confirm that an approved authorization is on file. Ordering physicians/health care professionals can obtain the required authorization number by contacting UnitedHealthcare through any of the following: • Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization Submission & Status(Medicare Part B) • Phone: (866) 889-8054 (Direct line) Additional details regarding this prior authorization requirement are available online at: UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug
Specific Medications as Indicated on the Prescription Drug List (PDL)	• Commercial	• Medicare Advantage	Call (877) 842-1435 when prescribing medications that require notification. These medications are so designated on the PDL. To view the Prescription Drug List PDL, visit UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources, or call (877) 842-1508 to request a copy of our PDL.
Surgical treatment of obstructive sleep apnea	• Commercial	• Medicare Advantage	Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea. Not applicable to diagnostic procedures related to sleep studies.
Transplant Services	• Commercial • Medicare Advantage	• No Applicable Exclusions	For services listed in this section, call OptumHealth directly at (888) 936-7246 or the notification number on the back of the Customer's 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:
			BONE MARROW - Peripheral Stem Cell 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

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Transplant Services (continued)			HEART / LUNG 33930 Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft 33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy
			HEART 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
			LUNG 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
			KIDNEY 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)
			PANCREAS 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
			LIVER 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
			INTESTINE 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

Standard notification requirements for facilities (for most states*)

Confirming Coverage Approvals:

- For any inpatient or outpatient service on the *Advance Notification list* (except for those benefit plans excluded from the Advance Notification Protocol by the table on page 20) the facility must confirm, prior to rendering the service, that the coverage approval is on file. The purpose of this Protocol is to enable the facility and the Customer to have an informed pre-service conversation, in those cases where it is determined that the service will not be covered, so that the Customer can decide whether to receive and pay for the service.
- If the facility fails to confirm that the coverage approval is on file and instead performs the service before a coverage decision is rendered:
  - If the service is ultimately determined not to have been covered under the Customer's benefit plan, then UnitedHealthcare may deny the facility's claim for the non-covered service and, as provided under the facility's contract, the facility must not bill the Customer or accept payment from the Customer, in light of the facility's non-compliance with UnitedHealthcare's notification Protocols.
  - If a coverage review is in process on the date of service as a result of the Advance Notification request AND that coverage review ultimately determines the service to have been a Covered Service under the Customer's Benefit Contract, UnitedHealthcare will not deny the facility's claim despite the facility's failure to take specific action to confirm the coverage approval.

Admission Notification:

Excluded Plans (benefit plans not subject to the following Admission Notification requirements)*	
• Benefit plans for which the Customer (rather than the physician) is required to provide notification, such as UnitedHealthcare Options PPO and UnitedHealthcare Indemnity • UnitedHealthOne or All Savers • MDIPA, OCI, or OneNet • NHP • Oxford • Benefit Plans subject to the River Valley Entities Supplement (as further described on page 4) • Sierra	• UnitedHealthcare West or UHC West • Erickson Advantage • UHC Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described on Page 6). As explained on Page 6, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Cardiology Notification Program. • Other benefit plans, such as Medicaid, CHIP and Uninsured, that are neither Commercial nor Medicare Advantage.
* The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.	

- Facilities are responsible for Admission Notification for the following types of inpatient admissions:
  - All planned/elective admissions for acute care
  - All unplanned admissions for acute care
  - All Skilled Nursing Facility (SNF) admissions
  - All admissions following outpatient surgery
  - All admissions following observation
  - All newborns admitted to Neonatal Intensive Care Unit (NICU)
  - All newborns who remain hospitalized after the mother is discharged (within 24 hours of the mother's discharge)
- Admission Notification must be received within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 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.

* For state specific variations, please refer to UnitedHealthcareOnline.com → Tools and Resources → Policies and Protocols → Advance and Admission Notification.

- Admission Notification by the facility is required even if Advance Notification was supplied by the physician and a pre-service coverage approval is on file.
- Admission Notifications must contain the following details regarding the admission:
  - Customer name and Customer ID number
  - 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 Customer 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 not apply any notification-related reimbursement deductions.

Reimbursement reductions for failure to timely provide Admission Notification

If a facility does not provide timely admission notification as described above, reimbursement reductions will apply as follows:

Notification Timeframe	Reimbursement Reduction
Admission Notification received after it was due, but not more than 72 hours after admission	100% of the average daily contract rate[1] for the days preceding notification[2]
Admission Notification received after it was due, and more than 72 hours after admission, Or No Admission Notification received	100% of the contract rate (entire stay)

1 The average daily contract rate is calculated by dividing the contract rate for the entire stay by the number of days for the entire length of stay.

2 Reimbursement reductions will not be applied to "case rate facilities" if admission notification is received after it was due, but not more than 72 hours after admission. As used here, "case rate facilities" means those facilities in which reimbursement is determined entirely by a MS-DRG or other case rate reimbursement methodology for every inpatient service for all benefit plans subject to these *Admission Notification* requirements.

Reimbursement reductions will not be imposed for maternity admissions.

Concurrent Review: Clinical Information

- You must cooperate with all UnitedHealthcare requests for information, documents or discussions 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 cooperate with all UnitedHealthcare requests from the inpatient care management team and/or medical director to engage our Customers directly face-to-face or telephonically.
- You must return/respond to inquiries from our inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the 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 sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. You may request a copy of the clinical criteria from your Case Reviewer or by calling the Voice Portal at (877) 842-3210.

Voluntary Notification list for Case and Disease Management Enrollment

The following list of Voluntary Notification requirements for physicians, other healthcare professionals and ancillary providers is for the purposes of enrolling our Customers in Case and Disease Management programs offered through OptumHealth. Additionally, notifications assist OptumHealth in identifying Customers for outbound calls to explain benefits and other programs. This list does not indicate or imply coverage. Coverage is determined in accordance with the Customer's benefit plan.

Procedures & services	Notification Required for:	Notification NOT Required for:	Explanation
Cancer Treatment Initiation	• Commercial	• Medicare Advantage	Initiation of cancer treatment for a diagnosis other than skin cancer or cervical cancer. Notification is required to assist us in identifying Customers that may be eligible for additional OptumHealth programs and services. For services listed in this section, call OptumHealth Cancer Resource Services directly at (866) 936-6002.
Healthy Pregnancy	• Commercial • Medicare Advantage	• Erickson Advantage	Upon confirmation of pregnancy, a notification is required by physicians or other health care professionals who provide obstetrical care to a pregnant Customer for: ICD-9-CM (or its successor): V72.42 or any other diagnosis code related to pregnancy. Notification provides OptumHealth with an opportunity to enroll pregnant members in the Healthy Pregnancy Program prior to the delivery of the baby. 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 Customer is no longer appropriate for a Healthy Pregnancy Program, for instance due to termination of the pregnancy, we ask that you notify us of that fact.

Cardiology Notification Program

The UnitedHealthcare Cardiology Notification Program will not apply to the following benefit plans. However, these benefit plans may have separate cardiology notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Excluded Commercial Plans (benefit plans not subject to the following Cardiology Notification requirements)*
Commercial benefit plans for which the Customer (rather than the physician) is required to provide notification, such as: • UnitedHealthcare Options PPO • UnitedHealthcare Indemnity
The following benefit plans: • UnitedHealthOne or All Savers • MDIPA, OCI, or OneNet • NHP • Oxford • Benefit Plans subject to the River Valley Entities Supplement (as further described on Page 4) • Sierra • UnitedHealthcare West or UHC West * The Cardiology Notification requirements below will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Excluded Medicare Advantage Plans (benefit plans not subject to the following Cardiology Notification requirements)*
• Florida: AARP Medicare Complete® Plan 1, HMO Gatekeeper Product Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021. UnitedHealthcare Dual Complete™ Group 29006 and 29007. UnitedHealthcare Medicare Advantage (HMO) Group 54011 and 54012. Existing process of obtaining authorization from Managed Service Organizations will continue. • UHC Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described on Page 6). As explained on Page 6, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Cardiology Notification Program. • Erickson Advantage® Plans • UnitedHealthcare® Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP) • UnitedHealthcare® Senior Care Options (HMO SNP)
The following benefit plans: • UnitedHealthcare West or UHC West • Sierra • Senior Dimensions Medicare Advantage plans. * The Cardiology Notification requirements below will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Other Excluded Plans
The UnitedHealthcare Cardiology Notification Program does not apply to other benefit plans, such as Medicaid, CHIP and Uninsured, that are neither Commercial nor Medicare Advantage.

State roll-out schedule

As of the date of the publishing of this Guide, 36 states and the District of Columbia participate in the Cardiology Notification Program. For information showing each state's participation status in this Program, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program for the latest information. If additional states are added, you will receive a written notice if you participate in that state.

Except as noted above, the Cardiology Notification Program requirements described below apply to all participating physicians ("Physicians") who perform diagnostic catheterizations and electrophysiology implant procedures on UnitedHealthcare Customers. Even Physicians who have received the UnitedHealthcare Premium quality and efficiency of care designation are required to comply with this notification requirement.

- This protocol is a notification requirement, not a precertification, preauthorization or medical necessity determination. Notification under this protocol is required for services rendered in all settings (e.g., outpatient, inpatient and office-based).
- Physician/Provider should not delay emergency care in order to notify. If a diagnostic catheterization or electrophysiology implant procedure is required on an emergent basis or during the course of an inpatient admission, the service should be performed, and notification can be provided retrospectively. Physicians/Providers should follow the Retrospective Notification Process described below.
- Compliance with this Protocol is required. Unless the entire notification process is completed (including a physician-to-physician discussion in some cases), a notification number will not be issued. Further, failure to complete the entire process may result in an administrative reimbursement reduction, individual claim line denial for the CPT codes subject to this protocol, and any action available under the terms of the Physician's participation agreement.
- The procedures subject to this notification requirement include:
  - Diagnostic catheterization procedures include, for example, coronary arteriogram, left heart catheterizations, and combined left-right heart catheterizations.
  - Electrophysiology implants include, for example, pacemaker and automated implantable cardiodefibrillators.

A list of CPT codes that are subject to this notification requirement is available online at UnitedHealthcareOnline. com → Clinician Resources → Cardiology → Cardiology Notification Program → Important Program Information.

Process for Physician:

- To receive payment for services rendered, prior to performing the stated diagnostic catheterization or electrophysiology implant procedure, the rendering Physician must:
- Contact us and follow the notification process:
  - Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification Submission and Status
  - Phone: (866) 889-8054
  - Fax: (866) 889-8061 (A fax form is available for download at UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program → Important Program Information)
- If the procedure requested for the Customer is not consistent with the Cardiology Notification Program Clinical Criteria or if further information is needed to assess the request, the Physician (or his or her designee such as a covering physician, physician's assistant, or nurse practitioner) must participate in a physician-to-physician dialogue to discuss the clinical rationale for the request, to provide additional clinical information as required and to discuss alternate approaches. Upon completion of the discussion, the rendering Physician (or their Physician designee) will confirm the procedure ordered and a notification number will be issued. The rendering Physician maintains final decision authority for the performance of the procedure.
- Please note that notification is required of the rendering Physician. However, notification will be accepted on behalf of the rendering Physician from either the Physician's office staff or the facility if the staff or facility has relevant clinical information to complete the notification process.

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

Customer's information

- Customer's UnitedHealthcare ID number
- Customer name, address and phone number
- Customer group number
- Customer date of birth

Physician information

- Physician name, TIN, specialty, address, and phone number
- The contact person at the Physician's office

Procedure/clinical information

- The procedure being requested, with the CPT code(s)
- The diagnosis or "rule out" with the ICD-9-CM (or its successor) code(s)
- The Customer's symptoms, listed in detail, with severity and duration. Treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Dates of prior imaging studies performed
- Any other information that the Physician believes will help in evaluating the request including, but not limited to, prior diagnostic tests, consultation reports, etc.

Note: The receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was made. Medical coverage and payment authorization is a separate process determined by the Customer's benefit plan and the Physician's participation agreement with UnitedHealthcare.

Urgent requests during regular business hours

The Physician/Provider may request a notification number on an "urgent" basis if the Physician/Provider determines it

to be medically required. Urgent requests should be requested via telephone by calling (866) 889-8054. The Physician/Provider must state that the case is clinically urgent and explain the clinical urgency. The notification number will be issued for urgent requests within 3 hours of our receiving all required information.

Urgent requests outside of regular business hours

If the Physician/Provider determines that a service is medically required on an urgent basis, and notification cannot be provided because it is outside of UnitedHealthcare's normal business hours the service may be performed and a notification number must be provided retrospectively following the Retrospective Notification Process described below.

Retrospective Notification process

- A Physician should not delay emergency care in order to notify. If a diagnostic catheterization or electrophysiology implant procedure is required on an emergent basis, the service should be performed, and notification can be provided retrospectively.
- In order to make sure that patient care is not delayed while in the inpatient setting, the Retrospective Notification Process is available for procedures performed during the course of an inpatient admission if the patient is admitted for a reason other than the procedures subject to this Protocol. For example, if a patient is admitted for a reason other than the procedures subject to this Cardiology Notification Protocol, and a cardiac consult indicates that a diagnostic catheterization or electrophysiology implant is required, the Physician should proceed with the procedure and obtain the notification number on a retrospective basis within 30 calendar days after the date of service. This Retrospective Notification Process does not apply to the facility's separate admission notification requirement.
- Retrospective Notification requests must be made within 30 calendar days after the date of service.
- Documentation must include an explanation as to why the procedure was required on an emergent basis and why notification could not be provided during UnitedHealthcare's normal business hours or explain the circumstances under which the service was provided during an inpatient admission.
- Rendering Physicians should follow the same notification process outlined above for a standard request.
- Claims submitted prior to the Retrospective Notification process being completed will receive an automated denial for lack of notification; however, the claim will be reprocessed automatically if Retrospective Notification is received within 30 calendar days after the date of service, and it meets criteria as an emergent procedure.

Outpatient Radiology Notification (for Commercial Customers only)

The UnitedHealthcare Commercial Radiology Notification Program does not apply to the following benefit plans. However, these benefit plans may have separate Radiology Notification or Prior-Authorization requirements. Please refer to the applicable Additional Manual listed on pages 3-6 of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following Outpatient Radiology Notification requirements)
Commercial benefit plans for which the Customer (rather than the physician) is required to provide notification, such as: • UnitedHealthcare Options PPO • UnitedHealthcare Indemnity
The following benefit plans: • UnitedHealthOne or All Savers • MDIPA, One Net or OCI • NHP • Oxford • Benefit Plans subject to the River Valley Entities Supplement (as further described on Page 4) • Sierra • UnitedHealthcare West or UHC West • Benefit plans sponsored or issued by certain self-funded employer groups • Additionally, this Radiology Notification Program does not apply to non-Commercial benefit plans such as Medicare Advantage, Medicaid, CHIP and Uninsured

The Outpatient Radiology Notification requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers ("Physicians/Providers") that order or render Advanced Outpatient Imaging Procedures. Advanced Outpatient Imaging Procedures are: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology.

This Protocol is a prior notification requirement, not a precertification, preauthorization or medical necessity determination. Notification under this Protocol is required for outpatient services only. Imaging services rendered in, and appropriately billed with, any of the following places of service do not require notification: emergency room visits, in an urgent care center, in the observation unit or during an inpatient stay.

- 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 Customer is performed and the claim is submitted without a notification number, an administrative claim reimbursement reduction, in part or in whole, will occur.

To see the states in which this Protocol applies, or for the most current listing of CPT codes that require Notification, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Authorization. If additional states are added to the program, we will communicate that information to impacted Physicians/Providers.

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:
  - Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status
  - Fax: (866) 889-8061
  - Phone: (866) 889-8054
- The information listed below may be requested at the time of the notification request:

Customer/procedure information

- Customer's name and Customer's UnitedHealthcare ID number
- Customer's address and phone number
- Customer's group number
- Customer'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/Provider's name, TIN/NPI, specialty, address, and phone number
- Physician/Provider to whom the Customer is being referred, if specified, address and phone number
- Rendering Physician's/Provider's name and TIN/NPI

Clinical information

- The Customer'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 issued to the ordering Physician/Provider.

OR

- If the imaging study requested for the Customer is not consistent with evidence-based clinical guidelines, or if further information is needed to assess the request, the ordering Physician/Provider must participate in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss 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/Provider 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.

- The notification number will be issued to the ordering Physician/Provider when the notification process is completed. The notification number will be communicated by phone, 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 Procedure. Please note that the receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was given. Medical coverage/payment authorization is a separate process determined by the Customer's benefit contract and your agreement with us.

Urgent requests during regular business hours

The ordering Physician/Provider may request a notification number on an urgent basis if the Physician/Provider determines that rendering the service urgently is medically required. Urgent requests should be requested via the phone by calling (866) 889-8054. The ordering Physician/Provider must state that the case is clinically urgent and explain the clinical urgency. We will issue a notification number for urgent requests within 3 hours of our receipt of all required information.

Urgent requests outside of regular business hours

If the ordering Physician/Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis and notification cannot be provided because it is outside of UnitedHealthcare's normal business hours, the service may be performed and notification must be provided retrospectively following the Retrospective Notification process described below.

Retrospective Notification

- Retrospective Notification requests must be made within 2 business days after the Advanced Outpatient Imaging Procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why notification could not have been provided during UnitedHealthcare's normal business hours.
- Ordering Physicians/Providers should follow the same notification process outlined above for a standard request.

Rendering Physician/Provider

Except as provided in this Protocol, in order to be eligible to receive payment for covered services rendered, the rendering Physician/Provider must validate with us prior to performing an Advanced Outpatient Imaging Procedure that a notification number is on file, by contacting us as follows:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - 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 number on file, and the ordering Physician/Provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to obtain the notification number from the participating ordering Physician/Provider prior to the rendering of services.

If the rendering Physician/Provider determines there is no notification number on file, and the ordering Physician/Provider does not participate in UnitedHealthcare's network, and is unwilling to complete the notification process, the rendering Physician/Provider is required to complete the notification process. If the rendering Physician/Provider does not provide notification for services ordered by a non-participating Physician/Provider, the rendering Physician/Provider's claim will be denied administratively, in part or in whole, for failure to provide notification, and the Customer cannot be billed for the service.

Provision of additional Advanced Outpatient Imaging Procedures

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Physician/Provider determines that additional Advanced Outpatient Imaging Procedure(s) should be delivered above and beyond the service(s) for which a notification number has already been obtained, a new notification number must be obtained in accordance with the protocol above, prior to rendering the additional procedure.

Provision of a modified Advanced Outpatient Imaging Procedure

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Physician/Provider determines that the procedure for which a notification number has already been obtained must be modified, the modified service may be performed, and the notification number request may need to be modified in accordance with the process described below:

- **Modifications within the CPT Code Crosswalk Table:**
  For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, Physicians/Providers will not be required to contact UnitedHealthcare to modify the existing notification number request. The CPT Code Crosswalk Table is available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification → Notification Resources: Reference Materials.
- **Modifications outside of the CPT Code Crosswalk Table:**
  In instances where the CPT code for the procedure for which a notification number has been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, a modification to the original notification number request must occur as follows:
  - If the procedure being performed is for a contiguous body part, either the ordering or rendering Physician/Provider must modify the original notification number request by calling (866) 889-8054 or online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status. The request must be modified within 2 business days after the procedure is rendered.
  - If the procedure being performed is not for a contiguous body part, the ordering Physician/Provider must obtain a new notification number. A test for a different, noncontiguous body part will be considered a new request for a notification number.

Radiology Prior Authorization Program (for Medicare Advantage Customers)

The UnitedHealthcare Medicare Advantage Radiology Prior Authorization Program does not apply to the following benefit plans. However, these benefit plans may have separate radiology notification or prior-authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following outpatient radiology prior authorization requirements)
• Florida: AARP Medicare Complete Plan 1, HMO Gatekeeper Product Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021. UnitedHealthcare Dual Complete Group 29006 and 29007. UnitedHealthcare Medicare Advantage (HMO) Group 54011 and 54012. Existing process of obtaining authorization from Managed Service Organizations will continue. • UHC Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described on Page 6). As explained on Page 6, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Radiology Prior Authorization Program . • Erickson Advantage Plans • UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP) • UnitedHealthcare Senior Care Options (HMO SNP)
The following benefit plans: • UnitedHealthcare West or UHC West • Sierra • Senior Dimensions Medicare Advantage plans. Additionally, this Medicare Advantage Radiology Prior Authorization Program does not apply to Commercial Benefit Plans or to other benefit plans, such as Medicaid, CHIP and Uninsured, that are not Medicare Advantage.

The outpatient Radiology Prior Authorization Requirements in this Protocol apply to all participating physicians, health care professionals, facilities and ancillary providers ("Physicians/Providers") that order or render Advanced Outpatient Imaging Procedures. Advanced Outpatient Imaging Procedures are: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology.

Please note that only select services within these radiology modalities will require prior authorization. For a complete list of services that require prior authorization, please visit UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program.

Prior authorization is required for outpatient advanced imaging services only. Imaging services rendered in and appropriately billed with any of the following places of service do not require prior authorization:

- emergency room visit in the observation unit,
- in an urgent care center, or
- during an inpatient stay.

Compliance with this Protocol is required. Incomplete prior authorization and/or non-authorization rates will be tracked through physician data sharing reports.

Failure to complete the Radiology Prior Authorization process will result in an administrative denial. Claims denied for failure to request prior authorization may not be billed to the Customer. Failure to meet clinical criteria will result in a denial for lack of medical necessity, because services that are not medically necessary are not covered under Medicare Advantage plans. Upon issuance of the denial for lack of medical necessity, the Customer and Physician/Provider will receive a denial notice with the appeal process outlined. Providers that render Advanced Outpatient Imaging Procedures within the scope of the Protocol must confirm that prior authorization has been obtained, or payment for their services may be denied (for both technical and professional components).

To see the states in which this Protocol applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program. If additional states are added to the program, we will communicate that information to impacted Physicians/Providers.

Please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program for the latest information on this program.

Ordering Physician/Provider:

The Physician/Provider ordering the imaging service is responsible for obtaining a prior authorization number prior to scheduling Advanced Outpatient Imaging Procedures. A Physician/Provider may obtain the required prior authorization number by contacting us via:

- Online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status, or
- By calling toll-free (866) 889-8054, or
- Faxing to (866) 889-8061. Fax forms can be found on UnitedHealthcareOnline.com → Clinician Resources → Radiology Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Modality-specific Fax Forms

Information required for a Prior Authorization request:

Customer/procedure information

- Customer's health care ID number
- Customer's group number
- Customer's name
- Customer's date of birth
- Customer's phone number and address (optional)
- Ordering Physician/Provider information
- Ordering Physician/Provider's TIN
- Ordering Physician/Provider's last name
- Ordering Physicians/Provider's phone number
- Ordering Physician/Provider's fax number
- Contact person at the ordering Physician/Provider's office

Clinical information

- The examination(s) being requested, with the CPT code(s)
- The working diagnosis or "rule out" with the ICD-9 code(s)
- The Customer's symptoms, listed in detail, with severity and duration. Any treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Any other information that the physician believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.
- Dates of prior imaging studies performed.

Rendering Physician/Provider information

- Rendering Physician/Provider's last name, first name
- Rendering Physician/Provider's address
- Rendering Physicians/Provider's phone number
- Rendering Physician/Provider's fax number

The prior authorization number will be issued to the ordering Physician/Provider when the prior authorization process is completed. The prior authorization number will be communicated by phone, fax and/or online, consistent with how the request was initiated. To help ensure proper payment, the authorization number should be obtained and communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to perform the imaging procedures.

Please note that receipt of an authorization means that the service was medically necessary. It does not guarantee or authorize payment. Payment of covered services is contingent upon the Customer being eligible for services on the date of service, the provider being eligible for payment, any claim processing requirements, and the Physician/Provider participation agreement with UnitedHealthcare.

The prior authorization number is valid for 45 days. When a prior authorization number is entered for a procedure, UnitedHealthcare will use the day prior authorization was issued as the starting point for the 45 day period in which the examination must be completed. If a procedure is not completed within 45 days, a new prior authorization number must be obtained.

Urgent requests during regular business hours

The ordering Physician/Provider may request a prior authorization number on an "urgent" basis if the Physician/Provider determines rendering the services urgently to be medically required. Urgent requests should be requested via the phone by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers. The ordering Physician/Provider must state that the case is clinically urgent and explain the clinical urgency.

The prior authorization number will be issued for urgent requests within 3 hours of our receiving all required information.

If the Physician/Provider determines that care must be provided before a prior authorization number can be issued on an urgent basis, the services should be performed and the prior authorization requested retrospectively following the Retrospective Prior Authorization process described below.

Urgent requests outside of regular business hours

If the ordering Physician/Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and prior authorization cannot be provided because it is outside of UnitedHealthcare's normal business hours the service may be performed and a prior authorization number must be provided retrospectively following the Retrospective Prior Authorization process described below.

Retrospective Prior Authorization

If an Advanced Outpatient Imaging Procedure is required on an urgent basis or prior authorization cannot be obtained because it is outside of our normal business hours, the service may be performed and authorization requested retrospectively.

- Retrospective authorization requests must be made within 2 business days after the Advanced Outpatient Imaging Procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why prior authorization could not be obtained during UnitedHealthcare's normal business hours. The ordering Physician/Provider should follow the same prior authorization process outlined above for a standard request.

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 UnitedHealthcare that an approved prior authorization number is on file by contacting UnitedHealthcare via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status
- Phone: (866) 889-8054 - select the appropriate option for Medicare Advantage Customers

If there is no prior authorization number on file, and the ordering Physician/Provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to request that the participating ordering Physician/Provider obtain prior authorization prior to the rendering of services.

If there is no prior authorization number on file, and the ordering Physician/Provider does not participate in UnitedHealthcare's network and is unwilling to complete the prior authorization process, the rendering Physician/

Provider is required to complete the prior authorization process. If the rendering Physician/Provider does not obtain a prior authorization number for services ordered by a non-participating physician/provider, the rendering Physician/Provider's claim will be denied administratively in part or in whole for failure to obtain prior authorization and the Customer cannot be billed for the service.

Note: Non-participating Physicians/Providers can still submit prior authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers.

Provision of additional Advanced Outpatient Imaging Procedures

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Physician/Provider determines that an additional Advanced Outpatient Imaging Procedure should be performed above and beyond the service(s) for which a prior authorization number has been obtained already, a new prior authorization number must be obtained in accordance with the Program above prior to rendering the additional procedure.

Provision of a modified Advanced Outpatient Imaging Procedure

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Physician/Provider determines that the procedure must be modified from the procedure for which a prior authorization number has already been obtained, the service may be performed, and the prior authorization request may need to be modified in accordance with the process described below:

- **Modifications within the CPT Code Crosswalk Table:**
  For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, Physicians/Providers will not be required to contact UnitedHealthcare to modify the existing prior authorization number request. This CPT Code Crosswalk Table is available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Reference Materials.
- **Modifications outside of the CPT Code Crosswalk Table:**
  In instances where the CPT code for the procedure for which a prior authorization number has been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, a modification to the original prior authorization number request must occur as follows:
  - If the procedure being performed is for a contiguous body part, either the ordering or rendering Physician/Provider must modify the original prior authorization number request by calling (866) 889-8054 or online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status. The request must be modified within 2 business days after the procedure is rendered.
  - If the procedure being performed is not for a contiguous body part, the ordering Physician/Provider must obtain a new prior authorization number. A test for a different, noncontiguous body part will be considered a new request.

Specialty Drug Prior Authorization Program (for Medicare Advantage Customers only)

The UnitedHealthcare Medicare Advantage Specialty Drug Prior Authorization Program will not apply to the following benefit plans. However, these benefit plans may have separate specialty drug notification/authorization requirements. Please refer to the applicable Additional Manual(s) listed on pages 3-6 of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following Specialty Drug Prior Authorization requirements)
• Florida: AARP Medicare Complete Plan 1, HMO Gatekeeper Product Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021. UnitedHealthcare Dual Complete Group 29006 and 29007. UnitedHealthcare Medicare Advantage (HMO) Group 54011 and 54012. Existing process of obtaining authorization from Managed Service Organizations will continue. • UHC Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described on Page 6). As explained on Page 6, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Specialty Drug Prior Authorization Program. • Erickson Advantage Plans • UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP) • UnitedHealthcare Senior Care Options (HMO SNP)
The following benefit plans: • UnitedHealthcare West or UHC West • Sierra • Senior Dimensions Medicare Advantage plans. • Additionally, this Medicare Advantage Specialty Drug Prior Authorization Program does not apply to Commercial Benefit Plans or to other benefit plans, such as Medicaid, CHIP and Uninsured, that are not Medicare Advantage

The Specialty Drug Prior Authorization requirements in this Program apply to all participating physicians, health care professionals, facilities and ancillary providers ("Physicians/Providers") that order or render certain specialty drugs.

For a complete list of specialty drugs that require prior authorization, please visit UnitedHealthcareOnline.com → Clinical Resources → Specialty Drug.

Prior authorization is required for outpatient and office services only. Specialty Drugs rendered in and appropriately billed with any of the following places of service do not require notification: emergency room, observation unit, and urgent care center or during an inpatient stay.

Compliance with this Program is required.

Failure to complete the Specialty Drug Prior Authorization Program will result in administrative denial. Claims denied for failure to request prior authorization may not be billed to the Customer. Failure to meet clinical criteria will result in a denial for lack of medical necessity because services that are not medically necessary are not covered under Medicare Advantage plans. Upon issuance of the denial for lack of medical necessity, the Customer and Physician/Provider will receive a denial notice with the appeal process outlined. Physicians/Providers that render specialty drugs within the scope of the Program must confirm that prior authorization has been obtained, or payment for their services may be denied.

To see the states in which this Program applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug. If additional states are added to the program, we will communicate that information to impacted Physicians/Providers.

Ordering Physician/Provider:

The Physician/Provider ordering the specialty drug is responsible for obtaining a prior authorization number prior to any rendering of the specialty drug. A Physician/Provider may obtain the required prior authorization number by contacting us via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization - Submission & Status (Medicare Part B), or
- Phone: Toll-free (866) 889-8054

Information required for a Prior Authorization request:

Customer/procedure information

- Customer's health care ID number
- Customer's group number
- Customer's name
- Customer's date of birth
- Customer's phone number and address (optional)

Ordering Physician/Provider information

- Ordering Physician/Provider's TIN
- Ordering Physician/Provider's last name
- Ordering Physician/Provider's phone number
- Ordering Physician/Provider's fax number
- Contact person at the ordering Physician/Provider's office

Clinical information

- The examination(s) being requested, with the CPT code(s)
- The working diagnosis or "rule out" with the ICD-9 code(s)
- The Customer's symptoms, listed in detail, with severity and duration. Any treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Any other information that the Physician/Provider believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.
- Dates of prior specialty drug procedures performed.

Rendering Physician/Provider information (if different)

- Rendering Physician/Provider's last name, first name
- Rendering Physician/Provider's address
- Rendering Physician/Provider's phone number
- Rendering Physician/Provider's fax number

A prior authorization number will be issued to the ordering Physician/Provider when the prior authorization process is completed. The prior authorization number will be communicated by phone and/or online, consistent with how the request was initiated. If the rendering Physician/Provider is different from the ordering Physician/Provider, to help make sure proper payment, the authorization number should be obtained and communicated by the ordering Physician/Provider to the rendering Physician/Provider scheduled to render the specialty drug.

Please note that receipt of an authorization for Medicare services means that the service was medically necessary. It does not guarantee or authorize payment. Payment of covered services is contingent upon the Customer being eligible for services on the date of service, the Physician/Provider being eligible for payment, any claim processing requirements, and the Physician/Provider participation agreement with UnitedHealthcare.

The length of time for which a prior authorization will be valid will vary by request.

- For all specialty drugs used in the palliative setting, the prior authorization will be valid for 90 days from the date the prior authorization is approved.
- For all specialty drugs used in the curative and adjuvant setting, the prior authorization number is valid for the number of days required to complete the requested course of treatment. This is calculated by multiplying the number of cycles requested by the length of each cycle and adding 14 calendar days. The resulting expiration date for the prior authorization will be provided to the ordering Physician/Provider.

When a prior authorization number is approved for a specialty drug, the day the prior authorization was approved will be the starting point for the period in which the course of treatment must be completed. If the course of treatment is not completed within the approved time period, a new prior authorization number must be obtained.

Urgent requests during regular business hours

The ordering Physician/Provider may request a prior authorization number on an "urgent" basis if the Physician/Provider determines it to be medically required. Urgent requests should be requested via phone by calling (866) 889-8054 and

selecting the option for Medicare Advantage Customers. The Physician/Provider must state that the case is clinically urgent and explain the clinical urgency. The prior authorization number will be issued for urgent requests within 3 hours of our receiving all required information.

Urgent requests outside of regular business hours

If the Physician/Provider determines that care is medically required on an urgent basis, and prior authorization cannot be provided because it is outside of UnitedHealthcare's normal business hours, the service may be performed and the prior authorization requested retrospectively following the retrospective prior authorization process described below.

Retrospective prior authorization process

If a specialty drug is required on an urgent basis or prior authorization cannot be obtained because it is outside of our normal business hours, the service may be performed and authorization requested retrospectively.

- Retrospective authorization requests must be made within 2 business days of rendering the specialty drug.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why prior authorization could not be obtained during UnitedHealthcare's normal business hours.
- The ordering Physician/Provider should follow the same prior authorization process outlined above for a standard request.

Rendering Physician/Provider (if different)

To receive payment for services rendered, prior to rendering the stated specialty drug, the rendering Physician/Provider must validate with UnitedHealthcare that an approved prior authorization number is on file by contacting UnitedHealthcare via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization - Submission & Status (Medicare Part B)
- Phone: (866) 889-8054 - Select the appropriate option for Medicare Advantage Customers.

If the rendering Physician/Provider determines there is no prior authorization number on file, and the ordering Physician/Provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering Physician/Provider to request that the participating ordering Physician/Provider obtain prior authorization prior to the rendering of services.

If the rendering Physician/Provider determines there is no prior authorization number on file, and the ordering Physician/Provider does not participate in UnitedHealthcare's network and is unwilling to complete the prior authorization process, the rendering Physician/Provider is required to complete the prior authorization process. If the rendering Physician/Provider does not obtain a prior authorization number for a specialty drug ordered by a non-participating Physician/Provider, the rendering Physician/Provider's claim will be administratively denied, in part or in whole, for failure to obtain prior authorization and the Customer cannot be billed for the service.

Note: Non-participating Physicians/Providers can still submit prior authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers.

Specialty Drug Crosswalk Table

Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, Physicians/Providers are not required to contact the Specialty Drug Prior Authorization Program to modify the existing prior authorization record. A complete listing of applicable CPT code combinations is available at UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug: Reference Materials.

However, for code combinations not listed on the CPT Code Crosswalk Table, Physicians/Providers must follow the Specialty Drug Prior Authorization Program process set forth above for additional specialty drugs.

Protocol for Providing Advance Notice to Commercial Customers when Involving Non-Participating Providers in Customers' Care (effective April 1, 2012)

Excluded Plans (benefit plans not subject to the following requirements)
The following benefit plans: • UnitedHealthOne or All Savers • NHP • MD IPA, OCI, or OneNet • River Valley • Sierra • UnitedHealthcare West or UHC West • Medicare Advantage • UHC Community Plan Medicaid, CHIP and Uninsured

In order to help our Customers make informed decisions regarding their healthcare and effectively control their out-of-pocket healthcare costs, it is imperative that in non-emergent situations, prior to services being rendered, a Customer know when his or her participating provider involves a non-participating physician, facility or other healthcare provider in their care (for example, in situations where a participating surgeon uses a non-participating assistant surgeon). Involving a non-participating provider in a Customer's care has the potential to carry additional out-of-pocket costs for the Customer. In fact, a Customer who does not have out-of-network benefits may be responsible for the entire cost of the services obtained from non-participating providers.

In order to assist Customers in making informed healthcare decisions and effectively control their out-of-pocket costs, you must:

1. **Discuss the Option to Use Participating Providers with Customers:** In non-emergent situations, prior to services being rendered, a participating physician or other healthcare professional must discuss with the Customer the option to use a participating provider in situations where the participating provider has decided to involve the following types of non-participating providers in the Customer's care. This includes, but is not limited to, situations where the participating provider refers or directs the Customer to a non-participating provider for the following types of services.
   - Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent
   - Home Health
   - Laboratory Services – for specimens collected in the physician's office and sent out to a non-participating laboratory for processing
   - Outpatient Dialysis
   - Specialty Drug vendor
2. **Complete the Member Advance Notice Form:** If, after a discussion with the Customer regarding his or her option to use a participating provider, the Customer elects to receive the above listed services from a non-participating provider or elects to receive services from the above listed non-participating provider types, the participating physician or other healthcare professional must complete the Member Advance Notice Form and obtain the Customer's signature on the form. A copy of the Member Advance Notice Form can be found at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols.

Participating physicians and other healthcare professionals must keep the signed Member Advance Notice Form on file to provide to us upon request. A separate Member Advance Notice Form is required for each service scheduled with a non-participating physician, facility or other healthcare provider.

As noted above, this Protocol does not apply in emergent situations. Also, this Protocol does not apply when the participating provider or Customer has obtained an in-network exception to use a non-participating physician, facility or other healthcare provider. Lastly, this Protocol does not apply when the participating provider does not involve or direct the Customer to any of the included non-participating provider types or services listed above.

Please note that this Protocol is not intended to deter Customers from using their out-of-network benefits, if available. Customers who have out-of-network benefits can exercise their right to use those benefits at any time.

Administrative Actions for Non-Compliance

We will monitor the involvement of the non-participating provider types outlined above in our Customer's care and may request a copy of the completed Customer Advance Notice Form at any time from providers with significant volumes of non-participating provider utilization. Compliance with this Protocol will be reviewed by UnitedHealthcare and failure to comply with the Protocol may result in appropriate action under your participation agreement, which may include, but is not limited to, ineligibility for performance based compensation or termination of your participation agreement.

Laboratory services protocol

Requirement to use participating laboratories

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 except as indicated in the following 2 bullets:

- This Protocol does not apply where the physician bears financial risk of laboratory services.
- This Protocol does not apply to laboratory services provided by physicians in their offices.

We maintain 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 HEDIS reporting, care management, the UnitedHealth Premium Designation program and other clinical quality improvement activities. It is important to note that in many benefit plans, Customers receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

You are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a Payer. Participating laboratory providers can be found in the UnitedHealthcare Physician Directory online at UnitedHealthcareOnline.com. If you need assistance in locating or using a participating laboratory provider, please contact UnitedHealthcare Network Management.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UnitedHealthcare in advance 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 out-of-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 we identify an ongoing and material practice of referrals to out-of-network laboratory service providers, we will inform the responsible participating physicians of the issue and remind them that physicians in the UnitedHealthcare network are generally required by contract to refer their patients to other network providers. 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 this Protocol:

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

For state-specific variations of this protocol, please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols

Specialist Referral Requirements (for commercial Navigate℠, Navigate Balanced℠ and Navigate Plus℠ only)

The Navigate portfolio of products, includes a gatekeeper feature and prior authorization by UnitedHealthcare for selected services as listed in the *Advance Notification* section this Guide. Customers are required to identify a Primary Physician. The Navigate product name and Customer's Primary Physician are indicated on the Navigate Customer's ID card. Reference to referrals being required is on the back of the ID card. The 3 Navigate product models are:

- **Navigate:** A single-tier benefit, network-only product. Customers must have a referral from their Primary Physician to receive network benefits for services from any network physician that is not in the same TIN as their Primary Physician. If Customers seek care from a network physician outside of their Primary Physician's TIN without a referral, then there is no benefit and the Customer is responsible for the billed amount. The exception is that the Customer does not need a referral from their Primary Physician for services from a network OB/GYN, for a routine refractive eye exam from a network provider, or for mental health/substance use disorder services with a network behavioral health clinician.
- **Navigate Balanced:** A two tier benefit, network-only product. Customers must have a referral from their Primary Physician in order to receive the highest level of network benefits for services from any network physician that is not in the same TIN as their Primary Physician. If Customers seek care from a network physician outside of their Primary Physician's TIN without a referral they receive a leaner level of benefits. The exception is that the Customer does not need a referral from their Primary Physician for any services from a network OB/GYN, for a routine refractive eye exam from a network provider, or for mental health/substance use disorder services with network behavioral health clinicians.
- **Navigate Plus:** A three tier benefit, network and non-network product. Customers must have a referral from their Primary Physician in order to receive the highest level of network benefit for services from any network physician that is not in the same TIN as their Primary Physician. If Customers seek care from a network physician outside of their Primary Physician's TIN without a referral they receive a leaner level of benefits. The exception is that the Customer does not need a referral from their Primary Physician for any services from a network OB/GYN, for a routine refractive eye exam from a network provider, or for mental health/substance use disorder services with network behavioral health clinicians. Non-network benefits are available for services from non-network providers.

Changing Primary Physicians:

Customers may elect to change their Primary Physician on a monthly basis. Changes submitted to UnitedHealthcare on or before the 15th of the month will be effective on the 1st day of the following month. Changes submitted on or after the 16th of the month will be effective on the 1st day of the second following month.

Covering Physician

When billing services as a covering physician, modifiers Q5 (substitute physician) and Q6 (locum tenens) can help make sure that your claim is recognized as submitted by a covering physician.

Specialist Referrals (see Quick reference on referral submission):

The Customer's Primary Physician coordinates the Customer's care and generates referrals to network specialists on the Referral Submission screen on UnitedHealthcareOnline.com prior to the Customer seeking care with any network physician.

1. On the UnitedHealthcare Online home page, move the cursor to 'Notifications' on the tool bar
2. Select 'Referral Submission' from the dropdown box

Referrals must be entered on UnitedHealthcareOnline.com prior to the specialist service being received. Retroactive referrals are not accepted. Referrals are not required for services from a network OB/GYN, for network routine refractive eye exams, and for mental health/substance use disorder services with network behavioral health clinicians. Each referral may include up to 6 visits and any unused visits expire after 6 months. At any time after the 6 visits have been used or if any unused visits expire after 6 months, an addition referral to that network specialist with up to 6 visits may be entered. For Customers with chronic conditions, the online referral screen will allow Standing Referrals for 99 visits to be entered if the Customer's diagnosis code is included in the Navigate Referrals for Chronic Conditions policy which can be found on UnitedHealthcareOnline.com. If any of the 99 visits are unused after 6 months, a new referral can be issued. Conditions eligible for Standing Referrals of up to 99 visits are:

ICD-9 Code	Diagnosis
042X	AIDS/HIV
28X, 773.0, 773.1 & 776.5	Anemia
140X – 208x & 230 – 234.9	Cancer
277.00; 277.0; 277.01	Cystic Fibrosis
295X	Schizoaffective disorders/schizophrenia
332.0; 332.1	Parkinson's Disease
335.20	Amyotrophic Lateral Sclerosis
340	Multiple Sclerosis
345.0 – 345.9	Epileptic Seizure
358.0	Myasthenia Gravis
365 – 365.9X	Glaucoma
446.6	Thrombotic Microangiopathy
477X	Allergies
584.X	Renal Failure (acute)
780.39	Seizure
8XX.XX – 829.XX, 733.8X	Fracture Care Note: It is not necessary to have the procedure performed indicated on the referral. "Fracture Care" is adequate.

A list of a Customer's existing referrals can be viewed on UnitedHealthcareOnline.com on the Referral Status Detail screen, including information on the network specialist to whom the referral is made, number of visits authorized and number of visits remaining. Only the Customer's Primary Physician or a physician in primary practice in the same TIN can write a referral to a network specialist. Referrals can only be entered for network physicians. Referrals cannot be entered for non-network providers.

If a network specialist to whom the Customer has been referred identifies the need for a Customer to see another specialty type, the Customer's Primary Physician must be contacted for their consideration of an additional referral. It is the specialist's responsibility to follow the Advance Notification or Prior Authorization procedures for any services they render. Specialists cannot enter referrals.

All other protocols and guidelines outlined in this manual for commercial managed care products apply to the Navigate products.

Protocols for UnitedHealthcare Nursing Home Plans

Applicability – This Protocol is only applicable to primary care physicians, nurse practitioners and physician assistants who participate in the network for the UnitedHealthcare Nursing Home Plan (i.e. Medicare Advantage Institutional Plans).

Definitions – Capitalized terms used in this Protocol but not otherwise defined will have the same meaning as in your participation agreement.

UnitedHealthcare Nursing Home Plan Customer: A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and who is enrolled in a Medicare Advantage Institutional Special Needs Plan 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 offered through UnitedHealthcare Medicare Solutions business unit, as indicated by a reference to Nursing Home Plan or Erickson Advantage in the plan name listed on the face of the valid ID card of any UnitedHealthcare Nursing Home Plan 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: A professional who meets all of the following criteria: (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 a UnitedHealthcare Nursing Home Plan Customer to provide and/or coordinate the UnitedHealthcare Nursing Home Plan 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.

UnitedHealthcare Nursing Home Plan Primary Care Physician Protocols

If these Primary Care Physician Protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan Institutional Customers, including all assessments mandated by regulatory requirements
3. Deliver health care to UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan Customer to discuss the UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan and any other treating professionals to provide and arrange for the provision of covered services to UnitedHealthcare Nursing Home Plan Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to UnitedHealthcare Nursing Home Plan Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled UnitedHealthcare Nursing Home Plan Customer reassessment, significant change in plan of care and/or condition.
6. Collaborate with UnitedHealthcare Nursing Home Plan when a change in the Primary Care Team is necessary.
7. Provide UnitedHealthcare Nursing Home Plan a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.
8. When admitting a UnitedHealthcare Nursing Home Plan Customer to a hospital, immediately notify the PCP and UnitedHealthcare Nursing Home Plan or Payer of the admission and reasons for such admission (i.e. if the admission is for an emergency or for observation).

UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan.
2. Deliver health care to UnitedHealthcare Nursing Home Plan Customers at their place of residence in collaboration with a Primary Care Physician, including making joint visits to UnitedHealthcare Nursing Home Plan Customers in the facility on a regular basis.
3. Family Care Conferences - Communicate with the UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan Customer to discuss the UnitedHealthcare Nursing Home Plan 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 UnitedHealthcare Nursing Home Plan and any other treating professionals to provide and arrange for the provision of covered services for UnitedHealthcare Nursing Home Plan Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to UnitedHealthcare Nursing Home Plan Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled UnitedHealthcare Nursing Home Plan Customer reassessment, significant change in plan of care and/or condition.
5. Collaborate and communicate with UnitedHealthcare Nursing Home Plan's designated Director of Health Services to coordinate all inpatient, outpatient and facility care delivered to UnitedHealthcare Nursing Home Plan Customers. Forward copies of required documentation to UnitedHealthcare Nursing Home Plan'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 UnitedHealthcare Nursing Home Plan Customers within 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, and 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 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 UnitedHealthcare Nursing Home Plan Customer's benefit contract including, but not limited to:
   - All medically necessary and appropriate facility services.
   - Outpatient procedures and consultations.
   - Inpatient care management.
   - Podiatry, audiology, vision care and mental health care provided in the facility.
8. When an UnitedHealthcare Nursing Home Plan Customer requires a hospitalization, notify PCP and UnitedHealthcare Nursing Home Plan or Payer immediately if the admission is for an emergency or for observation.
9. Provide UnitedHealthcare Nursing Home Plan a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.

Specialty pharmacy requirements for procurement of certain specialty medications– (for Commercial Customers only)

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®, Xolair®, Botox®, Dysport®, Myobloc®, Xeomin®, Hyalgan®, and Supartz® by physicians and other health care professionals.
- This protocol does not apply when Medicare or another health plan is the primary payer and UnitedHealthcare is the secondary payer.

Requirement to use a participating specialty pharmacy provider for certain medications:

- Synagis (palivizumab)
- Xolair (omalizumab)
- Botox (botulinum toxin type A)
- Dysport (botulinum toxin type A)

- Myobloc (botulinum toxin type B)
- Xeomin (botulinum toxin type A)
- Hyalgan (Sodium hyaluronate and hyaluronan cross-linked preparations. For consistency, these preparations will be referred to as sodium hyaluronate preparations)
- Supartz (sodium hyaluronate)

Note: This protocol does not apply to Euflexxa®, Orthovisc®, Synvisc® and Synvisc-One®. Euflexxa, Orthovisc, Synvisc and Synvisc-One 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.

UnitedHealthcare has contracted for the national distribution of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan, and Supartz. Our participating specialty pharmacy providers provide fulfillment and distribution services on a timely basis to meet the needs of our Customers and the physicians and other health care professionals participating in the UnitedHealthcare network. Our participating specialty pharmacy providers also provide reviews consistent with UnitedHealthcare's Drug Policy for these drugs, and work directly with the Clinical Coverage Review unit in UnitedHealthcare's Care Management Center to determine whether treatment is covered. The UnitedHealthcare Drug Policies for these drug preparations are 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 report clinical data and related information and are audited on an ongoing basis to support our clinical and quality improvement activities.

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

Requests for prescriptions of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz should be submitted to the 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 these drugs in compliance with the UnitedHealthcare Drug Policy and the Customer's benefit plan and eligibility, and bill us accordingly. 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 us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing of the medication to the physician office.

For a listing of the participating specialty pharmacy provider(s) by medication, please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2012 UnitedHealthcare Administrative Guide.

Administrative actions for non-network acquisition of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz

For a Customer meeting the clinical criteria for appropriate utilization, we anticipate that all participating physicians and other health care professionals will be able to procure Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan and Supartz from a participating specialty pharmacy provider.

Use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers by you or any other health care professional without prior approval from us will result in adjustment of your claim in whole or in part. In addition, you may be subject to other administrative actions as provided in your agreement.

Please contact UHCP if you have any questions about making effective use of the specialty pharmacy network.

Administration of Xolair in a health care setting

Since July 2007, the prescribing information for Xolair has included 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 1 year of regularly administered Xolair treatment. The labeling advises that patients should be observed closely 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 Customers 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 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.

Designated specialty pharmacy or home infusion providers for specialty medications (Commercial only)

Prohibition of provision of non-contracted services

- This Protocol applies to the provision and billing of specific specialty pharmacy medications covered under a Customer's medical benefit.
- This Protocol prohibits specialty pharmacy or home infusion providers from providing non-contracted services for a therapeutic category, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, and billing us 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 procures and bills directly to us for the specific specialty medications.
- This Protocol applies to Commercial Customers 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 a Customer's 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 Customer services. This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our Customers and our 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 us as a non-participating or non-contracted provider.

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 Customers are required to submit claims for reimbursement under the Customer's pharmacy benefit, if those medications are subject to the exclusion from the medical benefit described above.

Our claims process

Reimbursement policies

UnitedHealthcare reimbursement policies are available online at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols. Reimbursement policies may be referred to in your agreement with UnitedHealthcare as "payment policies."

Prompt claims processing

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

1. **Review the Customer's eligibility at UnitedHealthcareOnline.com, using bar code or swipe card technology or keying in the Customer's information.**

   You can also check Customer eligibility by phone by calling the United Voice Portal at (877) 842-3210 or the Customer Care number on the back of the Customer'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. For Medicare plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. **Notify us in accordance with the Advance and Admission Notification Requirements section in this Guide-** Please see the separate specific programs listed in the *Notification Requirements* section of this Guide that require notification.

3. **Prepare complete and accurate claims (see *Complete Claims* section).**

4 **Submit claims online at UnitedHealthcareOnline.com or use another electronic option.**

   a. **Connectivity Director is a 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 at no cost to you. Connectivity Director provides immediate response back to all transaction submissions (claims, eligibility, and more). Additional information can be found at 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 (OptumInsightTM, formerly 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 OptumInsight to submit batch claims to many government and commercial payers. For more information: UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → EDI Options for Submitting Claims.

   c. **Electronic Data Interchange (EDI) Gateway and Clearinghouse Connections** – UnitedHealthcare's preferred clearinghouse is OptumInsight, but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare. Both participating and nonparticipating physicians, 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. → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. 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, we have reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed. For more information and tips for submitting claims electronically, visit UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims.

5. **Receive Electronic Payments and Statements (EPS)**

   When you enroll in EPS, payments are electronically deposited into one or more banking account(s) which you designate. Explanations of Benefits (EOBs) that match each daily/weekly consolidated deposit are available on UnitedHealthcareOnline.com → Claims & Payments → Electronic Payments and Statements, where you can review, store and print hard copies to use for manual posting. Or, you can take the next step by auto-posting the electronic 835/Electronic Remittance Advice (ERA) that you receive from your clearinghouse, or obtain an ERA free of charge from our website at UnitedHealthcareOnline.com.

   EPS is the preferred method for receiving payments and statements and results in faster and easier payment processing for you. If you have not yet enrolled, learn more and start receiving electronic payments and statements now by visiting UnitedHealthcareOnline.com → Quick Links → Electronic Payments & Statements or by contacting us at (866) 842-3278, Option 5. Please note EPS is not available in all markets for our Medicare Advantage plans.

Complete claims

For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services in accordance with national coding guidelines. It is particularly important to accurately code because a Customer'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 Customer 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 the status online at UnitedHealthcareOnline.com → Claims & Payments → Claim Status. If you do need to submit second submissions or tracers, be sure to submit them electronically no sooner than 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 Customer's health care ID card. For questions specific to electronic submission of claims, please review the information at UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. If you need additional information on EDI, contact the EDI Support Line at (800) 842-1109, Option 3 or go to UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission.

You can learn more about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at 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: Claim Estimator is available for professional Commercial claims.

To order CMS-1500 (formerly HCFA-1500) and CMS-1450 (formerly UB-04) forms, contact the U.S. Government Printing Office at (202) 512-0455, or visit their website at cms.hhs.gov/CMSForms.

Complete claims requirements

- Customer's name
- Customer's address
- Customer's gender
- Customer's date of birth (dd/mm/yyyy)
- Customer's relationship to subscriber
- Subscriber's name (enter exactly as it appears on the Customer's health care ID card)
- Subscriber's ID number
- Subscriber's employer group name
- Subscriber's employer group number
- Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Name
- Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Representative's Signature
- Address where service was rendered
- Physician, Health Care Professional, Ancillary Provider, or Facility "remit to" address
- Phone number of Physician, Health Care Professional, Ancillary Provider, 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, Ancillary Provider's, or Facility's NPI and federal TIN
- Referring physician's name and TIN (if applicable)
- Date of service(s)
- Place of service(s)
- Number of services (day/units) rendered
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
- Current ICD-9-CM 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) greater than $1,000 for DME
- 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.
- Method of Administration (Self or Assisted) for Hemophilia Claims – the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order to make sure accurate reimbursement. Method of administration is either noted as self or assisted.

Additional information needed for a complete CMS-1450 form:

- Date and hour of admission
- Discharge date and hour of discharge
- Customer status-at-discharge code
- Type of bill code (3 digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current 4-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 procedure codes for inpatient procedures
- Attending physician ID
- For outpatient procedures, provide the appropriate revenue and CPT or HCPCS codes
- For outpatient services, provide specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- 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 Customer 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
- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission.

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 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 HIPAA electronic transaction x12N Implementation Guides.

- To avoid payment delays or denials, we require that a valid Billing NPI, Rendering NPI, and relevant Taxonomy code(s) be submitted on both paper and electronic claims. In addition, we strongly encourage the submission of all other NPIs as defined below.
- It is important that, in addition to the NPI, you continue to submit your 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.

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

1. UnitedHealthcareOnline.com: To update your NPI and related information online, login and go to "Practice/ Facility Profile" and select your TIN. Click "continue", then select the "View/Update NPI Information" tab.
2. Fax: For all UnitedHealthcare business, fax your NPI to the appropriate fax number based on your geographic location/state. The fax form can be found at UnitedHealthcareOnline.com → Contact Us → Forms - Form: Provider Demographic Change Form.
3. Credentialing/Contracting: 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

Information is provided for the location of NPI, TIN and Taxonomy on paper and electronic claims on UnitedHealthcareOnline.com. Also, see definitions in the UB-04 Data Specifications Manual. Updated information for HIPAA 837P, 8371 and CMS 1500 Professional Claim Form will be available as updated on UnitedHealthcareOnline.com.

Medicare Advantage benefit plan claim processing requirements

Section 1833 of the Social Security Act, prohibits payments to any provider unless the provider has provided sufficient information to determine the "amounts due such provider." To that end, UnitedHealthcare applies various claims processing edits based on National and Local Coverage Determinations, the Medicare Claims Manual, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the Official ICD9-CM Guidelines for Coding and Reporting. These edits are designed to provide UnitedHealthcare with sufficient information to determine:

- The correct amount to be paid;
- Whether the provider is authorized to perform the service;
- Whether the provider is eligible to receive payment;
- Whether the service is covered, correctly coded, and correctly billed to be eligible for reimbursement;
- Whether the service is provided to an eligible beneficiary; and
- Whether the service was provided in accordance with CMS guidance.

Providers participating in our Medicare Advantage network must comply with all CMS guidance regarding coding, claims submission, and reimbursement rules. For example, all participating Medicare providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the "Never Event" has not been reported, we will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS, as a Serious Reportable Adverse Event. To the extent that a provider fails to comply with these requirements, that provider's claim will be denied and be considered a provider liability. Provider cannot bill the Customer for these charges.

There may be situations when UnitedHealthcare implements edits and CMS has not issued any specific coding guidance. In these circumstances, UnitedHealthcare will review the available guidance in the Medicare Coverage Center and identify those coding edits that most align with the applicable coverage rules.

Effective January 1, 2012: Due to CMS requirements, all physicians and other health care providers, including delegated/ capitated claims and encounters, are required to adopt the 837 Version 5010 format for dates of service on and after January 1, 2012. Incomplete submissions including blank data fields will result in rejection of the claim or encounter submission. Note that a National Provider Identification (NPI) is a required data element on all submissions. Rejections will be returned for correction and resubmission.

Hospice – Medicare Advantage

When a Medicare Advantage Customer elects hospice, CMS pays Medicare Certified Hospice providers for all covered services related to the Medicare Advantage Customer's terminal illness. Claims for hospice services should be billed directly to CMS. For services covered under Medicare Part A and Medicare Part B that are not related to the Medicare Advantage Customer's terminal issue, claims must be billed to the applicable Medicare Administrative Contractor. UnitedHealthcare is not financially responsible for these claims; however, UnitedHealthcare may be financially responsible for any additional or optional supplemental benefits under the Medicare Advantage Customer's benefit plan. Additional and optional supplemental benefits are not covered by Medicare and are not related to the Customer's terminal condition e. g. eyeglasses, hearing aids, etc.

Claim submission tips

Estimating treatment costs

To facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of UnitedHealthcare's 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 percentage, if any, and what the claim payment will be. Claim Estimator enables you to share this information with your patient before treatment.

Claims submission tips for UnitedHealthcare HRA and HSA plans

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

Special note regarding UnitedHealthcare 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 UnitedHealthcare 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 UnitedHealthcare HSA enrollees are not available through the Patient Eligibility application.

Most UnitedHealthcare HRA and HSA plans do not require copayments; therefore, please do not ask your UnitedHealthcare Customers 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 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 might not be covered under a Customer'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 (i.e., 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) website at: irs.gov or call the IRS toll-free phone number at (800) TAX-FORM; (800) 829-3676.

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 Customers.

For laboratory services, you will only be reimbursed for the services for which you are certified through the Federal Clinical Laboratory Improvement Amendments (CLIA) to perform and you must not bill our Customers 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.

Special reporting requirements for certain claim types

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.

Laboratory claim submission requirement

Many UnitedHealthcare benefit plan designs exclude from coverage outpatient laboratory services that were not ordered by a participating physician. Our benefit plans may also cover such 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 both anatomic and clinical laboratory services. This requirement also 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 *Laboratory Services* section of this Guide.

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 Customers. UnitedHealthcare requires our participating providers to use reasonable commercial efforts to use the services of in-network providers, including in-network surgical assistants or assistant surgeons to render services to our Customers. 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 or denied with a request for medical records for medical claim review under an applicable medical or drug policy, to determine whether the service rendered is a covered service and eligible for payment. In these cases, a letter will be sent explaining the additional information that is needed.

To facilitate claim processing and avoid delays due to pended claims, please resubmit only what is requested in our letter. The claim letter will state specific instructions of any required information to resubmit, which may vary for each claim. Please note that you must also return a copy of our letter with your additional documents.

For more information about UnitedHealthcare drug and medical policies, please see UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Policies.

For Medicare Advantage benefit plans, if it is determined that you are ineligible for payment even though the service is covered, you will be denied reimbursement for these claims and will be liable for the cost of care. You may not bill your patient for the amount that was denied.

Erythropoietin (For Commercial Customers)

For Erythropoietin (EPO) claims we require the Hematocrit (Hct) level to be submitted in order for us to determine coverage under the Customer's benefit plan. For claims submitted via paper to UnitedHealthcare on a CMS-1500 Form, you must 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.

Additional information is available on-line at UnitedHealthcareOnline.com → Clinician Resources → Cancer – Oncology → Erythropoietin (EPO) Drug Policy.

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 30 calendar days (or as required by law or your participation agreement), 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 Customer'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 implement a claim reconsideration and request a refund at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. 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 the *Claim Reconsideration & 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 state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a Customer's health care services when a third party causes the Customer's injury or illness.
2. **Coordination of Benefits (COB)** — COB is administered according to the Customer's benefit plan and in accordance with applicable law. We accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions, contact your EDI vendor, or contact EDI Support via phone or online form at (800) 842-1109 or UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission.

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 a claim for services rendered to one of our Commercial or Medicare Advantage Customers, the provider should submit the claim to UnitedHealthcare, regardless of whether the case is being disputed. It is also helpful to send us the worker's compensation 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 Customer;
2. The Customer's policy/benefit contract has been terminated;
3. The Customer 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 except as otherwise required by state and/or federal law. The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA). If you are enrolled in Electronic Payment System (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. If we implement a claim reconsideration and a refund is requested, you will be notified at least 30 days prior to any adjustment, or as provided by applicable law or your agreement with us.

Claim correction/resubmit

If you need to correct and re-submit a claim, submit a new CMS-1500 or UB-04 (or their electronic equivalent) 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.

If you need to correct or re-submit a CMS-1500 via paper, please attach the UnitedHealthcare Claim Reconsideration forms located at UnitedHealthcareOnline.com.

Claim reconsideration and appeals process and resolving disputes

Step 1: Claim Reconsideration

If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration.

- The quickest way to submit a Claim Reconsideration request is online. 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 is needed, such as proof of timely filing or medical notes, 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 Customer's health care ID card. In certain states such as Arizona, use of this form is not required, but is strongly encouraged.

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 requests must also include documentation that the claim is for the correct patient and the correct visit.

If you are submitting a Claim Reconsideration Request Form for a claim which was denied requesting medical documentation:

1. Complete the Claim Reconsideration Request Form and check "Previously denied/closed for Additional Information" as your reason for request.
2. Provide a description of the documentation being submitted along with all pertinent documentation.

Note: It is extremely important to include the Customer name and ID number as well as the provider name, address and TIN on the Claim Reconsideration form to prevent processing delays.

- Alternatively, you can call the Customer Care number on the back of the health care ID card to request an adjustment for a claim that does not require written documentation.
- If you have a request involving 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 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

You must submit your appeal to us within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-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 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 below and in your agreement with us.

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

Medicare Advantage hospital discharge appeal rights protocol

Medicare Advantage Customers 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 Customer, 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 Customer, 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.

Resolving disputes – agreement concern or complaint

If you have a concern or a 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 these procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your agreement with us.

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 of this Guide.

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

South Dakota
Hennepin County, MN

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, MD

Washington
King County, WA

West Virginia
Montgomery County, MD

Wisconsin
Milwaukee County, WI
Waukesha County, WI

Wyoming
Laramie County, WY

Compensation

Additional fees for covered services

You may not charge our Customers fees for covered services beyond copayments, coinsurance or deductibles as described in their benefit plans. You may not charge our Customers 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 otherwise comply with our Protocols as required by your Agreement with us, or based on our reimbursement policies and methodologies. This does not prevent you from charging our commercial Customers nominal fees for missed appointments or completion of camp/school forms. Please note, however, that for Medicare Advantage Customers, CMS does not allow the provider to charge for "missed appointments" unless the provider has previously disclosed that policy to the Customer.

Charging Customers for non-covered services

For commercial and Medicare Advantage Customers, you may seek and collect payment from our Customer for services not covered under the applicable benefit plan, provided you first obtain the Customer's written consent. Such consent must be signed and dated by the Customer prior to rendering the specific service(s) in question. Retain a copy of this consent in the Customer'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 Customer, with knowledge of UnitedHealthcare's determination, agrees to be responsible for those charges.

In addition, for Medicare Advantage Customers, a Notice of Denial of Medical Coverage must be provided to the Customer advising the Customer when a service is not covered. In the event we are responsible for issuing the Notice of Denial of Medical Coverage, you should make sure that the Customer has received the Notice prior to providing any requested non-covered service.

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 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 Customer; 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.
- For Medicare Advantage benefit plans, CMS has published guidance, through National Coverage Determinations, Local Coverage Determinations, and other CMS guidance, indicating that the service may not be covered in certain circumstances. You are required to review the Medicare Coverage Center. You must not bill our Customer for non-covered services in cases in which you do not comply with this Protocol.

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

Customer financial responsibility

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

If you prefer to collect payment at time of service, you must make a good faith effort to estimate the Customer's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools on our website can help you determine Customer and health plan responsibility, including Claim Estimator (UnitedHealthcareOnline.com → Claims & Payments → Claim Estimator) and HRA Balance viewing through the Eligibility Inquiry function. (**Note:** Claim estimator is available for professional Commercial claims).

Some claims can be processed (adjudicated) in real time while the patient is still in your office. After services have been rendered, you can use the claim submission feature on UnitedHealthcareOnline.com. Within seconds you will receive a fully adjudicated claim that shows the plan's responsibility and the Customer'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 Customer pays you more than the amount indicated on the medical claim EOB, you are responsible for promptly refunding the difference to the Customer.

For Medicare Advantage Customers, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage Customer 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.

Coverage Determinations and Utilization Management Decisions

At UnitedHealthcare, all of its affiliated companies, and delegates, coverage decisions on health care services are based on the Customer's benefit documents. For Commercial Customers, this includes the contract the Customer's employer has with UnitedHealthcare. For Medicare Advantage Customers, this includes but is not limited to, National Coverage Determinations, Local Coverage Determinations, and general Medicare coverage guidelines.

- The coverage decisions are made based on:
  - For Commercial Customers, the appropriateness of care and services and existence of coverage as defined within the contract our Commercial Customer's employer has with UnitedHealthcare or,
  - For Medicare Advantage Customers, the definition of "reasonable and necessary" within Medicare coverage rules and regulations.
- The staff of UnitedHealthcare, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing non-coverage decisions.

UnitedHealthcare and its delegates do not offer incentives to physicians to encourage underutilization of care or services or to encourage barriers to care and service.

Hospital audit services

We use appropriate nationally recognized billing or coding guidelines, as the criteria for audits performed by our Hospital Audit Services Department. These coding guidelines are produced by the American Association of Medical Audit Specialists, in partnership with CMS aamas.org/news/natl-audits-guidelines.html. Audits may occur on a prepayment or post-payment basis, depending on the circumstances and the terms of your agreement with us.

The following sections, *Hospital Requirements and Access, Audit Findings & Exit Conference* and *Post Audit Procedures* are specific to our Standard Hospital Bill Audit (as described in the following paragraph), 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 our Standard Hospital Bill Audit includes review of medical records to substantiate charges billed by the hospital. The process below provides details on handling of inappropriate charges identified during the course of an audit. Generally, a UnitedHealthcare Nurse Reviewer is expected to report his or her written findings to the hospital representative and disallow any inappropriate charges at the conclusion of the audit. Inappropriate charges may include, but are not limited to: an individual charge that appears to have been unbundled from the more general charge in which it is commonly included or a charge not supported by the medical record. Post-audit claim reconsideration will reconcile any overpayments or underpayments identified as a result of the audit process, in accordance with applicable law and your agreement with us.

Hospital requirements and access

- UnitedHealthcare's Hospital Audit Services Department will notify the hospital of the intent to audit a claim by sending a Communication Form. This Communication Form will be addressed to the hospital CFO, his or 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 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 if a bill breakdown will be provided within 30 calendar days after we notify the hospital of our intent to audit.)
- The hospital will cooperate in a timely manner, so the UnitedHealthcare Nurse Reviewer can complete the audit scheduling process within 30 calendar days of the scheduling request.
- If there is a requirement for a valid authorization to release medical information, it is the hospital's responsibility to obtain this release from the Customer, or to waive the requirement if permitted under applicable law. In many cases, such authorizations are signed at the time of admission and may already be on file.
- If there is a hospital-imposed fee to audit the medical record, or a copy fee, such fee will be waived unless specified in the hospital's agreement with us.
- 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 procedures.
- The hospital will give our audit vendors the same level of access as our employee auditors, when those vendors are acting at our direction and on our behalf. Any vendor authorized by us to conduct an audit on our behalf will be bound by our obligations under the hospital's agreement with us. This includes any confidentiality requirements regarding the hospital audit, and compliance with HIPAA requirements and use of Protected Health Information.
- The hospital will not impose any time limitation on our right or ability to audit, unless stated in the hospital's agreement with us or permitted by applicable state or federal law.

Audit findings and exit conference

- 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 our 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. If the audit occurs at a location other than the hospital, a copy of the findings will be supplied promptly.
- The document findings 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.
- During this conference, the hospital representative will have the opportunity to present any conflicting audit findings. If additionally required by our agreement with us 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 30 calendar days of receipt of the refund request, or as required by or federal 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 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 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 our Network Management staff. 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 this Guide and in your agreement with us.
- Offsets – When a refund request has been issued in connection with a Standard Hospital Bill Audit, we will recoup or offset the identified overpayment, underpayment, and/or disallowed charge amounts after the expiration of 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 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 35 calendar day repayment period; or (3) your agreement or state law indicates otherwise.

Medicare Advantage risk adjustment data

The risk adjustment data you submit to us 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 the correct ICD-9-CM (or its successor) coding manual and code accurately, specifically and completely when submitting claims to us.
- Diagnosis codes must be supported by the medical record. Therefore, medical records must be clear, complete and support all conditions coded on claims or encounters you submit.
- Be sure to code all conditions that co-exist at the time of the patient visit and require or affect patient care, treatment or management.
- 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 and chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the Customer's condition and pertinent history at the time of the visit. Do not code conditions that were previously treated and no longer exist.
- 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 Customer's condition.
- Be sure that the diagnosis code is appropriate for the Customer's gender.
- Be sure to sign chart entries with credentials.
- CMS or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner.

Protocol for Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to Customers at least 2 calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the Customer's services are expected to be fewer than 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 services exceeds 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 Customer or Customer's authorized representative, if the Customer is incompetent. The notice uses the standard CMS approved version entitled, "Notice of Medicare Non-coverage" (NOMNC). The text may be found on the CMS website or you may contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text.

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 us or the QIO if the Customer has requested a fast track appeal.

Quality Management

Health management program information: Case and Disease Management programs

Physicians may refer individuals enrolled in our commercial and Medicare plans to any of our 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 Customer will be assessed to determine the appropriate level of intervention. Customers with coverage through UnitedHealthcare's affiliated health plans can be referred by calling the number on the back of the Customer's health care ID card.

Case Management

At the core of Case Management is the philosophy of identifying older, disabled, or otherwise vulnerable individuals and those with complex and chronic health needs, who can benefit from case management services. We partner with individuals, their families and their treatment team to facilitate healthcare access and decisions that can have a dramatic impact on the quality and affordability of their health care. Individuals who are at high risk may benefit from the programs listed below. Please note that the availability of programs may vary by product and location.

- High Risk Care Management Program
- Transitional Case Management Program
- Post Acute Transition Program
- Advanced Illness Program

We analyze medical, pharmaceutical, and behavioral health claims data using our proprietary predictive modeling algorithms to identify Customers based on their health risks. We also encourage and accept Customer self-referral, caregiver referral and physician referral.

Upon identification, we conduct an outreach and assessment to identify gaps in care, implement Customer and practitioner education as needed, and coordinate access to the services the Customer needs. The foundation of this process is the use of nationally recognized, evidence-based medical guidelines. Our case managers are registered nurses who engage the appropriate resources needed to address the gaps in care 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 (e.g. transplant services), behavioral health, employee assistance and disability. Case management services are voluntary and a Customer can opt out at any time.

Case managers engage the individual's physician, including primary care or specialists, to make sure the individual is receiving 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. Depending on an individual's needs, Customer engagement in the Case Management programs can range from a few weeks to an indefinite period of time.

Disease Management Programs

UnitedHealthcare and its affiliated health plans* offers population based disease management programs that are designed to use multiple sources of information, including but not limited to the predictive models to identify and stratify individuals with these conditions into the appropriate level of intervention. The programs are voluntary and at no additional cost to the participant. Depending on the Customer's product line, health plan, and benefit plan, design offerings vary and may include:

- Coronary Artery Disease
- Diabetes
- Congestive Heart Failure
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- High Risk Pregnancy
- End Stage Renal Disease
- Acute MI**
- Transplant
- Hemophelia**

Our programs include screening for depression and coordination to enable those Customers with behavioral health needs to access the appropriate resources. We also help the Customer to address lifestyle-related health issues through the active referral of the individual to programs for weight management, nutrition, smoking cessation, exercise, diabetes care, stress management and other health conditions. Our programs provide information and resources that Customers 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 to prevent unplanned transitions.

The goals of Disease Management are to assist individuals in managing their condition and to support the physician's treatment plan. 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.

For some programs, individuals may receive comprehensive assessments by specialty-trained registered nurses to determine the appropriate level and frequency of interventions required. After a comprehensive assessment, based on the Customer's acuity, a structured intervention program is implemented. Based on an individualized risk assessment, individuals discharged from the hospital may be enrolled in transitional case management. Based on clinical condition, individuals may also receive an outbound call and a letter reinforcing discharge instruction and follow-up. The programs use evidence-based medicine to identify gaps in care and prevent avoidable admissions or slow the progression of the chronic condition. For high risk individuals, the outbound call program provides a series of structured calls as needed to address their particular gaps in care. The participant may also call a disease management nurse at any time during normal business hours or NurseLineSM*** 24 hours a day. For many of our programs individuals may also receive educational mailings, newsletters and tools such as a HealthLog to assist them in tracking their physician visits, health status and recommended targets or other screenings.

Physicians are notified when their patients participate in the high-risk disease management program. Physicians with patients in moderate intensity programs may receive information on gaps in care. Individuals also receive this information and are encouraged to talk to their physicians about health screenings, screening results and goals of treatment. For those programs that include a Health Log, customers and their practitioners are encouraged to work together to maintain the Health Login order to facilitate continuity of care. Practitioners are also advised that the program is designed to complement the treatment plan, reinforce instructions the practitioner may have provided, and to offer support for

* Affiliated health plans include Oxford Health Plans, MD IPA and OCI, UnitedHealthcare of the River Valley, Neighborhood Health Partnership and UnitedHealthcare West (formerly known as PacifiCare). Please call the number on the back of the patient's health insurance card to refer a patient for Case or Disease Management services

** Limited to eligible UHC River Valley and NHP members

*** For informational purposes only. NurseLine nurses cannot diagnose problems or recommend specific treatment and are not a substitute for a doctor's care. NurseLine services are not an insurance program and may be discontinued at any time.

healthy lifestyle choices. The program is not intended to diagnose or treat, and it is not a substitute for the practitioner's professional medical advice.

UnitedHealth Premium Designation Program (Commercial only)

The UnitedHealth Premium® 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 21 specialty areas 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 measures for quality and local cost efficiency benchmarks in the same specialty. Individual physicians are evaluated for the Premium program if they are contracted and credentialed with UnitedHealthcare and practice in a specialty and geographic location that are included in the Premium program. Designation results are publicly displayed in online physician directories.

In general, the evaluation of physicians for quality of care compares the observed practice of one physician to the observed practice of other UnitedHealthcare participating physicians nationally who are responsible for the same interventions, based on published scientific evidence and national standards applied to administrative data. The evaluation of physicians for cost efficiency compares observed episodic costs to the risk-adjusted costs of their peers in the same specialty and geographical area.

We strongly support transparency in our performance assessment criteria and methods. For more information regarding the UnitedHealth Premium physician designation program (including the criteria we use), go to UnitedHealthcareOnline.com → 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.

View 360 - HEDIS Gaps in Care

View360™ Online, where available, gives physicians and their practices a new tool to monitor and update the status of preventive screening measures for their patients who are UnitedHealthcare members.

View360 monitors month-to-month changes in preventive screening measures for patients with Commercial and Medicare benefits who receive care from the following UnitedHealthcare-contracted primary care physicians and specialists:

- Primary Care - General Practice
- Primary Care - Internal Medicine
- Primary Care - Family Practice
- Pediatrician
- Nephrologist
- Allergist
- Neurologist
- Cardiologist
- Pulmonologist
- Geriatrician
- Endocrinologist
- Rheumatologist
- Obstetrician/Gynecologist

Through a secure interactive website participating physicians receive information regarding patients who may be due for recommended treatments, screenings or exams, consistent with national quality guidelines. The information is available in both summary and detailed forms, and is presented in a manner consistent with applicable state and federal patient privacy laws. For example, if a law precludes disclosure of certain types of sensitive information without a patient's consent or authorization, that information will not be disclosed through the View360 tool.

To learn more about View360 and access the web-based tools, please visit

UnitedHealthcareOnline.com → Clinician Resources → View360. If you have questions, please contact us via email at mailto:View360@uhc.com View360@uhc.com, or by calling (866) 270-5588.

Oncology/Hematology - UnitedHealthcare Cancer Registry

Clinical data collection for breast, colorectal, lung and prostate cancer

UnitedHealthcare is committed to improving the quality of oncology care. We initiated the UnitedHealthcare Cancer Registry in 2007. This registry includes clinical data such as clinical stage, date of diagnosis and current clinical status. As your UnitedHealthcare patients are identified with breast, colorectal, lung and prostate cancer, we will be requesting that you provide this clinical information, unavailable on claims data, to UnitedHealthcare. UnitedHealthcare will contact you prior to faxing the initial Cancer Status Form for completion. In advance, your time and effort is very much appreciated.

For this program, UnitedHealthcare and its participating physicians, as covered entities, may share clinical information with other covered entities for health care operations without obtaining patient authorization.

Why should I submit UnitedHealthcare Cancer Status Forms?

Submitting the UnitedHealthcare Cancer Status Form allows you to contribute clinical staging information to the UnitedHealthcare Cancer Registry. This information will be used to conduct ongoing Oncology Care Analysis in the area of cancer care. Oncology Care Analysis results will be leveraged to identify national quality improvement opportunities. UnitedHealthcare previously shared the Oncology Care Analysis reports with oncologists. These reports combined the clinical information supplied by oncologists and incorporated into our Cancer Registry with UnitedHealthcare claims data. The report compared patient care data to UnitedHealthcare claims data. The report compared patient care data to recognized and widely accepted treatment guidelines for three conditions: breast, colorectal and lung cancer.

These reports are intended to supplement your practice, help physicians understand practice strengths and identify areas for improvement. This data is not used to rank, reward or penalize any physician. Overall, the results from our first edition support our belief that oncology care in the United States follows established professional standards. That report identified some gaps in care and we hope that the report will assist physicians in addressing those gaps in care with their patients. For more information regarding this program, go to UnitedHealthcareOnline.com → Clinician Resources → Cancer – Oncology, or contact us at unitedoncology@uhc.com.

Clinical guidelines

UnitedHealthcare uses evidence-based clinical guidelines from nationally recognized sources to guide our quality and health management programs. We hope you will consider this information and use it, when it is appropriate for your eligible patients. The clinical guidelines are published each September in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News → Network Bulletin. If you do not have internet access and would like information on how to obtain copies of a guideline, please contact our National Clinical Excellence Team at (954) 447-8818.

Important behavioral health information

Screening for Common Behavioral Health Concerns

The U.S. Preventive Services Task Force (USPSTF) recommends screening patients for depression and alcohol misuse in primary care settings. If left untreated, these disorders can adversely affect patient quality of life and clinical outcomes. Screening for these disorders is key to treatment since it can contribute to the patient's readiness to change.

You can help by screening all patients, including adolescents, for depression and alcohol misuse. To assist, United Behavioral Health and UnitedHealthcare recommend the following screening tools:

Depression	• PHQ-9 • PRIME MD	CPT 99420
Alcohol Misuse	• PHQ-9 • NIAAA Single Question Screen (NSQS) • AUDIT and AUDIT-C	CPT 99420

You will find these screening tools for free online. You may also email your request to United Behavioral Health at BHInfo@uhc.com.

For more information on depression and alcohol misuse disorders, you and your patients may access a United Behavioral Health Website, www.liveandworkwell.com. To refer a patient to a United Behavioral Health network practitioner for assessment and/or treatment, call United Behavioral Health at the toll free number on the back of your patient's UnitedHealthcare health insurance ID card.

The Reimbursement policy for Preventive Medicine and Screening notes that counseling services are included in preventive medicine services. This policy and the Preventive Care Services Coverage Determination guideline are available at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Reimbursement Policies.

Depression, Alcohol Abuse and Drug Abuse and Addiction & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

United Behavioral Health has developed an online Preventive Health Program that offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse and drug abuse and addiction 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, Customers and their families. Physicians and other health care professionals may access the program via UnitedHealthcareOnline.com → Clinician Resources → Patient Safety Resources → Behavioral Health or at http://prevention.liveandworkwell.com.

The importance of collaboration between primary physicians and behavioral health clinicians

A substantial number of Americans who have serious illnesses also have behavioral health conditions. Approximately 20% of Americans who have had a heart attack are likely to develop depression within 12 months of the event; at least 15% of Americans with diabetes also have depression.

It is important to determine if a behavioral health clinician is treating a Customer 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 Customers 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 Customers 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 Customers being prescribed psychotropic medication. It can also help reduce the risk of relapse for Customers 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 Customer that allows you to share appropriate treatment information with the Customer's behavioral health clinician.

Psychiatric consults for medical patients

Please contact United Behavioral Health if you would like to arrange a psychiatric consultation for a Customer 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 phone number on the back of the Customer's health care ID card.

Together, improving health care quality

The excellent care you deliver to your patients is reflected in the quality of our health care plans. By taking a big picture view of quality and incorporating feedback from your patients' health care experience and working with you, we can provide higher quality health care plans to your patients — and our members — and, together, help them live healthier lives.

UnitedHealthcare is committed to providing high quality health care products for your patients. From the time your patient enrolls in one of our plans, our quality initiatives touch every claim, phone call and physician visit. Our evidence-based wellness and care management programs help your patients achieve the best possible health, in coordination with physicians like you and with the support of our own clinicians. We've built a quality infrastructure to measure our performance and quality, and make health care simpler and more efficient.

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 us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and annual Health Care Effectiveness Data and Information Set (HEDIS®) record review;
- If we request medical records, provision of copies of such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax.

Medicare Advantage and Prescription Drug Plans

Several industry quality programs, including the Centers for Medicare & Medicaid Services (CMS) Star Ratings, provide external validation of our Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1 to 5-star scale, with 1 star representing the lowest quality and 5 stars representing the highest quality. Star Ratings scores are derived from four sources:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) or patient satisfaction data,
2. Health Care Effectiveness Data and Information Set (HEDIS) or medical record and claims data,
3. Health Outcomes Survey (HOS) or patient health outcomes data, and
4. CMS administrative data on plan quality and Customer satisfaction.

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D plans, go to CMS' consumer website at cms.gov.

Imaging accreditation

If you perform outpatient imaging studies and bill on a CMS -1500 or the electronic equivalent, you must obtain accreditation from one of the accrediting agencies listed below.

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

Accreditation is required for the following procedures: CT scan, MRI, Nuclear Medicine/Cardiology, PET scan and Echocardiography, in order to avoid the potential reimbursement reductions described below. This accreditation requirement applies to global and technical service claims. The accreditation process takes approximately 6 to 9 months to complete. This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards.

Upon notice from us, 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 for global and technical service claims, in part or in whole, will occur.

Accreditation is obtained by submitting an application and fulfilling accreditation standards.

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

General administrative requirements

Access standards

UnitedHealthcare establishes standards for appointment access and after-hours care to make sure timely access to care for Customers. Performance against these established standards is measured at least annually. UnitedHealthcare's standards are shown in the table below.

Type of service	Standard
Preventive Care	Within 4 weeks
Regular/Routine Care Appointment	Within 14 days
Urgent Care Appointment	Same day
Emergency Care	Immediate
After-Hours Care	24 hours/7 days a week for primary physicians

The guidelines listed above are general UnitedHealthcare guidelines; state regulations may require more stringent standards. Contact your Network Management representative for state-specific regulations.

After-hours care

We ask that you and your practice have a mechanism in place for after-hours access to make sure every Customer calling your office after-hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911, or its local equivalent, or
- Go to the nearest emergency room.

In non-emergent circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:

- Go to an in-network urgent care center,
- Stay on the line to be connected to the physician on call,
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames, or
- Call an alternative phone or pager number to contact you or the physician on call.

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 Customer's in-network benefit. We encourage you to go to UnitedHealthcareOnline.com to find the most current directory of our network physicians and health care professionals.

Continuity of Customer Care following termination of your participation

If your network participation agreement terminates for any reason, you are required to assist in the transition of our Customers' care to another physician or health care professional who participates in the UnitedHealthcare network. This may include providing services for a reasonable time at our contracted rate during the continuation period, as further described in your agreement with us. Our Customer Care staff is available to help you and our Customers with the transition. At least 30 calendar days prior to the effective date of your departure from the network, we will send notification to affected Customers. If applicable state law requires earlier notification, we will follow the state law.

Additional Medicare Advantage requirements

If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements for services you provide to our Medicare Advantage Customers.

- You may not discriminate against Customers in any way based on health status.
- You must allow Customers to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on Customers for influenza vaccine or pneumococcal vaccine.
- You must provide female Customers with direct access to a women's health specialist for routine and preventive health care services.
- You must make sure that Customers have adequate access to covered health services.
- You must make sure that your hours of operation are convenient to Customers and do not discriminate against Customers and that medically necessary services are available to Customers 24 hours a day, 7 days a week. Primary Care Physicians must have backup for absences.
- You may not distribute marketing materials or forms to Customers without CMS approval of the materials or forms.
- You must provide services to Customers 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 Customers of health care needs that require follow-up and provide necessary training to Customers in self-care.
- You must document in a prominent part of the Customer's medical record whether the Customer has executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.

- You must make sure 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 Customers in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying Customers of network participation agreement terminations.
- You must comply with our Medicare Advantage 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.

Fraud, Waste and Abuse Requirements & Training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage Organizations and Part D Plan Sponsors to communicate with and provide training and education to their "first tier, downstream, and related entities." This term includes contracted physicians, health care professionals, facilities and ancillary providers, as well as vendors, contractors, and related parties. The required training, education and screening requirements to which we – and you – are subject include the following:

Code of Conduct/Conflict of Interest Policy Awareness. Our first tier, downstream, and related entities working on Medicare Advantage, Part D or Medicaid programs – including contracted providers – must provide a copy of our Code of Conduct (which incorporates our Conflict of Interest policy) to their employees/contractors.

What You Need to Do: Review our Code of Conduct, available at unitedhealthgroup.com → About → Ethics & Integrity, and provide this to your employees/contractors.

Fraud, Waste, and Abuse & Compliance Training. Our first tier, downstream, and related entities working on Medicare Advantage, Part D or Medicaid programs – including contracted providers – must provide compliance program training and Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training can come from UnitedHealthcare or from another source, subject to certain requirements.

First tier, downstream, and related entities meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider are deemed by CMS rules to have met the training and education requirements. It is our responsibility to make sure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we are providing training materials through UnitedHealthcareOnline.com → Tools & Resources → Training & Education.

What You Need to Do: Administer the compliance and FWA training materials available at UnitedHealthcareOnline.com to your employees and/or contractors. If your organization has already completed a compliance and FWA training program – either on your own or through another health plan sponsor – that meets CMS requirements, UnitedHealthcare will accept documentation of that training. Please maintain records of the training (i.e. sign-in sheets, materials, etc). Documentation of the training may be requested by UnitedHealthcare or CMS to verify that training was completed.

Exclusion/ Sanction/Debarment Checks. Our first tier, downstream, and related entities must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to make sure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals /Entities: http://oig.hhs.gov/exclusions/index.asp
- General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Non procurement programs: epls.gov/

What You Need to Do: Review applicable exclusion/sanction/debarment lists to make sure that none of your employees or contractors are excluded from participation in federal health care programs.

If you identify compliance issues and/or 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. UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

Credentialing and recredentialing

We are dedicated to providing our Customers 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 Customers. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use 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 designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application.

Physicians and other health care providers can view the Credentialing and Recredentialing Plan at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Credentialing & Recredentialing Plan.

Customer rights and responsibilities

We tell our Customers that they have specific rights and responsibilities outlined in the Customer materials for Commercial and Medicare Advantage benefit plans, all of which are intended to help uphold the quality of care and services that they receive from you.

A copy of the Customer Rights and Responsibilities can be obtained by contacting your Provider Advocate at (877) 842-3210. The Customer Rights and Responsibilities Statement is also published each July for Commercial plans and each November for Medicare in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News → Network Bulletin.

Inform Customers 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 patients on state law about advance treatment directives, about patients' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform Customers of state laws on advance directives through our Customers' benefit material. We encourage these discussions with our Customers.

Access to records

We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our Customers within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a Customer grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for confidentiality for 6 years or longer if required by applicable statutes or regulations. For example, for the Medicare Advantage plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

Medical record standards

A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. Our recommended medical record standards are published each November for Commercial and Medicare plans in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News → Network Bulletin.

Non-discrimination

You must not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer of UnitedHealthcare or its affiliates, 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 Customers in need of the services you provide.

Provide official notice

You must send notice to us at the address noted in your agreement with us and delivered via the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of, liability insurance;
- Bankruptcy or insolvency;
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;

- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice;
- For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility; or
- Relocation or closing of your practice, and, if applicable, transfer of Customer records to another physician/facility

Medicare opt-out providers

UnitedHealthcare abides by, and requires its providers to abide by, Medicare's physician/practitioner opt-out policy. Physicians/practitioners who opt-out of Medicare (this may include physicians/practitioners not participating in Medicare) are not allowed to bill Medicare or its Medicare Advantage plans for 2 years from the date of official opt-out. For its Medicare Advantage membership, UnitedHealthcare and its delegated entities will not contract with, or pay claims to, providers who have opted-out of Medicare.

Exception: In an emergency or urgent care situation, a physician/practitioner who opts-out of Medicare may treat a Medicare beneficiary with whom he or she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a non-participating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with the physician/practitioner.

Provide timely notice of demographic changes

Physician/health care professional verification outreach

UnitedHealthcare is committed to providing our Customers 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

We ask that you notify us of changes to the following demographic information 30 calendar days prior to the effective date of the change: 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 your W-9 form to make a TIN change or to add a physician or other 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 → Contact Us → Service & Support → Forms.

Changes can also be made by submitting the detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

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 by using the Practice/Facility profile function found on the global navigation at the top of any 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.

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.

UnitedHealthOne & All Savers Supplement

Important information regarding the use of this Supplement

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers individual personal health products including Golden Rule Insurance Company, American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, Oxford Health Insurance, Inc. and Oxford Health Plans (NJ) that offers personal health insurance products.

Golden Rule Insurance Company ("GRIC") plans are underwritten and administered by GRIC. PacifiCare Life and Health Insurance Company ("PLHIC") Individual Plans in CA and American Medical Security Life Insurance Company ("AMSLIC") plans are administered by AMSLIC.

All Savers Insurance Company (ASIC), a UnitedHealthcare company, offers health insurance to small employers, typically with 2-50 employees. ASIC is administered by AMSLIC.

This Supplement applies to services provided to Insureds enrolled in GRIC, PLHIC, AMSLIC and ASIC benefit plans. For services you render to GRIC, PLHIC, AMSLIC and ASIC Insureds, if there is any inconsistency between the rest of this Guide and either this GRIC, PLHIC, AMSLIC and ASIC Supplement or the Insured's benefit plan, this GRIC, PLHIC, AMSLIC and ASIC Supplement and the Insured's benefit plan will prevail.

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

Resource	Where to go	What you can do there
GRIC		
Notification	Call the number on the back of the Insured's health care ID card or (800) 999-3404	To notify of hospitalizations exceeding 3 days or transplant services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 657-8205 or go to myuhone.com/provider	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services	GoldenRule.com	To review the Prescription Drug List.
	Call the pharmacy number on the back of the Insured's health care ID card (800) 922-1557	To request a copy of the Prescription Drug List.
PLHIC & AMSLIC		
Notification	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To notify of hospitalizations exceeding 3 days or transplant services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services (Prescription Solutions)	Call the pharmacy number on the back of the Insured's health care ID card or (800) 797- 9791	To request a copy of the Prescription Drug List.
ASIC		
Notification	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To notify of hospitalizations exceeding 3 days, or 5 days prior to a transplant evaluation and selected medical services outlined in the *Notification Requirements* section of this Supplement.
Benefits and Eligibility	Call the number on the back of the Insured's health care ID card or (800) 232-5432	To inquire about an Insured's plan benefits or eligibility.
Pharmacy Services	Call the pharmacy number on the back of the Insured's health care ID card or (800) 922- 1557	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. This is what you can do to help promote prompt payment:

1. Notify GRIC, PLHIC, AMSLIC or ASIC in accordance with the notification requirements set forth in this Supplement.
2. Prepare a complete and accurate claim form.
3. For GRIC Insureds - submit electronic claims using Payer ID # 37602. This is the electronic claims routing number for GRIC Insureds. Submit paper claims to the address on the Insured's health care ID card.
4. For PLHIC, AMSLIC & ASIC Insureds - submit electronic claims using Payer ID # 81400. This is the electronic claims routing number for PLHIC, AMSLIC and ASIC Insureds. Submit paper claims to the address on the Insured's health care ID card.
5. For contracted providers who submit electronic claims for PLHIC, AMSLIC and ASIC Insureds who would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at (877) 620-6194. Select option 1 followed by option 1 again to speak with a representative. You can also log onto OptumHealthFinancial.com.

Claim adjustments

If you believe your claim was processed incorrectly, please call PLHIC, AMSLIC or ASIC at (800) 232-5432 or GRIC 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 identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination (see the *Claims appeals* section in this Supplement).

Claims appeals

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

GRIC Insureds:

Golden Rule - Appeals Department
7440 Woodland Drive
Indianapolis, IN 46278

Your appeal must be submitted to GRIC within 12 months from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

PLHIC, AMSLIC and ASIC Insureds:

American Medical Security – Appeals Review
P.O. Box 13597
Green Bay, WI 54307-3597

Your appeal must be submitted to PLHIC, AMSLIC or ASIC within 180 days from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

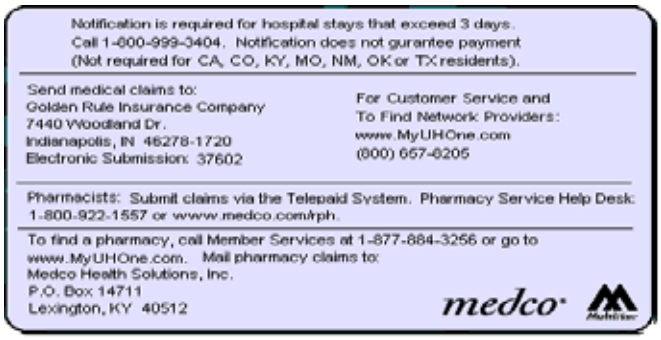
If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your participation agreement.

Health care ID card

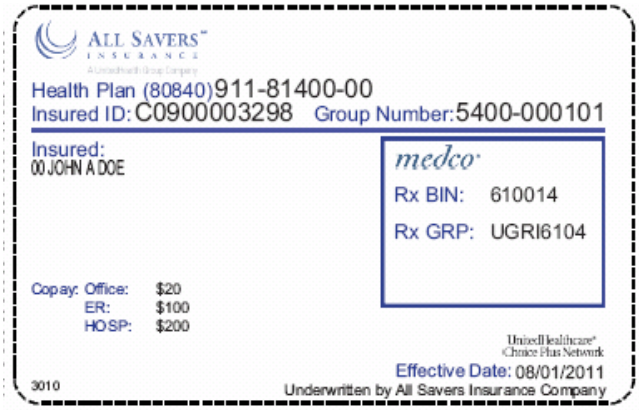
GRIC, PLHIC, AMSLIC and ASIC Insureds receive health care ID cards containing information that helps you submit claims accurately and completely. Information will vary in appearance or location on the card. However, cards display essentially the same information (e.g., claims address, copayment information, and phone numbers).

Be sure to check the Insured's health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use PLHIC, AMSLIC and ASIC electronic Payer ID # 81400 or GRIC electronic Payer ID # 37602.

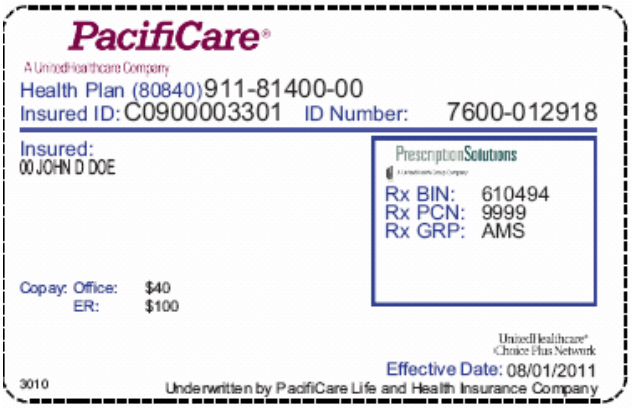
GRIC sample ID card



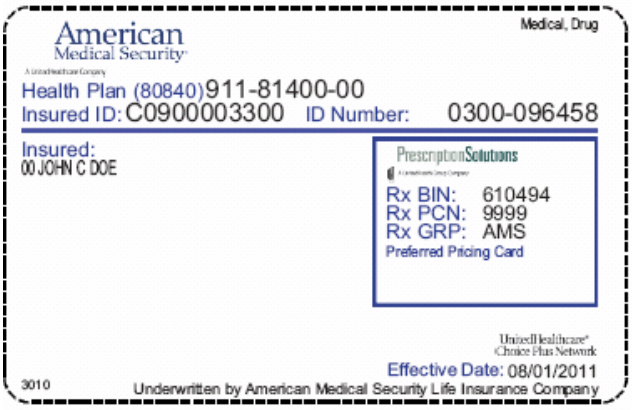
ASIC sample ID card



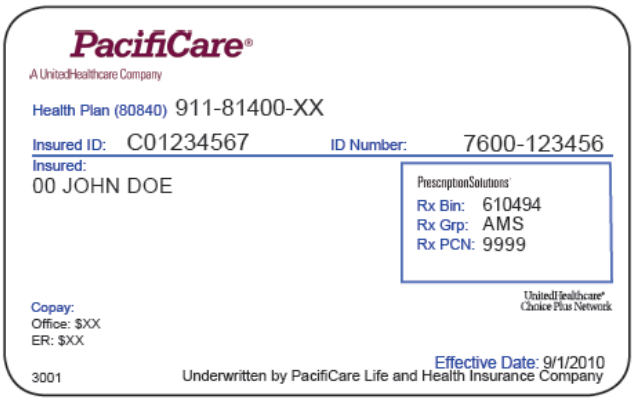
PLHIC sample ID card



AMSLIC sample ID card



PLHIC sample ID card



Notification requirements

Notify American Medical Security or Golden Rule at the number listed on the Customer's health care ID card for any inpatient facility admission that will exceed 3 days and for proposed transplant services. In addition, notify All Savers members prior to the beginning of a clinical trial.

Notification, in order to be effective, must contain all necessary information including, but not limited to: Insured's name, Insured's health care ID number, hospital name, hospital TIN, 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 phone number listed on the Insured's health care ID card.

Notify GRIC, PLHIC and AMSLIC prior to:

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

Notify ASIC prior to:

Procedures and services	Explanation
Inpatient facility admissions	Inpatient admissions expected to exceed 3 days including: Acute hospitalizations (includes long term acute care), rehabilitation facilities, and skilled nursing facilities (includes sub acute and hospice) that will exceed 3 days. Notify on or before 4th inpatient day.
Transplant services	5 business days prior to pre- transplant evaluations.
Clinical Trials	5 business days prior to beginning a clinical trial.

Notice to Texas providers

- For Verification of Benefits for GRIC Insureds, please call (800) 395-0923.
- For Verification of Benefits for PLHIC, AMSLIC and ASIC Insureds, please call (800) 232-5432.

GRIC, PLHIC, AMSLIC and ASIC use tools developed by third parties, such as the Milliman Care Guidelines, to assist them in administering health benefits and to assist clinicians in making informed decisions in many health care settings, including acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, GRIC, PLHIC, AMSLIC and ASIC may also use the medical policies as guidance. These policies are available online at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols.

Notification does not guarantee coverage or payment (unless mandated by law). The Insured's eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the phone number on the back of the Insured's health care ID card.

Important information regarding diabetes (Michigan only)

Michigan has a law requiring insurers to provide coverage for certain expenses to treat diabetes. The law also requires insurers to establish and provide to Insureds and participating providers a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines published by the ADA.

The program for participating providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations for 2010 at care.diabetesjournals.org. To use the Quick Search in the Diabetes Care site, enter the article name in the Keyword(s) box: Standards of Medical Care in Diabetes 2010 and enter Year: 2010; Vol: 33; Pages: S11-S61.

Subscription information for the American Diabetes Journals is available on the website or by calling (800) 232-3472, select option 1, 8:30 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday. You may view journal articles without a subscription online at the website listed above.

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

This Guide is supplemented by the Leased Network Supplement (the "leased Supplement") for physicians, health care professionals, facilities and ancillary providers who participate with UnitedHealthcare through a leased network for certain products accessed by UnitedHealthcare in an area where UnitedHealthcare does not have a direct network.

Physicians, health care professionals, facilities and ancillary providers participating in UnitedHeathcare's network through a leased network are subject to both the Guide and the leased Supplement. However, in the event of any inconsistency between the Guide and this leased Supplement, the leased Supplement will prevail for Customers accessing UnitedHealthcare benefits through a leased network arrangement.

Leased Supplement

Any reference in the Guide to a physician's, health care professional, facility, or ancillary provider's "agreement with us" refers 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 ("Supplement") applies to services provided to members enrolled in Medical Doctor's Practice Association, Inc. ("M.D. IPA"), Optimum Choice, Inc. ("Optimum Choice") or any benefit plan serviced or administered by OneNet PPO, LLC ("OneNet") (collectively "MAHP members"). In the event of any inconsistency between the Guide found on UnitedHealthcareOnline.com – regarding payments policies and protocols and this Mid-Atlantic Regional Supplement, the Supplement will prevail for the products described in this section.

Product summary

This table provides information about M.D. IPA and Optimum Choice products for the Mid-Atlantic Region.

Attributes	M.D. IPA and Optimum Choice	M.D. IPA Preferred and Optimum Choice Preferred
How do members access physicians and health care professionals?	Members choose a Primary Care Physician (PCP) who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care. *** In-network benefits only. (Lock in) Products may also be referred to as Gated HMO.	In-network benefits: Members choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care. Products may also be referred to as Gated HMO Out-of-network benefits: Members are not required to have their care be arranged or coordinated by a PCP.
Does a Primary Care Physician have to write a referral to a specialist?	Yes, except for visits to a network OB/GYN routine eye refraction care, and for emergency services.	In-network benefits: Yes, except for visits to a network OB/GYN, routine eye refraction care., and for emergency services. Out-of-network benefits: No referral needed.
Is the treating physician required to precertify or preauthorize some procedures or services?	Yes. Please view section on precertification and preauthorization process located within this supplement.	Yes, please view section on precertification and preauthorization process located within this supplement

*** MAMSI Life and Health Insurance Company underwrites a product that uses the Choice Plus network in the Mid-Atlantic Region that follows all Choice/Choice Plus policies.

Health care ID cards

Customers enrolled in M.D. IPA and Optimum Choice benefit plans will have a plastic health care ID card. For all M.D. IPA and Optimum Choice benefit plans, the health care ID card displays the UnitedHealthcare logo at the upper left-hand corner. The M.D. IPA and Optimum Choice, Inc. benefit name is displayed in both the upper and lower right corners of the card. Be sure to use the phone numbers and addresses noted on these health care ID cards.

Since 1/1/2011, M.D. IPA and Optimum Choice ceased producing and distributing paper cards that include ID number with an asterisk, and issued plastic cards to all Customers. All Customers must present an updated, plastic card containing their 9-digit Customer ID numbers. You can verify the Customer's benefits on UnitedHealthcareOnline.com.

Please note the following unique features on these ID cards:

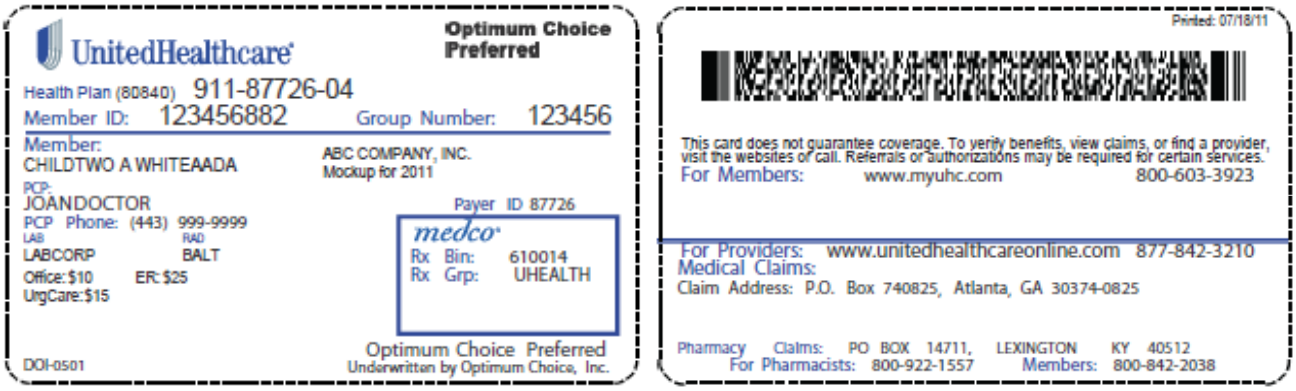
1. Logos for M.D. IPA and Optimum Choice are located on the top and bottom right-hand corners
2. Laboratory provider information is located on the front of the cards; please see the *Laboratory Services* section of this Supplement
3. Radiology county information is located on the front of the cards; please see the *Radiology Services* section of this Supplement
4. Information regarding the necessity of referral and authorization requirements is now listed on the back of the cards

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

MD I.P.A.

Optimum Choice

* Please note that some members may have ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits.



Laboratory Services

M.D. IPA and Optimum Choice Customers must use the outpatient commercial medical laboratory noted on their health care ID card (See above example under *Health Care ID Cards*) for outpatient commercial medical laboratory services. Any specimens collected in the office, MUST be sent to the laboratory indicated on the Customer's ID card. Depending on where the Customer lives, the health care ID will note:

- LAB = LABCORP (Laboratory Corporation of America)
- LAB = PAR (may use any participating outpatient commercial medical laboratory). Our online directory of healthcare professionals is available at UnitedHealthcareOnline.com.

Please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols → Mid Atlantic Protocols → Mid-Atlantic - Laboratory

Radiology Services

M.D. IPA and Optimum Choice Customers must use the radiology county noted on the health care ID card. Depending on the Customer's Primary Care Provider's office location, the health care ID card will note:

- RAD = PAR (may use any office based participating provider) A complete list of these providers may be found at UnitedHealthcareOnline.com → Physician Directory → General Physician Directory
- RAD = County (the name of a county, i.e., "Montgomery" will be listed on the card) Specific vendors are available for referral based on the county listed on the Customer ID card. A complete list of county specific radiology vendors may be found at UnitedHealthcareOnline.com → Tools and Resources → Protocols → Protocols for the Mid-Atlantic Region → Mid-Atlantic - Radiology Services

Referrals and Authorizations

Most specialist services require a referral from the patient's PCP. Referrals should be submitted by the PCP and reviewed by the specialist online. Please refer to the Referral Process Policy which can be located at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols → Protocols for the Mid-Atlantic Region → Mid-Atlantic - Referral Process.

Clinical service guidelines

The following guidelines apply to all M.D. IPA, Optimum Choice, M.D. IPA Preferred and Optimum Choice Preferred Customers.

Certain services require preauthorization or precertification. To contact us regarding preauthorization/precertification for these procedures and services call the number listed on the back of the health care ID card. The Health Services staff is available during the business hours of 8:30 a.m. to 5:30 p.m. EST.

Preauthorization and precertification requirements

The following lists services requiring preauthorization or precertification. You must submit your request at least 2 business days prior to the provision of services. Also, please keep in mind that some procedures and services listed here may not be covered under the Customer's benefit plan.

Procedures and services requiring preauthorization or precertification: Written request

- Acupuncture[1]
- Angiomas/hemangioma (with pictures)
- Biofeedback
- Blepharoplasty (with pictures/indicated testing)
- Breast implant Removal
- Breast Reconstruction (non-cancer diagnoses only)
- Chiropractic Services[1] (if not subject to a maximum dollar amount)
- Clinical Trials
- Cochlear implants
- Congenital Anomaly Repair (with pictures, indicated testing)
- Cosmetic and Reconstructive Surgery (with pictures and other documentation as required) –including but not limited to vein procedures, nasal surgery, orthognathic surgery)
- Dental procedures in a facility
- Dental services (except removal of cysts/ tumors and fracture care)
- Discectomy/Fusion (inpatient or outpatient)
- Durable Medical Equipment (for a complete list of DME items which do not require preauthorization, visit UnitedHealthcareOnline.com
- Elective inpatient procedures and admissions must be preauthorized. Precertification also required for:
  - Joint replacement (hip, knee, ankle, shoulder)
  - Morbid Obesity surgery
- Experimental Services/New Technologies
- General Anesthesia for Dental Procedures
- Gynecomastia Surgery (with pictures/ indicated testing)
- Home Care
- Hysterectomy (inpatient or outpatient)
- Injectable medications (listed below)[5]
- Infertility Services[1]
- Joint Replacement (hip, knee, ankle, shoulder)
- Laminectomy/Fusion (inpatient or outpatient)
- Occupational Therapy (after 8 visits)
- Morbid Obesity (surgery/procedures)
- Pelvic Laparoscopy
- Physical Therapy[2] (after 8 visits)
- Prosthetic devices except for prosthetic contact lenses
- Psychiatric Therapies including, but not limited to:[3]
  - Electroconvulsive Therapy (ECT)
  - Psychological Testing (including Psychological and Neuropsychological testing and extended developmental testing)
  - Substance Abuse Treatment (outpatient, detoxification, intensive outpatient Services, routine outpatient services with a primary diagnosis of substance abuse)
- Pulmonary rehabilitation
- Radiology[6]
  - Capsule Endoscopy
  - CT - Brain, Chest, Musculoskeletal, Colonography
  - MRI - Brain, Heart, Chest, Musculoskeletal
  - PET Scans (non-cancer diagnoses)
  - Virtual procedures
- Rhinoplasty/Septo-rhinoplasty (with pictures/indicated testing)
- Sclerotherapy (with pictures/indicated testing)
- Sleep Apnea (oral appliances and surgery)
- Speech Therapy[2] (after 8 visits)
- Syndrome (MPD) Treatment
- Temporomandibular Disorder (TMD) or related Myofascial Pain Dysfunction
- Transplants (and evaluations)
- Vagal Nerve Stimulator

Procedures and services requiring preauthorization or precertification: Telephonic or written request

- Ambulance Services (non-emergency)
- Cardiac Angioplasty (inpatient or outpatient)
- Coronary Artery Bypass Graft
- Dialysis (precertification by PCP)
- Psychiatric Therapies (preauthorization/precertification can be made by phone)
  - Inpatient Services (non-emergency)
  - Psychiatric Partial Hospitalization and Intensive Outpatient Treatment
  - Substance Abuse Treatment (Inpatient Rehabilitation, Partial Hospitalization)
- Radiation Therapy

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 hospitals in Montgomery and Prince George's counties in Maryland in a hospital
- Referral of an HMO Customer out-of-network to a non-participating physician, health care practitioner or facility.

1. Initial preauthorization/precertification request must be submitted by the Customer's PCP.
2. All Occupational Therapy, Physical Therapy and Speech Therapy services in an outpatient setting.
3. Precertify these services through the Behavioral Health Department.
4. For DME, please go to UnitedHealthcareOnline.com → Tools and Resources → Policies and Protocols, click on more in the *Protocols* sections, and select Mid-Atlantic Protocols, Durable Medical Equipment.
5. Refer to the Injectable Medications section in this Supplement for a list of drugs requiring preauthorization.
6. UnitedHealthcare's Radiology Notification Program does NOT apply to M.D. IPA or Optimum Choice members. Please follow the precertification and preauthorization requirements listed above.

Preauthorization is required for all non-emergency, planned admissions for all M.D. IPA and Optimum Choice members. This occurs prior to the hospitalization. Notification of actual admission takes place as described below. Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon Customer eligibility, benefits and applicable state law.

Inpatient admission notification

Provide admission notification to Health Services via phone at (800) 962-2174 or via fax at (800) 352-0049.

All participating facilities are required to notify applicable health plan of an admission of a Customer within 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 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 1st day of the admission if the treating provider previously received preauthorization of the scheduled admission.

In the event a Customer 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 make sure that covered services are provided to members in a timely manner. A 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 Customer. 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 Clinical 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 Customer 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 Customer'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 level of care 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 Customer 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 Customer. If any of the conditions above are not met, coverage for the transfer will be denied. Services at the receiving hospital will be approved if

- medical necessity criteria for admission were met at the receiving hospital, and
- there were no delays in providing services at the receiving hospital.

Injectable medications

The following medications require a preauthorization and are appropriate for office-based administration.

Drugs that require both preauthorization and the use of a specific vendor:

- Botox (Botulinum Toxin Type A)
- Myobloc (Botulinum Toxin Type B)
- Dysport (Botulinum Toxin Type A)
- Xeomin (Botulinum Toxin Type A)
- Synagis (Palivizumab)
- Xolair (Omalizumab)
- Supartz (Sodium Hyaluronate)
- Hyalgan (Sodium Hyaluronate)

Requests for preauthorization must be faxed to (800) 787-5325. Include clinical notes and name of specialty pharmacy vendor. For questions on required information or the precertification process, call (800) 355-8530. UnitedHealthcare will call provider's office within 3 days if conditions are not met for preauthorization of the drug. If authorized, Pharmacy Services will provide a written authorization number and coverage dates. This authorization must be submitted to the specialty pharmacy vendor along with the medication order.

Specialty pharmaceutical vendor information available at: UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources, or call (866) 429-8177.

Drugs that require preauthorization:

- Avastin (Bevacizumab)
- Euflexxa (Sodium Hyaluronate)
- Immune Globulin
- Orencia (Abatacept)
- Orthovisc (Sodium Hyaluronate)
- Remicade (Infliximab)
- Rituxan (Rituximab)
- Synvisc – SynviscOne (Sodium Hyaluronate)
- Tysabri (Natalizumab)

Note: 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 & Drug Policies and Coverage Determination Guidelines. For additional policies and information, call (800) 355-8530.

Claims process

Please refer to the *Prompt Claims Process* section in the main section of this Guide for detailed information about our claims process. Claims for specialist services that require referrals must be submitted on paper accompanied by a copy of the referral unless the referral was done electronically through UnitedHealthcareOnline.com. Please refer to the Referral Process Policy which can be found on UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols → Protocols for the Mid-Atlantic Region → Mid-Atlantic - Referral Process.

All claims that can be submitted electronically must be submitted electronically to Payer Number 87726. For claim reconsiderations for M.D. IPA and Optimum Choice, please send your request for reconsideration to the address on the back of the Customer's health care ID card or follow the instructions on the Provider Remittance Advice (PRA) or on the correspondence received from UnitedHealthcare. Instructions are also available on the UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration.

Appeals and reconsideration processes

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 will provide you with the filing deadlines and the address to use to submit the appeal. In the event a Customer designates a healthcare professional to appeal the decision on the Customer's behalf a copy of the Customer's written consent is required and must be submitted with the appeal.

Requests for additional information

In the event your claim is received and we need additional information to complete the processing of your claim, you will receive written notice. The letter will provide you with the filing deadlines and the address to use to submit the additional information as well as the information necessary to finalize your claim. A copy of the letter should be returned with the requested documentation.

How to request reconsideration of an administrative denial

Requests for Reconsideration for M.D. IPA and Optimum Choice should be submitted with a letter and any attached documentation to the address listed on the on the back of the Customer's health care ID card. The subject line of the letter should state "Reconsideration".

Note: This is not an appeal and should not be stated as such in the letter.

Customer 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 are located at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols → Protocols → Mid-Atlantic Protocols.

Primary care physician (PCP)

The Primary Care Physician (PCP) is the primary provider of medical services for Members. This includes preventive care and chronic care. The PCP is responsible for coordinating all care that Members may need through the Network Specialists. This includes Referrals to consultant Specialists, Home Health Care, and testing facilities such as Radiology

and Laboratory Centers. PCPs are reimbursed for medical services through capitation or fee-for-service payments. Primary Care Physicians are required to submit encounter data for services covered under capitation.

When a Customer enrolls in a M.D. IPA or Optimum Choice Benefit Plan, he or she is asked to select a PCP. The collective group of members who have chosen a specific PCP is referred to as the PCP Panel. The Customer-to-PCP ratio may be reviewed and/or modified if any Customer complains about access, or if UnitedHealthcare of the Mid-Atlantic region identifies a quality related issue. UnitedHealthcare of the Mid-Atlantic region may close any PCP panel.

Note: For all requests relating to panel status (i.e. Open/Closed to New/Existing Patients), the physician is required to contact their Network Account Representative prior to any action. To locate your Network Account Representative, please go to the Contact Us page at UnitedHealthcareOnline.com and reference the network contact section.

M.D. IPA and Optimum Choice copayment amounts for PCP services are printed on the Customer's health care ID card. If the Customer does not present a card, Eligibility and Copayment amounts may be determined by calling the United Voice Portal or at UnitedHealthcareOnline.com. You may obtain a copy of the Customer's current health care ID card on the Provider Portal. Copayments are due at the time PCP services are rendered.

Capitation

Capitation payment will be paid to the practice for covered services on a per member per month (PMPM) basis. The PCP receives separate capitation payments for members of M.D. IPA and Optimum Choice monthly on the fifth day of the month.

The PMPM is calculated by multiplying the fixed monthly rates (detailed in the Capitation Rate Schedule contained within the contract) times the number of members who have selected or been assigned to a PCP within the practice.

Payment Rules:

The capitation payment for a given month is calculated based on the 15/30 rule. This rule is used to determine whether a capitation payment is made for the full month or not at all. If the effective date of Customer change falls between the 1st and 15th of the month, the change is effective for the current month. If the effective date of the Customer change falls on or after the 16th of the month, the capitation adjustment is reflected on the first of the following month. As such, retroactive adjustments to capitation payments may be made based on the Members eligible on the 15th of the month.

15/30 Rule	The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not all. If the effective date of a change falls between the 1st and 15th of the month, the change is effective for the current month, and capitation is paid for that month. However, if the effective date falls on the 16th or later, the change is reflected the 1st of the following month and capitation is paid for the following month. For purposes of capitation payments, members are added on the 1st day of the month or terminated on the last day of the month, with the exception of newborns, who are added on the date of their birth(s). Capitation will be paid for full months, and conversely recouped for full months if appropriate. As an example: **Retroactive Add:** A Customer added retroactively on the 14th of the month would generate a capitation payment for the entire month. However, a Customer added on the 16th or later would not generate a capitation payment, even though the Customer would be considered eligible for services. To aid the provider in identifying these members, the Customer's standard services capitation will be reported as $0. **Retroactive Term:** A Customer retroactively terminated between the 1st and 14th of the month would generate a capitation recoup entry for the capitation previously paid for the entire month. However, a Customer retroactively terminated on the 16th or later would not generate a capitation recoup entry for the capitation previously paid for the entire month.

UnitedHealthcare of the Mid-Atlantic region provides Capitation Reports to PCPs, as described below:

ECap Report Name	ECap Report Purpose
7030-A01: Capitation Analysis Summary – Provider Medical Group Report	High-level capitation information by current and retro periods for each provider.
7010-A01: Capitation Paid ECap – Provider Medical Group Report – Summary	A contract-level report that summarizes the capitation paid by current and retro periods. The 3 sections of the report include amounts for: 1. Standard services; 2. Supplemental benefits and capitated adjustments; 3. Non-capitated adjustments and withholds.
701 0-A02: Capitation Paid ECap – Primary Care Provider Report - Detail	A PCP-level report that summarizes the capitation paid by current and retro periods. The 3 sections of the report include amounts for: 1. Standard services; 2. Supplemental benefits and capitated adjustments; 3. Non-capitated adjustments and withholds.
721 0-A01: Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed capitation information for each current Customer assigned to a PCP.
7240-A01: Customer Changes Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed retroactive change information on added, changed and terminated members. The 3 sections of the report include information on: 1. Customer adds; 2. Customer demographic changes; 3. Customer terms.
7290-A01: Capitation Adjustment Details – Primary Care Provider Report- (PMG)	Capitation adjustment details for Customer and provider-level manual adjustments. The 2 sections of the report include information on: 1. Current period; 2. Retro period.

Note: The PCP Practice should reconcile the capitation payment and report upon receipt. Any requests for an adjustment or reconciliation of the capitation payment must be made within 60 days of receipt. If the PCP/Medical Group (Practice) does not request reconsideration of the capitation payment within 60 days, the capitation payment provided will be accepted as payment in full (as per contract).

Bill above

In addition to the capitation payments, certain covered services are eligible for reimbursement. To obtain a copy of this information, please contact your Network Account Representative. To locate your Network Account Representative, please go to UnitedHealthcareOnline.com → Contact Us and reference the Network contacts section near the bottom of the page.

OneNet PPO

OneNet PPO, LLC (OneNet) is a network of physicians, health care practitioners and facilities offering medical, behavioral health and workers compensation services in the Mid-Atlantic region.

OneNet Terminology

A "OneNet Customer", also called a "Participant", is a person authorized by OneNet to access OneNet participating physicians, health care practitioners, hospitals and facilities under the terms of the physician, health care practitioner, hospital or facility's agreement.

A "OneNet Payer" is a person or entity that has an obligation to pay for services rendered by a OneNet participating physician, health care practitioner, hospital or facility to a OneNet Customer. OneNet Payers may include insurance carriers, workers compensation carriers, self-funded health plans and others. OneNet Payers may use the services of a Third Party Administrator (TPA) or other entity to provide administrative services. References in the physician, health care practitioner, hospital or facility agreement to "participating entity, "Payer" or "Payor" also apply to OneNet Payers.

The term "OneNet Client" is used to refer to a OneNet Payer or any entity that provides administrative services to a OneNet Payer (e.g. a TPA).

OneNet PPO does not adjudicate or pay claims. OneNet produces pricing sheets to reflect your contracted allowable rate. These pricing sheets are sent to the OneNet Payer for claims processing. These claim determinations will be detailed on the OneNet Payer's explanation of benefits or workers compensation remittance advice.

OneNet operational and administrative guidelines may differ from UnitedHealthcare, M.D. IPA and Optimum Choice. For information and instruction on OneNet's policies and processes with regard to services provided to OneNet Customers, refer to the OneNet Physician, Health Care Practitioner, Hospital and Facility Manual ("OneNet Manual").

The OneNet Manual provides information on ID cards for OneNet Customers, how and where to submit claims for OneNet Customers, Utilization Management guidelines and who to contact if you have a question about OneNet claim pricing.

A copy of the OneNet Manual is available from:

- UnitedHealthcareOnline.com → Administrative Guides → OneNet PPO
- Professional Services Department at (800) 342-3289 (Mon. - Fri., 8:00 a.m. to 8:00 p.m.)
- onenetppo.com → Providers Section

Questions about OneNet claims payment should be directed to the OneNet Client at the phone number listed on the OneNet Customer's ID card, or at the contact information listed on the OneNet Client's explanation of benefits.

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

Neighborhood Health Partnership Supplement

Important information regarding the use of this Supplement

This Neighborhood Health Partnership ("NHP") Supplement applies to services provided to members enrolled in NHP Benefit Plans. In the event of any inconsistency between the Guide and this NHP Supplement, the NHP Supplement and all Protocols and Payment Policies found on myNHP.com will prevail for NHP members.

How to contact us

Resource	Where to go	What you can do there
Website Support	e-Services (800) 276-8237 (for Website technical issues, password resets, etc.)	• Get technical support for website issues
Electronic Data Interchange (EDI) Support	(866) 509-1593	• Obtain information on submitting claims electronically
Customer Care	(877) 972-8845 For the hearing impaired, please call 711 and ask for the number above Customer Service hours: 8 a.m. – 6 p.m. ET	• Check Customer eligibility information • Verify benefits • Check claim(s) status
Claims	Electronic Payer ID 95123 or 96107 P.O. Box 5210 Kingston, NY 12402-5210	• Submit claims and claims attachments
Appeals	P.O. Box 5210 Kingston, NY 12402-5210 Attn: Appeals Dept Fax: (305) 715-2110	• Reconsiderations and appeals
Automated Referral Line (IVR System)	(877) 972-8845	• Request referrals to specialist • Obtain status of referrals • Obtain Eligibility & Benefits
Utilization Management	(800) 550-5568 Fax: Authorizations: (800) 731-2515 OB: (800) 729-1574 Hospital Admissions: (800) 731-2430	• Request prior authorizations and Precertifications • Obtain status of prior authorizations and Precertifications • Request urgent pre-service appeals on behalf of a Customer
United Behavioral Health (UBH)	(800) 817-4705	• Obtain information about Behavioral Care Services
Foot and Ankle Network	(305) 558-0444 Fax: (305) 557-3810	• Obtain information about Podiatry Services
OptumHealth	(800) 873-4575 Fax: (763) 595-3333	• Physical Therapy (PT) • Occupational Therapy (OT) • Speech Therapy (ST)
Advocare Health Alliance	(305) 728-2747 (866) 374-4326 (outside Miami-Dade) Fax: (305) 728-1425 (800) 722-4148	• Home Health Care Services • Durable Medical Equipment
Quality Managed Healthcare, Inc.	(954) 236-3143 Fax: (954) 236-3254	• Obtain information about Chiropractic Services
Medco Health Solutions, Inc.	Rx Prior Auth (800)753-2851 UHC Specialty Referral Line (866)429-8177 Prescription Solutions (888) 739-5820 Fax: (800) 837-0959	• Obtain information about Pharmacy Services • Obtain Rx Authorization
CareCore National (CCN)	(866) 242-9546 Fax: (866) 466-6964	• Obtain information about Precertification Services

Health care ID card

The Customer's NHP ID card will indicate what type of plan the Customer has and all applicable copayments. Below is a sample of the NHP Plan ID card.

Sample ID card

Definitions

Agency means the State of Florida Agency for Health Care Administration.

Authorization means referrals and precertifications.

CMS means the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services.

OIR means the State of Florida Office of Insurance Regulation, Department of Financial Services.

Emergency means emergency medical condition and/or emergency services

Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: serious jeopardy to the health of the individual (or an unborn child); serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, Emergency Medical Condition is present when there is inadequate time to effect safe transfer to another hospital prior to delivery; when a transfer may pose a threat to the health and safety of the patient or fetus; or when there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency services means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists, and if it does, the care, treatment or surgery for a covered service by a physician which is necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

Medically necessary means those covered services that, as determined by the NHP Medical Director or designee, a) are appropriate and necessary to diagnose or treat the Customer's symptoms or medical condition; (b) are provided for the diagnosis or direct care of the Customer's medical condition; c) are not primarily for the convenience of the Customer, the Customer's family, attending or consulting physician; (d) are in accordance with standards of good medical practice within the community where provider is located; (e) are approved for use in he manner prescribed by a Participating Provider by the appropriate medical body or board for the diagnosis or treatment of the Customer's medical condition; and (f) are the most appropriate, efficient and economical medical supply, service or level of care which can be safely provided for the Customer's medical condition.

Participating Provider means a provider of health care goods and services including, without limitation, physicians, hospitals, skilled nursing facilities, home health agencies, and ancillary service providers, which has contracted with NHP to provide certain services to members in accordance with the terms of an agreement between the provider and NHP.

Practitioner means a medical doctor, osteopathic doctor, podiatrist, chiropractor, nurse practitioner, and other individual health care providers.

Primary care (including Primary Care Services) means comprehensive and readily accessible medically necessary covered services including, without limitation, health promotion and maintenance, treatment of illness and injury, early detection of disease and referral to participating providers when appropriate, coordinated by the Primary Care Physician with other participating providers.

Primary Care Physician or **PCP** means a physician, duly credentialed in accordance with the policies and procedures of NHP, who has agreed to provide Primary Care Services to members in accordance with the terms of an agreement with NHP.

Specialist physician means a Participating Provider, licensed to practice medicine in the State of Florida, duly credentialed in accordance with the policies and procedures of NHP, who has agreed to provide medically necessary specialty physician services in accordance with the terms of an agreement with NHP.

Urgent care means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain), or which substantially restrict a Customer's activity (e.g., infectious illness, flu, respiratory ailments).

Eligibility

Verify eligibility of all NHP Customers before rendering any services. You may verify eligibility in the following ways.

You may:

- Log on to myNHP.com
- Call our Interactive Voice Response System (877) 972-8845
- Call Customer Care (877) 972-8845

Verification of eligibility is not a guarantee of payment. NHP's website, myNHP.com, offers you and your office staff quick access to information that simplifies your administrative processes.

Through myNHP.com you may:

- Verify Customer's Primary Care Physician
- Obtain key Customer and claims statistics
- Verify Customer eligibility
- Submit a referral (only PCPs can submit referrals through myNHP.com)
- Check referral/authorization status
- View claims status

Support

NHP's website, myNHP.com, was designed to be easy to use with helpful tips and prompts. If you need further assistance, email NHP at providerrelations@mynhp.com or call Customer Care at (877) 972-8845.

Site login and password

Go to the myNHP.com Provider Home Page and click "Access eServices." If your office does not have a password, the site will prompt you to obtain a password.

Interactive Voice Response (IVR) system

To check Customer eligibility through our IVR System, call (877) 972-8845.

You may call NHP's automated Customer Care 24 hours a day, 7 days a week. You will need the Customer's 7-digit ID number to obtain the following Customer information:

- Enrollment status
- PCP name and number
- Office visit copay
- Inpatient copay
- Prescription drug copay (if applicable)

IVR system automated referral instructions

The NHP IVR System will simplify the process for routine specialist referrals for the PCP office staff. The IVR System is used to enter routine referrals to network specialists. Only a PCP can refer a Customer to a specialist. A specialist cannot refer to another specialist.

The NHP IVR System uses the phone keypad to input numeric responses to generate a referral to a specialist within the NHP provider network. By following the instructional prompts, a referral can be processed in a matter of minutes.

The NHP IVR System uses the 12-digit PCP and specialist numbers which are printed in the IVR listing found in the mynhp.com website, and the Customer's 7-digit ID number printed on the ID card. PCPs will require a password and can only refer to specialists.

A referral authorization letter will be generated and mailed to the specialist and Customer within 24 hours after entry of the referral.

Referrals processed through the NHP IVR System are not guarantees of eligibility, benefit limitations, or coverage at the time of service. The authorization shall in no way limit or otherwise restrict the physician's ultimate responsibility for patient care and the provision of medical services.

How to use the IVR system

Please have the PCP number, PCP password, 7-digit Customer ID number, and the specialist number available. The PCP number and the specialist number are printed in the Provider Directory or found in the mynhp.com website. If you cannot locate the provider number, call Provider Relations (866) 582-7567.

To enter a referral, call (877) 972-8845

Changes to the referral can only be made at the specific prompt; once you go to another referral or exit the system, the referral can no longer be deleted or changed.

To verify a referral, call (877) 972-8845

The system will prompt you to the automated system. Press the correct prompt and follow directions.

Only those referrals entered through the IVR System within the last 180-days can be verified through the automated verification process.

Specialties for which a referral cannot be processed through the IVR system

Referrals to the following specialties cannot be processed through the NHP IVR System:

- Hematology
- Oncology
- Plastic & Reconstructive surgery
- Behavioral health services
- Perinatology
- Neonatology
- Ophthalmology Sub-Specialists (Retinal, Corneal, Occuloplasty)
- Infertility Specialists

In addition, there are services that require precertification or referral and cannot be processed through the IVR System. Please refer to the Utilization Management section of this Supplement for a complete list. The PCP office will need to contact Medical Management at (800) 550-5568 or fax the request to (800) 731-2515 or (800) 729-1574.

Physician, hospital and ancillary provider responsibilities

As an NHP physician, hospital or ancillary provider, you accept responsibility for:

Responsibility	PCP	Specialist Physician	Hospital or Ancillary Provider
Providing coverage by a participating NHP provider, 24 hours a day, 7 days a week	X	X	
Providing or arranging for covered services to plan Customers.	X		
Accepting assigned members without discrimination or any screening of such Customers based on health status.	X		
Providing appropriate preventive measures including, but not limited to, routine physical examinations, immunizations, hypertension screening and PAP smears.	X		
Providing Customers care and/or treatment without discrimination or any screening of such members based on health status.	X	X	X
Arranging for appropriate referrals to participating specialist physicians for services not normally provided within the PCP's (your) scope of training and credentials.	X		
Providing covered services to plan Customers only upon receiving the appropriate referral authorization from an NHP PCP or health plan Utilization Management.		X	
Informing the PCP of the Customer's care. This includes informing the PCP of any testing, hospitalizations, or other care that is ordered or arranged to make sure continuity of care. For specialist physicians, this includes consulting with the Customer's PCP with respect to the Customer's care treatment and communicating the results of the consultation to the PCP having responsibility for the ongoing care of a particular Customer and providing a written report to the PCP within 7 days of the examination of the Customer.		X	X
Obtaining any required referrals and precertifications.		X	X
Retaining active and unrestricted admitting privileges at one or more participating hospital.	X	X	
Except in the case of Emergency Services, providing covered services to Customers only upon receiving the appropriate referral or precertification from a PCP or NHP, as may be required.			X
Maintaining medical records relating to plan Customers in such a form as required by NHP guidelines and accepted medical practice.	X	X	X
Providing medical records as needed for compliance with State and Federal laws and regulation and protect patient confidentiality.	X	X	X
Participating and cooperating with reasonable reviews and continuing education programs as requested by NHP.	X	X	X
Adhering to all applicable state and federal statutes, regulations and CMS guidelines and requirements.	X	X	X
Cooperating with NHP's Utilization Management, Quality Management, policies and procedures and Customer Grievance policies, procedures and protocols.	X	X	X
Collecting applicable copayment, coinsurance, and deductibles only, and accepting NHP's reimbursement as a payment in full.	X	X	X
Not requiring a Customer to pay a "membership fee" or other fee in order to access your services; not refusing any Customer based on failure to pay such fee.	X	X	
Not billing the Customer for services other than non-covered services and coinsurance, deductibles and copayments including missed appointments.	X	X	X
Communicating freely with Customers regarding the treatment options available to them, including medication treatment options and regardless of benefit coverage limitations.	X	X	X
Submitting encounter/claims data for capitated or global services.	X	X	X
Providing Customers with appointments that are in compliance with NHP's accessibility standards.	X	X	
Arranging for appropriate referrals to participating hospitals and physicians so that all services are provided by Participating Providers within the network..	X	X	X

Office administration

Discharge of a Customer from physician's care

If, after reasonable effort, the physician is unable to establish and maintain a satisfactory relationship with a Customer, the physician may request that the Customer be discharged from care and transferred to an alternate physician. The physician must submit the request in writing to NHP Customer Care. Reasons for discharge include:

- Disruptive behavior
- Physical threats/abuse (This warrants immediate action which must be documented. Please contact NHP Customer Care and notify the proper authorities.)
- Verbal abuse
- Gross non-compliance with the treatment plan

Note: The PCP must provide adequate documentation in the Customer's medical record of the verbal and written warnings. The physician is obligated to provide care to the Customer until it is determined that the Customer is under the care of another physician.

Covering physicians

NHP physicians must arrange for coverage of their practice 24 hours a day, 7 days per week. The covering physician must be an NHP participating physician. If the covering physician is not in your group practice, you must notify NHP to prevent claims payment issues.

Closing Customer panels

If a physician wishes to close his or her panel, the request must be made in writing 30 days in advance and state that the office is closing to all new patients, not only those of NHP. Once a panel is closed, it may not be opened to allow only select Customers to enter.

Referrals and precertifications

Providers must comply with NHP's Utilization Management and referral and precertification policies, procedures, and protocols. Except in the case of Emergency Services or when otherwise prior authorized by NHP, providers shall refer Customers only to Participating Providers for Covered Services.

Specialist provider referrals

The PCP is responsible for determining when he or she should refer the Customer for "specialty care". Initial referrals can only be initiated by the PCP. All referrals must be made to Participating Providers. Referrals to a specialist may be necessary:

- When a Customer fails to respond to current medical treatment,
- To confirm or establish a Customer's diagnosis and/or treatment modality,
- To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP.

PCP's may make referrals to Specialist physicians according to the 3 levels below. Referrals should be requested through the NHP website at myNHP.com or the IVR system for automated referrals by calling (877) 972-8845.

Specialties not available through the website or the IVR are the following: Hematology, Oncology, Plastic and Reconstructive Surgery, Perinatology, Neonatology, Behavioral Health Services, Reproductive Endocrinology/Infertility Specialists and Ophthalmic Retinal Specialists. With the exception of Behavioral Health Services, requests for these specialties can be sent to NHP Utilization Management at (800) 550-5568 or faxed to (800) 731-2515 or (800) 729-1574. Paper referrals may result in certification delays.

Requests for referrals to Behavioral Health providers may be directed to UBH by calling (800) 817-4705.

Level 1 One time consultation: This level certifies a specialist to see the Customer for 1 visit during a 60-day period. This referral does not authorize diagnostic testing or treatment.

Level 2 Consultation and diagnostic testing: This level certifies a specialist to see a Customer 3 times during a 90-day period. This covers diagnostic testing performed by the specialist in the office. Those services that require precertification are not covered by this referral. (See the Precertification and referral list, which follows in this section.)

Level 3 Consultation, diagnostic testing and treatment: This level certifies the specialist to see a Customer 3 times during a 90-day period. This covers diagnostic testing and treatment performed by the specialist in the office. Those services that require precertification are not covered by this referral.

Chronic care - PCP is authorizing 3 or more visits, diagnostic tests and/or treatments over a course of more than 90 days that will be performed by the specialist in the office and billed by the specialist. The referral needs to include a written plan of care. Specialized diagnostic tests and treatments that are identified on the precertification protocol are not covered as part of this referral.

Important facts

- Once the specialty services have been properly authorized, the Customer may schedule an appointment with the specialist. The PCP's office staff may also schedule the specialty appointment depending on the particular health care needs of the Customer.
- Faxed or mailed referrals will be date-stamped by NHP and processed in the order received and/or severity of the request as defined below. Urgent referrals ("Urgent," see definition below) will be handled on a priority basis. Such cases should be handled through the NHP website, IVR or Medical Management. (See the *Precertification and Referral List*, which follows in this section.).
- Definition of "Urgent" – Waiting the routine time period for a standard referral could seriously jeopardize the life or health of the Customer or the ability of the Customer to regain maximum function; or, in the opinion of a physician with knowledge of the Customer's medical condition, would subject the Customer to severe pain that cannot be adequately managed without the care or treatment.
- Should there be a question/concern regarding the referral, such as eligibility, coverage or medical necessity, the Utilization Management staff will notify the PCP's office staff.
- An authorization letter will be mailed to the specialist for retention in the Customer's medical record.
- Specialist claims will not be paid without a referral being on file. It is imperative that all referrals are submitted in a timely fashion.
- The specialist should re-verify the Customer's eligibility at the time of visit. This may be done by calling Customer Care at (877) 972-8845.

Referral form

The PCP may choose to complete the referral form, available on mynhp.com, for those specialties or services not available through the IVR.

The following information must be included in the referral form:

- **PCP information**
  - Name of the referring physician
  - PCP provider ID number
  - PCP phone number
  - Date of referral

- **Customer information**
  - Name
  - ID number and group number
  - Phone number
- **Purpose of referral (one must be indicated)**
  - Level 1: One time consultation
  - Level 2: Consultation and diagnostic testing
  - Level 3: Consultation, diagnostic testing and treatment
- Documentation of any pertinent clinical summary information which would be helpful to the specialist or UM
- The PCP must sign and date the referral form and fax the referral form to Utilization Management: (800) 731-2515 or (800) 729-1574

Referrals

The following professional services do not require a referral:

- Chiropractic (subject to benefit limitations)
- Dermatology (5 visits per calendar year)
- Gynecology
- Podiatry, subject to the coordination requirement below
- Alcohol/chemical dependency treatment, subject to the coordination requirement below.
- Mental health, subject to the coordination requirement below.

The following professional services require coordination with the following entities:

- Home health: Advocare Health Alliance (305) 728-2747 or (866) 374-4326.
- Podiatry: Foot and Ankle Network (FAN): (305) 558-0444.
- Substance abuse and mental health treatment: UBH, (800) 817-4705.
- Outpatient therapy PT/OT/ST: OptumHealth,(800) 873-4575.
- Radiology Services: CareCore National (CCN). For Precertification Services (866) 242-9546.
- Diagnostic catheterization procedures including, for example, coronary arteriogram, left heart catheterizations and combined left-right heart catheterizations. For all places of service other then inpatient hospital. (Care Core National (866) 242-9546 fax (866) 466-6964.
- Electrophysiology Implants, including for example, pacemaker and automated implantable cardio-defibrillators. For all places of service, even if the inpatient admission has been authorized. Care Core National (866) 242-9546 fax (866) 466-6964.

Precertification

Please refer to Protocol III in this Guide for a Precertification and Referral List.

Additional specialist visits

1. If the PCP determines that the Customer requires continued specialty visits or treatments by the Specialist physician, the PCP may request additional visits by submitting a Precertification form (treatment plan) to Utilization Management (UM).
2. The PCP may submit the Precertification form which is available on mynhp.com. The treatment plan must include the following information.

- Date of request
- PCP name
- Customer name and ID number
- Specialist name, phone number, and specialty
- Pertinent medical information substantiating the need for additional visits › he number of additional visits requested and the time frame for the visits

3. The Precertification form may be faxed to UM: (800) 731-2515 or (800) 729-1574.
4. Upon receipt of the Precertification form, UM will review for medical necessity and appropriateness of care. A letter will be sent to the PCP, specialist, and Customer with the outcome of the decision. This letter should be filed in the Customer's medical record.
5. If the Precertification form treatment plan is authorized, it will be valid for a specific number of visits and/or treatments. Once the specific number of visits or authorized time frame have been reached, whichever comes first, a new Precertification form treatment plan must be submitted for additional visits to be authorized. This is necessary to make sure proper claims payment.
6. The specialist should re-verify the Customer's eligibility at each visit to make sure that the Customer is still eligible under the health plan.

Out-of-network specialty referrals

1. Out-of-Network specialty referrals are only approved when the services required are not available within the network to make sure continuity of care (as determined by the health plan).
2. All Out-of-Network specialty referrals must be precertified.
3. If services are requested as "Urgent," as defined in Definitions in this Supplement, it will be processed in 24 hours upon receipt of request. (Definition of "Urgent" – Waiting the routine time period for a standard referral could seriously jeopardize the life or health of the Customer or the ability of the Customer to regain maximum function; or, in the opinion of a physician with knowledge of the Customer's medical condition, would subject the Customer to severe pain that cannot be adequately managed without the care or treatment.)
4. 4. Out-of-network referrals may be requested by calling NHP. All providers must contact NHP Utilization Management (UM) for authorization at (800) 550-5568.
5. Upon receipt of the referral by UM, the data will be reviewed and, if approved, entered into the system to make sure payment of the specialist claims.
6. Should there be a question/concern regarding the referral, such as eligibility, coverage, or medical necessity, the UM staff will notify the PCP's office staff.
7. The PCP will be verbally notified of the authorization and an authorization letter will be mailed to the Customer and the specialist for retention in the Customer's records.
8. The PCP's office must receive approval before sending the Customer to the specialist.
9. Upon authorization by UM, the PCP sends a copy of the referral to the specialist and retains a copy in the Customer's medical records.

Obstetrical referrals

1. Once it is determined or suspected that a Customer is pregnant, the obstetrician must complete the Total OB Notification Form, which is available on mynhp.com.
2. Indicate total OB care and the estimated due date on the Total OB Notification Form. Additionally, identify any high-risk OB patients.

3. The Total OB Care Authorization will cover all prenatal care and 1 ultrasound between 13 and 24 weeks of gestation and delivery.
4. The following procedures will require additional precertification: amniocentesis, fetal echo, biophysical profiles, consult with specialist, non-stress tests and any additional ultrasounds. Additional ultrasounds also will require documentation of medical necessity.
5. During pregnancy, the obstetrician may issue referrals. Total OB care should be billed at the time of delivery along with the hospital authorization number of the delivery.
6. Venipuncture performed outside of the Obstetrician's office requires precertification.
7. Laboratory services: LabCorp must be used for all laboratory services including any genetic testing. An alternative provider for genetic testing may be available. Please contact NHP Utilization Management at (800) 550-5568.
8. The delivering hospital will be verified at the time of the total OB authorization request to the physician. A precertification will be required at the time of delivery.

Non-referral provider services

The following services do not require a referral from the PCP. The Customer has direct access to these services.

- Gynecology

  Annual well woman exam – Please use diagnosis code V72.3 1 (includes pap smear and pelvic examination) and appropriate CPT code as listed below.

	Code	Age
New patient:	99384	12-17
	99385	18-39
	99386	40-64
	99387	65+
Established patient:	99394	12-17
	99395	18-39
	99396	40-64
	99397	65+

- Dermatology (5 visits per calendar year)
- Chiropractic (subject to benefit limitations)
- Mental health and substance abuse
- Podiatry

IMPORTANT: Precertification requirements still apply to non-referral providers.

Hospital admissions

1. All admissions must be to participating hospitals, unless an out-of-network admission has been approved by the plan or it is an emergency.
2. All inpatient admissions require precertification by NHP UM. All emergency admissions require certification within 1 business day; including admissions after outpatient surgery or observation care. Only a PCP or an NHP designated hospitalist may serve as the admitting physician for inpatient services, unless NHP has provided prior written authorization for a particular Specialist physician or category of specialist physician to serve as the admitting physician for the member.

3. Participating Providers must be used for all services required during the hospital stay unless precertified by UM.
4. Notify NHP UM for hospital precertification review.
   Phone: (800) 550-5568
   Fax: (800) 731-2515 or (800) 729-1574
5. NHP approved criteria are used for all hospital reviews. All questionable cases are referred to the medical director for review. Please refer to the criteria grid under Utilization Management Decisions.
6. Upon completion of the medical review, either a certification or a denial letter will be sent to the PCP, specialist (if applicable), Customer, and the hospital.
7. Concurrent review will be conducted through the hospital stay by NHP Health Services. The attending physician may be contacted during the review process for additional information as necessary.
8. Discharge planning will be coordinated through the Inpatient Care Manager (ICM) in cooperation with the physician and the hospital discharge planning staff.
9. If the treating physician would like to discuss a case with a Physician advisor, please call NHP Utilization Review.

Precertification time frames

To efficiently and appropriately process requests for procedures that require precertification, UM encourages our providers to submit information at the time service is requested. Be sure to provide all the necessary information with your request. With complete information, UM can process precertification requests within the guidelines below. Refer to the NHP precertification and referral list in Protocol III for a complete list of services requiring precertification. For "Urgent" requests, please call Medical Management (800) 550-5568.

Precertification standards

Authorization Type	Definitions	Examples	UM decision time frame with complete information
Pre-service non-urgent	Any prior request for service that is of non-urgent nature.	• Elective surgery • Sleep Study • Diagnostic tests (CT Scan, MRI, MRA) • CareCore National (866) 242-9546	15 calendar days of receipt of request
Pre-service urgent	Any prior request for service.	• A request for suture removal follow up ER visit	24 hours of receipt of request.
Concurrent urgent	Any urgent request for an extension of a previously approved ongoing course of treatment over a period.	• Request for Authorization of a Customer admitted on an emergency basis	24 hours of receipt of request.
Post service	A request for authorization on a previously rendered service.	• Emergent hospital admission to non-participating facility	30 calendar days of receipt of request

If a request is received with insufficient information to make a determination, UM will contact the provider to submit the necessary information. In the event that we do not receive this information, the Customer may be notified via mail of the specific information that is required to make the determination. This letter will, in turn, extend the UM decision time frame in order to receive this required information. A decision due date will be included in this letter. If this requested information is not received by the decision due date, a decision will be made with the information that was made available to UM. Notification of the outcome will be sent to the Customer, PCP, and requesting provider.

Protocol I: Specialty referral process

Effective Date; 3/00

Revised Dated: 7/03, 3/10

All NHP HMO Customers require a referral before scheduling appointments for specialty services. PCPs will request one of the following referral types:

- Level I - Consult: PCP is authorizing a consultation only. The PCP requires a written or verbal communication prior to authorizing additional services. This level certifies a specialist to see the Customer for 1 visit during a 60-day period.
- Level II - Consultation & Diagnostics: PCP is authorizing a consultation and diagnostic tests that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostics tests that are identified on the precertification protocol are not covered as part of this referral. This level certifies a specialist to see the patient 3 times during a 90-day period.
- Level III - Consultation, Diagnostics & Treatment: PCP is authorizing a consultation and diagnostic tests and any treatment that will be performed by the specialist and billed by the specialist on the same day as the consultation. Specialized diagnostics and treatments that are identified on the precertification protocol are not covered as part of this referral. This level certifies a specialist to see the patient 3 times during a 90-day period.
- Chronic care - PCP is authorizing 3 or more visits, diagnostic tests and/or treatments over a course of more than 90 days that will be performed by the specialist in the office and billed by the specialist. The referral needs to include a written plan of care. Specialized diagnostic tests and treatments that are identified on the precertification protocol are not covered as part of this referral.

IMPORTANT: Reimbursement for services that have not been authorized will be denied. The patient cannot be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services.

Protocol II: Clinical laboratory services

Effective Date; 3/1/00

Revised Dates: 10/05, 107, 3/10

All NHP Customers should be directed to LabCorp, Inc. service centers for outpatient laboratory procedures. If a physician draws the specimen in the office before sending the specimen to LabCorp, Inc., the provider will be reimbursed a blood draw fee.

If the physician performs clinical laboratory services in the office and bills NHP for such services, the services will be reimbursed at the rate specified in the provider agreement. Reimbursement will be made only for the procedures approved according to the NHP laboratory procedure lists I & II below. Procedures noted on list I may be performed by any physician in the office in accordance with state and federal guidelines. Specialty-specific lab procedures on list II will only be reimbursed if the NHP physician who bills for the service is listed as the specialty type in column one.

Home healthcare agencies will be responsible for "drop off" of drawn specimens at one of the LabCorp, Inc. service centers.

Hospital laboratory services associated with the following types of services will be reimbursed according to the hospital agreement:

- Emergency room
- Chemotherapy
- Ambulatory surgery
- Transfusions
- Hemodialysis

Lab drawn at a skilled nursing facility (SNF) must be processed by LabCorp, Inc.

NHP laboratory procedure list I

May be performed by any NHP physician, regardless of the physician's specialty.

Code	Description
81000	Urinalysis, non-automated, with microscopy, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity urobilinogen, any number of these constituents, with microscopy non-automated
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis, qualitative or semiquantitive, except immunoassays
81007	Urinalysis, bacteriuria screen, by non-culture technique, commercial kit (specify type)
81015	Urinalysis, microscopic only
81025	Urine pregnancy test
82270	Blood, occult; feces, one-three simultaneous determinations
82947	Glucose quantitative, blood (except reagent strip)
82948	Glucose blood, reagent strip
82962	Glucose blood, one-touch monitor
84703	Gonadotropin, chorionic (hCG); qualitative
85008	Manual blood smear examination without differential parameters
85009	Differential WBC count, buffy coat
85013	Spun microhematocrit
85014	Blood count, other than spun hematocrit
85018	Blood count, hemoglobin
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBS).
85610	Prothrombin time
85730	Thromboplastin time, partial (PTT) plasma or whole blood
86308	Heterophile antibodies; screening
86317	Immunoassay for infectious agent antibody, quantitative, not elsewhere specified
86403	Particle agglutination, antibody (rapid strep screen)
86580	Skin test, tuberculosis, intradermal
86585	Tuberculosis, tine test
87070	Culture, bacterial, definitive (throat or nose)
87081	Culture, bacterial, screening only, for single organisms
87084	Culture, presumptive, pathogenic organism, screening only by commercial kit, with colony est. from density chart
87086	Culture, bacteria, urine, quantitative, colony count
87088	Culture, bacterial, urine, commercial kit
87177	Smear, primary source, with interpretation, wet and dry mount, for ova and parasites
87184	Sensitivity study, antibiotic, disk method, per plate (12 or fewer disks)
87205	Smear, primary source, with interpretation, routine stain for bacteria, fungi, or cell types
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacterial, fungi, ova and/or parasites
87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A –
89055	Leukocyte Cout, Fecal
87880	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
89230	Sweat collection by iontophoresis

Specialty specific and outpatient facility laboratory procedure list II

NHP will reimburse only NHP physicians in the specialty noted in column one of specific lab services listed for that specialty.

Specialty	Code	Description
Hematology	85007	Blood smear, microscopic examination with manual differential WBC count
	85025	Automated CBC/platelet/complete differential
	85027	Automated hemogram and platelet count
	85060	Blood smear, peripheral
	38220	Bone marrow, aspiration only
	85097	Bone marrow, smear interpretation only, with or without differential cell count
	38221	Bone marrow biopsy, needle or trocar
	G0306	Complete CBC, automated (HG B, HCT, RBC, WBC w/o platelet count)
	G0307	Complete CBC, automated (HG B, HCT, RBC, WBC)
Urology/Infertility	**Semen Analysis:**	
	89257	Sperm identification from aspiration (other than seminal fluid)
	89260	Sperm isolation: simple prep (e.g., Sperm Wash and swim-up) for insemination or diagnosis with semen analysis
	89261	Sperm isolation, complex prep
	89300	Presence and/or motility of sperm including Huhner test (post-coital)
	89310	Motility and count
	89320	Complete (volume, count, motility and differential)
	89325	Sperm antibodies
Rheumatology	89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
	85651	Sedimentation rate, erythrocycte: non-automated
Infectious Disease	85652	Sedimentation rate automated
OB/GYN	87110	Chlamydia culture
	89330	Sperm evaluations cervical mucus penetration, with or without Spinnbarkeit test
Gen.Surgery/ Radiology/ Endocrinology	**Fine needle aspiration with or without preparation of smears:**	
	10021	Superficial tissue (e.g., thyroid, breast, prostate)
	10022	Deep tissue under radiologic guidance
All Outpatient Facilities	82247	Bilirubin, total (for members under 30 days old, if LabCorp, Inc. unable to draw)
	82248	Bilirubin, direct (for members under 30 days old, if LabCorp, Inc. unable to draw)
	82800	Blood gases (ABG) X pH only
	82803	Blood gases (any combination of pH, pCO2, p02, C02, HC03)
	82805	With oxygen saturation, by direct measurement, except pulse oximetry
	82810	Bloodgases, oxygen saturation only
	82820	Hemoglobin X oxygen affinity (p02 for 50% saturation with oxygen)
	83850	Antibody screen, RBC, each serum technique
	86860	Antibody elution (RBC), each elution
	86870	Antibody identification. RBC antibodies, each panel for each serum technique
	86900	Blood typing, ABO
	86901	Blood typing (Rh)
	86903	Antigen screening for compatible blood unit using patient serum, per unit screened
	86904	Antigen screening for compatible blood unit using patient serum, per unit screened
	86905	RBC antigens, other than ABO or Rh (D), each

Specialty	Code	Description
All Outpatient Facilities (continued)	86906	RH phenotyping complete
	87070	Microbiology, any other source
	87430	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus, group A
	89190	Nasal smear for eosinophils
	89230	Sweat collection by iontophoresis
Hematology/ Oncology/ Neurology/ Pediatrics	**Lumbar puncture:**	
	82947	Glucose, quantitative
	84155	Protein, total, except refractometry
	85007	Blood count, manual differential WBC count
	89050	Cell count, miscellaneous body fluids, except blood
	82948	Glucose; quantitative, blood (except regent strip)
Cardiology/Cardio-Vascular/ Thoracic Surgery	85610	Pro thrombin time
	85730	Thromboplastin time, partial (PTT); plasma or whole blood
Pediatrics & Family Medicine	82247	Bilirubin, total (for members under 30 days old)
	82248	Bilirubin, direct (for members under 30 days old)

Protocol II-A: Use of non-participating laboratory services

Effective Date; 3/1/07, 3/10

- This Protocol applies to all participating providers, and it applies to all laboratory services, clinical and anatomic, ordered by any practitioner.
- This Protocol does not apply to laboratory services that are approved to be provided by physicians in their offices.
- This Protocol does not apply where the physician bears financial risk of laboratory services.

You are required to refer laboratory services to Labcorp, except as otherwise authorized by NHP. Services can be obtained by either sending your NHP patient to a LabCorp drawing center or by obtaining the laboratory specimen from the patient and then sending the specimen to LabCorp. To get more information on local LabCorp sites in your area, you can:

- Go to mynhp.com to view a complete list of participating laboratories. or
- Go to LabCorp.com or call (888) LABCORP (522-2677) Option #3 to determine how to conveniently access their services.

If you need assistance in locating or using a participating laboratory provider, we are also prepared to respond to your information needs via Customer Care at (877) 972-8845.

We are aware of the vital importance of laboratory services to your patients, and we are committed to maintaining a laboratory network that is both reliable and affordable.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UM at (800) 550-5568.

NHP recognizes that in some instances, physicians need immediate lab results in order to determine the best course of treatment for the Customer. We have developed a list of procedures for which we will reimburse all physicians when performed in the office (see Protocol II, List I). In addition, Protocol II, List II indicates those laboratory services which, when performed by the designated specialty or outpatient facility, will be reimbursed to the provider by NHP.

NHP reimburses providers for phlebotomy, unless the provider is reimbursed under a capitation methodology or the laboratory service is performed in the physician's office. Claims must be submitted using a valid CPT code.

LabCorp requires the following to make sure accurate testing and billing:

- Customer's NHP ID number
- LabCorp requisition forms with all required fields completed specific test orders using test codes
- Diagnosis (ICD-9) codes

Administrative actions for out-of-network laboratory services referrals:

NHP 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 that Labcorp will meet their needs.

If NHP determines an ongoing and material practice of referrals to non-network laboratory service providers, NHP will promptly notify the responsible physician of the issue and remind him/her of his or her contractual requirements. Moreover, 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:

- a decreased fee schedule; or
- termination of network participation, as provided in your participation agreement.

It is the intent of NHP to work with participating physicians to promote network viability and stability, and to maximize the value of in-network laboratory services. Our expectation is that this collegial approach will continue to succeed, and that the interventions listed above will be applied only in rare circumstances, if at all. Please contact Network Management at United Healthcare if you have any questions about making effective use of our participating laboratory network.

Protocol III: Precertification process

Effective Date; 3/00
Revised Dated: 11/07, 3/10

All NHP Customers require prior certification for the services listed on the attached precertification list.

All providers of services must call NHP for precertification. Our staff is accessible to callers who have questions about the UM process at (800) 550-5568.

A participating provider must provide all services at a plan facility unless an out-of-network certification has been issued by NHP UM.

All inpatient admissions, including hospitals, acute rehabilitation facilities and skilled nursing facilities, must be precertified prior to admission with the exception of admissions from the emergency room and admissions to the ICU/CCU or admission for emergency surgery. NHP must be notified by the next business day following the admission, if the admission occurs as a result of the above exception.

The provider must provide clinical information that justifies the medical necessity of the admission, by the next business day following the admission. Criteria are used to review all admissions and surgical procedures. All questionable cases will be referred to the medical director for final determination.

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including all OB care.

If the diagnosis or treatment of a Customer is delayed secondary to the inability of the facility to provide a needed service, payment for these days will be denied. This includes, but is not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

NHP Precertification list

The following professional services require coordination or precertification with the following entities:

DME, Home health and Home Infusion services: Advocare Health Alliance: (305) 728-2747 or (866) 374-4326
Podiatry Services: Foot and Ankle Network (FAN): (305) 558-0444
Substance abuse and mental health treatment: United Behavioral Health (UBH) at (800) 817-4705
Oncology Services (other than pediatric and specific skin cancers): NHP Medical Management: (800) 550-5568
Outpatient Therapy PT/OT/ST: OptumHealth: (800) 873-4575.
Radiology/Cardiology/Nuclear Imaging Services: CareCore National (CCN): (866) 242-9546, Fax: (866) 466-6964

Precertification

The following services must be precertified before services are rendered in order for such service to be paid. Contact Medical Management at (800) 550-5568 to obtain precertification.

- Inpatient: hospital (including observation), psychiatric, rehab, and SNF
- Surgery and invasive procedures: performed in an outpatient hospital or ambulatory facility (with the exception of Colonoscopies for members 50 years of age and older; and sigmoidoscopies).
- Diagnostic catheterization procedures including, for example, coronary arteriogram, left heart catheterizations and combined left-right heart catheterizations. For all places of service other then inpatient hospital. (Care Core National (866) 242-9546 fax (866) 466-6964.
- Electrophysiology Implants, including for example, pacemaker and automated implantable cardio-defibrillators. For all places of service, even if the inpatient admission has been authorized. (CareCore National (866) 242-9546 fax (866) 466-6964.)
- Sleep Study
- MRI, MRA, CT Scans, CTA scans, PET scans: (CareCore National CCN (866) 242-9546 Fax (866) 466-6964)
- 30 Day Event Monitor
- Nuclear Medicine Imaging, including without limitation: (CareCore National CCN (866) 242-9546) Fax (866) 466-6964.
    - Pulmonary perfusion/ventilation
    - Venous imaging
    - Nuclear bone scans
    - Echo stress test
    - Bone marrow imaging
    - Thyroid imaging
    - Liver/Spleen imaging
    - Brain imaging
- Nuclear stress tests, including without limitation thallium, technetium, Cardiolite, Myoview, sestamibi; and myocardial perfusion and ejection fraction, and wall motion studies. Nuclear stress tests encompass nonpharmacological (exercise) and pharmacological stress tests, including without limitation, adenosine, persantine and dobutamine. (CareCore National CCN (866) 242-9546) Fax (866) 466-6964.

- DME: Advocare Health Alliance (305) 728-2747 or (866) 374-4326
- Insulin Pumps and supplies
- Prosthetic and orthotic devices
- Home healthcare: Advocare Health Alliance (305) 728-2747 or (866) 374-4326 Sleep studies
- Outpatient therapy: physical, occupational, speech: OptumHealth (800) 873-4575
- Outpatient: Cardiac and Pulmonary rehab
- Hyperbaric oxygen treatment
- Wound care
- Mental health/substance abuse: UBH (800) 817-4705
- Dialysis
- Chemotherapy (chemotherapeutic agents regardless of indication), radiation therapy, transfusions, infusions
- Chronic specialist care
- Pain management
- Hospice
- Total OB Care, including one screening OB ultrasound for fetal anatomy performed between 13-24 weeks of gestation. All ultrasounds performed for specific clinical indications require a separate authorization and are reviewed for medical necessity.
- Biophysical profiles and amniocentesis
- Drugs: refer to Protocol V.
- Laboratory services
- Any services not provided by LabCorp, Inc., and not listed on the NHP Protocol II;
- Dermatology:

CPT	Procedure
77401 – 77416	Grenz X-ray therapy
14000 – 14350	Adjacent Tissue Transfer
15000 – 15401	Free skin grafts
15570 – 15738	Flaps
15740 – 15776	Other flaps and grafts
15780 – 15879	Other procedures

- Ambulance service
- Genetic Testing
- All out-of-network and out of area services

Note: Reimbursement for services that have not been precertified will be denied. The Customer cannot be billed for these services unless they have signed a waiver of liability or the service is denied as non-covered services. The Customer is held harmless in these proceedings. Physicians may be reimbursed for their services when the facility fails to precertify the required services and the services were for an emergency medical condition.

Protocol IV: Concurrent review process

Effective Date; 1/01
Revised Dated: 7/03, 3/10

NHP requires all hospital, inpatient rehabilitation facility and skilled nursing facility admissions to be precertified prior to admission with exception of admissions from the emergency room and admissions to the ICU/CCU or admission for emergency surgery. NHP or its delegated entities must be notified by the next business following admission if the admission occurs as a result of the above exception.

The provider must provide clinical information that justifies the medical necessity of the admission, by the next business day following the admission. All questionable cases will be referred to the medical director for final determination.

The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, the provider must submit to NHP or its delegated entities, by phone, or fax, sufficient clinical information to justify the continued stay and to allow the review of the Customer's medical status during an inpatient stay, extend the Customer's stay, coordinate the discharge plan, determine medical necessity at an appropriate level of care, and to perform quality assurance screening.

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including OB care.

If the diagnosis or treatment of a patient is delayed secondary to the inability of the facility to provide a needed service, payment for these days will be denied. This includes, but is not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

Note: Reimbursement for continued stay that does not meet NHP medical necessity criteria will be denied. The patient cannot be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services. The Customer is held harmless in these proceedings.

Protocol V: Drug Prior Authorization (PA)

Effective Date: 04/00,
Revised Date: 08/05, Revised 04/06, Revised 12/06, Revised 2/08,
Revised 4/09, Revised 3/10, Revised 11/10, Revised 9/11

Neighborhood Health Partnership's pharmacy benefit manager is UnitedHealthcare Pharmacy, which uses Medco Health Solutions, Inc. (Medco) for certain pharmacy benefit services. In order to promote appropriate utilization, NHP requires a PA for selected medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician's service (medical benefit) to be eligible for coverage. PA criteria have been established with input from physicians and consideration of current medical literature. The PA list and criteria are dynamic and reflect the P&T Committee's review and responsiveness to the needs of plan members and network physicians. For a plan member to receive coverage for a medication requiring PA, the physician must provide clinical information to Medco. (if the medication is to be dispensed by a participating pharmacy), or to NHP UM (if the medication is to be provided incident to a physician's service). PA does not guarantee coverage.

For a full description of our clinical programs on medications dispensed through the outpatient pharmacy benefit, please use the link below to UnitedHealthcare Online. In addition, NHP has additional requirements for PA on Celebrex, erythropoietin medications, CNS stimulants, and Zyvox, that are described in the following table.

Link to Outpatient Pharmacy information on UnitedHealthcare Online:

UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → UnitedHealthcare → Clinical Programs.

The following table summarizes medical drugs requiring PA for NHP members as well as the requirements the outpatient medications listed above:

Drug Name	Criteria	PA Through PBM Drug Available at Pharmacy	PA Through NHP Drug Available at Physician Office Only
Alferon	Coverage is provided for intralesional treatment of refractory or recurring external condylomata acuminata inpatient 18 years of age or older		X
Amevive	Coverage is provided for treatment of adults with moderate to severe plaque psoriasis		X
Botox Dysport Myobloc Xeomin	Botulinum Toxins A and B Drug Policy		X
Celebrex	Coverage is provided for patients who have tried and failed at least two Tier 1. NSAIDs. Exceptions exist if the Customer is at high risk of a NSAID-induced adverse GI event.	X	
Cerezyme	Coverage is provided for Enzyme Replacement		X
Epogen Procrit Aranesp	Anemia Drugs: Darbepoetin Alfa and Epoetin Alfa Drug Policy	X If dispensed through pharmacy	X If dispensed through MD office
Neupogen/ Neulasta	Coverage is provided for treatment of neutropenia and in bone marrow transplantation	X If dispensed through pharmacy	X If dispensed through MD office
Prolastin	Coverage is provided for a diagnosis of congenital alpha 1-antitrypsin deficiency with emphysema		X
Remicade Orencia	Remicade (infliximab) Drug Policy Orencia (abatacept) Drug Policy		X
ADHD, Adderall, Adderall XR, Concerta, Daytrana, Desoxyn, Dexedrine, Dextrostat, Focalin, Focalin XR, Liquadd, Ritalin, Ritalin SR, Ritalin LA, Metadate CD, Methylin ER, Strattera, Vyvanse, and Intuniv	Coverage is provided for treatment of attention deficit hyperactivity disorder, narcolepsy and idiopathic somnolence, fatigue associated with multiple sclerosis, and refractory depression.	X	
Sodium Hyaluronic Acid Synvisc, Synvisc-One, Euflexxa, Othovisc Hyalgan & Supartz	Sodium Hyaluronate For The Treatment of Arthritis List as preferred Buy and Bill or Specialty Pharmacy Obtain through Specialty Pharmacy		X
Synagis	Synagis® (palivizumab) Drug Policy Required to obtain through Specialty Pharmacy		X
Xolair	Xolair® (omalizumab) Drug Policy Obtain through Specialty Pharmacy		X
Zyvox	Coverage is provided for treatment of infections caused by susceptible strains of Vancomycin-Resistant Enterococcus faecium; nosocomial pneumonia caused by Staphylococcus aureus or Streptococcus pneumoniae; complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae; uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible only) or Streptococcus pyogenes; community-acquired pneumonia caused by Streptococcus pneumoniae, or Staphylococcus aureus (methicillin-susceptible strains only).	X	

Pharmacy Drug PA Requests

Phone: (800) 753-2851

Fax: (800) 827-0959

(All fax requests are responded to in 24 hours)

NHP Drug PA Requests

Phone: (877) 488-5576

Fax: (800) 731-6984

Claims inquiries and appeals

NHP has a formalized process for handling provider claim inquiries and claim appeals. Following are the details of when and how to use each of these processes.

Claim inquiry

- What: A request may be sent either verbally or electronically to request a review of a particular claim, or a further explanation regarding the disposition of a claim.
- How: Contact Customer Care at (877) 972-8845 or submit your request online at uhcrivervalley.com (Documentation sent to the plan should clearly explain the nature of the review request.)
- Who: The provider or the office staff of the provider may request a claim inquiry.
- NHP will respond to you in writing on all claim inquiries that do not result in the re-adjudication of the claim. You must file a claim inquiry before you file a claim appeal.

*__Note:__ Not intended as claims coverage guidelines

*Drugs which are considered to be self-injectable are not covered in the physician's office

Claim appeal

- What: A written request for the purpose of requesting NHP to reconsider its decision on how a claim was originally processed.
- How: Claim appeals must be requested in writing. Please use the Provider Appeal Request Form available on mynhp.com.
- Who: The provider or the office staff of the provider may request a claims appeal.
- Where: Claim appeal forms, along with all accompanying documentation, should be mailed to:

NHP Provider Claims Appeals
P. O. Box 5210
Kingston, NY 12402-5210

Customer grievance and appeals

There are situations when Customers have questions about their coverage or are dissatisfied with NHP services. Such questions and Complaints will be handled by NHP in a timely manner. Questions relating to the Agreement should be addressed by members to Customer Care.

Grievances and Appeals will be addressed to the Grievance Coordinator who is the person responsible for the maintenance of records and for the supervision of the Grievances and Appeals process for NHP. A specific set of records will be maintained to document Grievances and Appeals filed. Records will include the reason for Grievances and Appeals, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Coordinator.

Complaint procedures

NHP encourages Customers to resolve individual inquiries and problems without the initiation of a formal Grievance. Any Customer who has an inquiry or Complaint regarding a matter arising under the Agreement should contact Customer Care for verbal resolution. A Customer Care Representative will respond to the Customer's inquiry or complaint promptly.

Formal grievance procedure

In the event the Customer's problem has not been settled at the informal level and the Customer is still dissatisfied, the Customer will be advised to file a formal written grievance. This is called a Level I Grievance. Grievances must be submitted within 180 days of occurrence (i.e. the date when the issue, and subject of the Grievance, is known to Customer). Grievance forms are available from NHP by writing to the address below. Additional information or assistance in preparing the written Grievance may be obtained by contacting Customer Care.

The Grievance must contain the following information:

1. The Customer's name, address and ID number;
2. A summary of the Grievance, any previous contact made with NHP, and a description of relief sought;
3. The Customer's signature; and
4. The date the Grievance is signed.

The written Grievance must be mailed to the following address:

NEIGHBORHOOD HEALTH PARTNERSHIP
P.O. Box 5210
Kingston, NY 12402-5210
Attn: Grievance Coordinator

UnitedHealthcare West Non-Capitated Supplement

Important information regarding the use of this Supplement

This Supplement is intended for use by non-capitated physicians, health care professionals, facilities, ancillary providers and their respective staff. Unless otherwise specified herein, any references to UnitedHealthcare West in this Supplement are intended to apply to any or all of the entities and benefit plans listed below. This information is subject to change.

This Supplement refers to a "Customer" as a person eligible and enrolled to receive coverage from a payer for covered services as defined in your agreement with us. (Your contract may use the term "member"). "You" or "your" refers to any provider subject to this supplement as described above, unless otherwise specified in that specific section. All referenced items are applicable to all providers subject to this Supplement. "Us", "we, "our" or "UnitedHealthcare" refers to UnitedHealthcare West as defined above, for those products and services subject to this Supplement former references to any PacifiCare "Provider Manual," other than the PacifiCare Capitated Administrative Guide, are replaced with this supplement, in conjunction with the core "UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide".

Note: Please be aware that we will be continuing to make changes in 2012 to the PacifiCare name with the PacifiCare companies listed above. If and when these changes occur, we will communicate with you about them.

Legal Entities	Products Offered	Benefits Plans
PacifiCare of Arizona, Inc.	Medicare Advantage	• AARP MedicareComplete® • UnitedHealthcare Dual Complete™ • UnitedHealthcare® Group Medicare Advantage
PacifiCare of Colorado, Inc.	Medicare Advantage	• AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
PacifiCare of Nevada, Inc.	Medicare Advantage	• UnitedHealthcare® MedicareComplete® • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of California	Commercial and Medicare Advantage	**Commercial**: UnitedHealthcare SignatureValue™ family of products including, but not limited to: • UnitedHealthcare SignatureValue • UnitedHealthcare SignatureValue Advantage • UnitedHealthcare SignatureValue featuring • the HealthCare Partners Network Plans • UnitedHealthcare SignatureValue VEBA • UnitedHealthcare SignatureValue Alliance **Medicare:** • AARP MedicareComplete SecureHorizons • Sharp® SecureHorizons Plan by UnitedHealthcare • UnitedHealthcare Dual Complete • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of Oklahoma, Inc.	Commercial and Medicare Advantage	**Commercial:** • UnitedHealthcare SignatureValue **Medicare:** • AARP MedicareComplete SecureHorizons • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of Oregon, Inc.	Commercial and Medicare Advantage	**Commercial:** • UnitedHealthcare SignatureValue **Medicare:** • AARP MedicareComplete • UnitedHealthcare Group Medicare Advantage

Legal Entities	Products Offered	Benefits Plans
UnitedHealthcare Benefits of Texas, Inc.	Commercial and Medicare Advantage	**Commercial:** • UnitedHealthcare SignatureValue **Medicare:** • AARP MedicareComplete SecureHorizons • UnitedHealthcare Chronic Complete • UnitedHealthcare Dual Complete • UnitedHealthcare Nursing Home Plan • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of Washington, Inc.	Commercial and Medicare Advantage	**Commercial:** • UnitedHealthcare SignatureValue **Medicare:** • AARP MedicareComplete • UnitedHealthcare Group Medicare Advantage

Administrative services provided by the following affiliated companies: PacifiCare Health Plan Administrators, Inc., Prescription Solutions or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

How to contact us

Resource	Where to go	What you can do there
UnitedHealthcare West Provider Portal	uhcwest.com	• Self service available 24/7 to provide flexibility to access information you need and the time you need it • Get a printable response for all posted information • Navigation Guide to help you navigate through uhcwest.com • Register to gain secured access (Login) for uhcwest.com • Create/manage individual user accounts for your team • View the provider directory • Check Customer eligibility Status, up to 10 Customers at a time › Primary Care Physician (PCP) assignment and history › Plan codes and coverage history • Review Customer benefits/copay detail (including benefits) › Medical · Outpatient (surgical, rehab, maternity, lab and x-ray) · Office visit · Medical equipment · Home care · Inpatient hospital › Riders/Supplemental (Pharmacy/Vision/Behavioral) • Check claim(s) detail and status (by Customer ID or by TIN) • Access/download Capitation/Financial Reports by provider/by state if applicable • Access and submit Medicare Advantage Risk Adjustment data via CMS-HCC Risk Adjustment functionality • Access iEXCHANGE™ › Online hospital admissions, prior authorizations & Referrals (as applicable per region) › If not already granted access to iEXCHANGE, please request it by sending an email to iexchange@uhc.com

Resource	Where to go	What you can do there
UnitedHealthcare West Provider Portal (continued)	uhcwest.com	• Use the Library/Resource Center (before and after authentication) to access the following information: › Grievance forms › Guidelines & interpretation manuals › Health Care Reform › Customer related Information (Customer Rights, Health Programs etc.) › Pharmacy related information (Formulary/ Pharmacy Directory) › Plan schedules and codes › Product information › Provider Disputes Resolution for California providers ONLY › Provider Policy and Procedures Manuals › Publications (California Language Assistance Program, Communication Highlights) › Quality Index Profiles › Continuing Medical Education › Electronic Data Interchange (EDI) and Clearinghouse information › Prior authorization information › IVR system information › Medicare Physician Fee Schedule Look Up › National Provider Identifier (NPI) • Contact us via secure email by clicking on "Contact Us".
Preauthorization (Non-delegated) For urgent requests For routine requests	*Arizona:* Medicare Advantage Phone: (800) 746-7405 *California, Oregon and Washington:* SignatureValue, Medicare Advantage, Direct contract network and medical group/IPA carve-out Phone: (800) 762-8456 *Colorado:* Medicare Advantage Phone: (800) 746-7405 For complex radiology, contact MedSolutions - medsolutionsonline.com Phone: (888) 693-3211 *Nevada:* Medicare Advantage Phone: (800) 337-8114 *Texas and Oklahoma:* Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management Phone: (800) 668-8139	• Request urgent preauthorization approval • Request routine preauthorization approval
Hospital Inpatient Notification (Non-delegated)	*Colorado only* (866) 822-0591 Fax: (888) 714-3991 Inpatient & observation (800) 799-5252 Fax: (800) 274-0569 *Mental health* Medicare Advantage: (800) 508-0088 *Transplant* (866) 300-7736 Fax: (888) 361-0502	• Notify us of any admission

Resource	Where to go	What you can do there
EDI Support **Encounter Collection, Submission & Controls**	uhcwest.com Password and User ID are not required to review and access EDI information (800) 203-7729 edisupport@uhc.com (866) 351-0390 encountercollection@optum.com	Select Provider → Under "Quick Link" → Select "Service and Tools" to review services available for: • Eligibility • Claim Status • Capitation Reports • CMS-HHC Risk Adjustment ASM iEXCHANGE Select Provider → Library → Resource Center → Electronic Data Interchange (EDI) to access EDI information. Select Library → Resource Center → Electronic Data Interchange (EDI) to review: • HIPAA Resources • Companion Guide • EDI Payer ID • EDI Resources • FAQ • Helpful Hints • Obtain information on how to submit and receive transactions electronically and technical support
United Voice Portal	Commercial & Medicare Advantage HMO/ MCO: California: (800) 542-8789 Arizona: (800) 283-7525 Colorado: (800) 831-4388 Nevada: (800) 501-1199 Oklahoma: (877) 847-2862 Oregon: (800) 920-9202 Texas: (877) 847-2862 Washington MCO: (800) 213-7356	• Check eligibility: • Access Primary Care Physician assignment • Verify Plan Code • Verify Provider History • Access Coverage History • Check copay and benefits • Check claim status (TIN required) • Quick FAX (eligibility and claims) • Pharmacy approval • Prior authorization • Inpatient notification
iEXCHANGE™ (Online Hospital Admissions, Notifications, and Authorizations Requests)	uhcwest.com → Login → Services and Tools → iEXCHANGE (The iEXCHANGE portal is available in CA, OK, OR, TX, and WA. It is not currently available in AZ, CO and NV.)	• Request routine and urgent preauthorizations and extensions and receive immediate status feedback • Receive a tracking number upon submission of a request, which can be used to track the case status or request an extension to the initial request • Receive alerts when a request is reviewed and updated by the Medical Management department • Provide clinical notes to in the comments section • Check Customer eligibility and look up existing authorizations online • Submit inpatient admission notifications and outpatient authorization information • Print copies of authorization requests
Standard Customer Appeals Applies only to Commercial UnitedHealthcare Signature Value HMO/MCO	*California, Oklahoma, Oregon, Texas, Washington* Mail : P.O. Box 6107 Mailstop CA124-0160 Cypress, CA 90630 Fax: (866) 704-3420 CA Phone: (800) 624-8822 OK/TX Phone: (800) 825-9355 OR/WA Phone: (800) 932-3004	• Request a standard decision on an appeal

Resource	Where to go	What you can do there
Expedited Appeals (applies only to Commercial HMO) UnitedHealthcare SignatureValue HMO	California Oklahoma, Oregon, Texas, Washington Phone: (888) 277-4232 Fax: (800) 346-0930	• Request an expedited decision on an appeal
Pharmacy Services	For Commercial products: uhcwest.com For Medicare products: UHCMedicareSolutions.com → Search the Drug List AARPMedicarePlans.com → Search the Drug List	• Access formularies, preauthorization guidelines and after-hours procedures, 24 hours a day, 7 days a week • View the Medicare Advantage Part D (MAPD) Formulary or request a copy
	Phone: (800) 711-4555 Fax: (800) 527-0531 Fax: (800) 853-3844 Website: PrescriptionSolutions.com	• Request a prior authorization • For oral medications • For injectable medications
	(866) 798-8780, Option 2 (applies only to Medicare Advantage products)	• Request information on the Medicare Part D Medication Therapy Management Program
Mental Health, Substance Abuse/ Substance Use, Vision or Transplant Services	See Customer's health care ID card for carrier information and contact numbers	• Inquire about a Customer's behavioral health, substance abuse, substance use, vision or transplant benefits
California Language Assistance Program (applies only to Commercial products in California)	uhcwest.com → Provider → Spotlight → California Regulation SB 853 - Language Assistance Program Information Phone: (800) 752-6096	• Access information regarding the California Language Assistance Program
Health Management and Disease Management Programs	uhcwest.com → Login → Providers → Library → Click on the desired state → Forms To enroll patients: Phone: (877) 840-4085 Fax: a completed referral form to (877) 406-8212	• Access referral forms for Disease Management and Health Management information

Health care identification (ID) cards

Each Customer receives a health care identification (ID) card containing information that helps you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. It is important to check the Customer's health care ID card at each visit and to keep a copy of both sides of the card for your records.

Sample health care ID cards

Medicare Advantage products

To help identify Customers associated with Medicare Advantage products offered through the AARP MedicareComplete, UnitedHealthcare and Erickson Advantage brands, please go to the following provider website for ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → 2011 UnitedHealthcare Medicare Solutions Physician & Provider Information → Scroll to "Benefit Plan Name Overview" section at the bottom of the page.

UnitedHealthcare West Commercial health care ID card (generic)

Our products

We offer a wide range of products and services for employer groups, families and individual Customers. Plan availability may vary. Contact us for more information about plan availability and service areas where each of these products and supplemental benefits are available.

Commercial products - UnitedHealthcare SignatureValue Portfolio

This plan is a Health Maintenance Organization (HMO) or a Managed Care Organization (MCO). Health services are accessed through contracting/participating network primary care physicians (PCPs) who know the Customer's medical history and individual needs. HMOs/MCOs offer minimal paperwork and low, predictable out-of-pocket costs. Customers pay a predetermined copayment or a percentage copayment each time they receive health care services.

Medicare Advantage products

Please reference the *Medicare Advantage Products* section of the UnitedHealthcare Guide for details on Medicare Advantage Products offered.

Verification of Customer eligibility

A Customer's eligibility and benefits must be verified each time the Customer receives services. We provide several ways to verify eligibility:

- Our provider website at uhcwest.com
- United Voice Portal
- iEXCHANGE (available in CA, OK, OR, TX, WA; not available in AZ, CO, NV)
- Electronic eligibility lists (upon request)

Customer's benefit plan details

Additional details regarding a specific Customer's benefit plan, be it may be contained in the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, or may be addressed in procedures/protocols communicated by us. Such details may include, but are not limited to, the following:

- Selection of a PCP;
- Effective date of coverage;
- Changes in membership status while a Customer is in a hospital or skilled nursing facility (SNF);
- Customer transfer/disenrollment; or
- Removal of Customer from receiving services by a PCP.

For Customer-specific information, please use one of the following:

- Our Provider website at uhcwest.com
- United Voice Portal
- iEXCHANGE (available in CA, OK, OR, TX, WA; not available in AZ, CO, NV)

Electronic Data Interchange (EDI) (does not apply in Nevada)

EDI is our preferred choice for conducting business transactions with contracting/participating physicians and healthcare industry partners. We accept EDI claims submission for all of our product lines.

EDI tools

We offer an array of EDI tools designed to help you save time and money by automating several of your daily office administrative and reimbursement functions. Please refer to the UnitedHealthcare West-published Companion Guides for the required data elements. Companion guides are available for viewing or download at uhcwest.com.

EDI claims/encounters

EDI claim is the preferred method of submission for contracted physicians and health care providers. You may submit all professional and institutional claims and/or encounter electronically for UnitedHealthcare West and Medicare Advantage HMO product lines as described more fully in this supplement. The HIPAA ANS1 X1 2 837 format is the only acceptable format for submitting claims/encounter data.

1. Electronic Remittance Advice (ERA)

ERA allows a provider to obtain an electronic version of the Explanation of Payment (EOP). Depending on your system's capability, the data may be uploaded directly to the ledger of your practice computer system. ERA can potentially replace the tedious process of Guide EOP reconciliation, posting and data entry. This transaction is available only in the HIPAA ANSI X1 2 835 format.

2. Electronic eligibility inquiry/response

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. This EDI transaction is a powerful productivity tool that allows providers to instantly obtain Customers' eligibility and benefit information in "real-time," using a computer instead of the phone, prior to scheduling and confirming the patient's appointment. The HIPAA ANSI X1 2 270/271 format is the only acceptable format for this EDI transaction.

3. Electronic claims status inquiry/response

This EDI transaction allows a provider to send and receive in "real-time" an electronic status of a previously submitted claim using a computer. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the provider's receivables and cash flow cycle. The HIPAA ANSI X1 276/277 format is the only acceptable format for this EDI transaction. To determine the status of your submitted electronic claims, log on to uhcwest.com. (First, you must register online before receiving this information electronically.) Some software vendors and/or clearinghouses

may also offer Electronic Claims Status and Inquiry transaction services. Or, you may call us at the phone number on the back of the Customer's health care ID card for more information.

Please refer to the UnitedHealthcare West-published Companion Guides for the data elements required for these transactions. Companion guides are available for viewing or download at uhcwest.com.

With the exception of any required set-up and/or recurring monthly or annual fees, (if applicable), there may be a transaction fee for physicians and health care professionals to transmit EDI claims through OptumInsight HIN.

Though we accept EDI claims sent directly to us, we prefer to conduct EDI business transactions primarily through clearinghouses. Clearinghouses normally have established EDI connectivity to many payers. This arrangement benefits the physicians and health care professionals by allowing transmission of EDI transactions to multiple payers using a single connection.

For more information, please call (800) 203-7729 or contact us at edisupport@uhc.com.

OptumInsight Connectivity Solutions is available to assist you to begin submitting and receiving electronic transactions. Please contact them at (800) 341-6141, option 3, for more information.

Begin submitting your claims and encounters electronically

- Before submitting your EDI claims to us, you must first refer to the front of the Customer's health care ID card to determine the appropriate UnitedHealthcare West product type.
- Finally, refer to the EDI Payer ID Quick Reference Tool for the correct Payer ID number and the corresponding claim address of the UnitedHealthcare West product in your market.
- Claims previously submitted that were either denied or pended for additional information should not be resubmitted as electronically or as a new paper claim. Please contact us at the phone number on the back of the Customer's health care ID card for more information.

EDI Payer ID quick reference tool

Market	Product type	EDI Payer ID
Arizona	Commercial/HMO	87726
California	Commercial/HMO	87726
Colorado	Commercial/HMO	87726
Oregon	Commercial/HMO	87726
Washington	Commercial/MCO	87726
Oklahoma	Commercial/HMO	87726
Texas	Commercial/HMO	87726
California	Medicare Advantage/HMO	87726
Oregon	Medicare Advantage/HMO	87726
Washington	Medicare Advantage/MCO	87726
Texas	Medicare Advantage/HMO	87726
Oklahoma	Medicare Advantage/HMO	87726
Colorado	Medicare Advantage/HMO	87726
Arizona	Medicare Advantage/HMO	87726
Nevada	Medicare Advantage/HMO	P.O. Box 95638, Las Vegas, NV 89193-5638 Call P5 Health Solutions (702) 318-2468
All Markets	UnitedHealthcare MedicareDirect (Private Fee for Service - PFFS)	87726

All Markets (Except Nevada) Online:	encountercollection@optum.com
For additional EDI information Visit us:	uhcwest.com
To get started with EDI or EDI technical support	Call: (800) 203-7729 Write to: edisupport@uhc.com

Refer to the patient's Customer health care ID Card for the appropriate product name that corresponds to the Payer ID listed above.

The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims/encounters. In some cases, the Payer ID listed above may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate Payer ID number or refer to your clearinghouse published Payer Lists.

Medical management

The purpose of the UnitedHealthcare Medical Management Program is to determine if medical services are:

- Covered under the Customer's UnitedHealthcare West benefit plan;
- Medically necessary and appropriate; and
- Performed at both the appropriate place and level of care.

In evaluating medical appropriateness of services, we use Milliman Care Guidelines.

Compliance with the medical management program

Complying with the Medical Management Program includes, but is not limited to:

- Allowing our staff to have on-site access to Customers and their families while the Customer is an inpatient;
- Allowing our staff to participate in individual case conferences;
- Facilitating the availability and accessibility of key personnel for case reviews and discussions with the Medical Director or designee representing UnitedHealthcare West, upon request;
- Providing appropriate services in a timely manner.

Types of treatment

Medical emergencies/emergency medical conditions

Please obtain from the Customer, the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable to the Customer, for plan definitions of emergency care. In general, medical emergencies/emergency medical conditions are manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the Customer or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- "Active labor" – a labor at a time when either of the following would occur:
  - Inadequate time to effect safe transfer to another hospital prior to delivery;
  - Transfer may pose a threat to the health and safety of the Customer and/or unborn child. The Customer should be directed to call 911 or its local equivalent, or should be directed to the nearest emergency room.

Prior authorization/notification is not required. However, notification of your emergency should be provided telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

After-hours and weekend emergency services should be provided as clinically appropriate, the request should be entered into iEXCHANGE or faxed to us at (800) 274-0569 on the next business day.

Urgently needed services

Please check the Customer's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for the plan definition of urgent care. In general, urgently needed services are services: (a) that are required without delay to prevent the serious deterioration of a Customer's health as a result of an unforeseen illness or injury; and (b) for which it was not reasonable, given the circumstances, to obtain in accordance with the terms of the Customer's benefit plan. You must contact the Customer's PCP or hospitalist upon a Customer's arrival for services. These services should be requested telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Routine

All other services are considered routine. To request preauthorization, the PCP must enter all the necessary information into iEXCHANGE, or complete and submit the appropriate Preauthorization Request Form. Routine requests will be responded to within the following time frames if all pertinent clinical information is received:

Product	State	Time frame
Medicare Advantage Urgent	All	72 Hours
Medicare Advantage Standard	All	14 Calendar Days
Commercial Urgent	OR, WA	2 Business Days
	CA, OK	72 Hours
	Texas	3 Calendar Days
Commercial Routine	OR, WA	2 Business Days Exception - a delay of decision (DOD) letter
	CA	5 Business Days Exception - a delay of decision (DOD) letter
	OK,	15 Calendar Days
	TX	3 Calendar Days

Authorization status determination

Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may determine whether to delay, modify or deny services to a Customer for reasons of medical necessity.

Preauthorization

A list of services that require preauthorization is available at uhcwest.com → Providers → Login → Library → Select State → Resource Center. Services that are rendered without the required preauthorization will be denied as provider liability. The Customer cannot be billed for such services.

- Most in-office PCP and specialty services do not require preauthorization.
- Contracting/participating network physicians and health care professionals, also known as "Participating Providers," should refer Customers to network providers. Referrals to non-network providers require preauthorization from us.
- Once the PCP refers a Customer to a network specialist, that specialist may then see the Customer as needed for the referring diagnosis. The specialist is not required to direct the Customer back to the PCP to order tests and/or treatment.
- If a specialist feels that a Customer needs other services related to the treatment of the referral diagnosis, the specialist may then refer the Customer, according to the UnitedHealthcare West Preauthorization List, to a contracting/participating network physician or ancillary provider.

UnitedHealthcare West or its agents shall conduct review throughout a Customer's course of treatment. Multiple authorizations may be required throughout such course of treatment as authorizations may be limited to specific services or time periods.

Referral process

If there are no network specialty or ancillary providers identified within the service area for a necessary service, the physician must submit a completed UnitedHealthcare West Precertification Request Form to us or to the delegated Medical Group for approval, as appropriate. The Precertification Request Form can be found at uhcwest.com → Providers → Login → Library → Select State → Resource Center.

Primary care services

Most PCP services do not require prior authorization. However, if prior authorization is required, the following guidelines apply:

1. The PCP is responsible for verifying eligibility and benefits prior to rendering services;
2. To request prior authorization, the PCP must enter the request into iEXCHANGE or complete and submit the appropriate Preauthorization Request Form (unless the services are required urgently or on an emergency basis). The completed Treatment Request Form must include the following information:
   - Customer's presenting complaint,
   - Physician's clinical findings on exam,
   - All diagnostic and lab results relevant to the request,
   - Conservative treatment that has been tried,
   - Applicable CPT and ICD-9-CM codes;
3. The PCP may also check the status of a treatment request through iEXCHANGE;
4. Upon approval, the treatment request will be given a tracking number that can be viewed through iEXCHANGE or faxed back to the physician office based on the method that the PCP used to submit the form;
5. The tracking number should be noted on the claim when it is submitted for payment;
6. All authorizations expire 90 calendar days from the date of issuance.

Referrals for serious or complex medical conditions

The PCP should identify any UnitedHealthcare West Customers with serious or complex medical conditions and develop appropriate treatment plans for these Customers, in conjunction with case management. The treatment plan should include an authorization for referral to a specialist for an adequate number of visits to accommodate the treatment plan.

Specialty care (including gynecology) in an office-based setting

1. The specialist will receive via fax or an iEXCHANGE notice (approved as requested, approved as modified, delayed or denied) of the status of the authorization request for services requiring prior authorization. For those services that do not require prior authorization, the specialist office will receive a referral request directly from the PCP;
2. All specialist authorizations will expire 90 calendar days from the date of issuance;
3. Plain film radiography rendered by a designated UnitedHealthcare West Participating Provider, or in the specialist's office in support of an authorized visit, does not require prior authorization;
4. Routine lab services that are performed in the specialist's office, or are provided by a designated UnitedHealthcare West contracting/participating provider in support of an authorized visit, do not require prior authorization;
5. Customers may self-refer to a gynecologist who is a Participating Provider for their annual routine gynecological exams. UnitedHealthcare West Customers in Colorado may self-refer to a participating gynecologist. The only exception to this OB/GYN direct access process is OB/GYN specialists whose practices primarily consist of subspecialty care such as infertility or genetics. Such sub-specialists can be accessed only by referral from the Customer's PCP.
6. Female Medicare Advantage Customers over age 40 may self-refer to a UnitedHealthcare West radiology provider who is a Participating Provider for a screening mammogram. (Note: Mammograms may require authorization in California.)

Obstetrics

1. A Customer may self-refer to a UnitedHealthcare West obstetrician who is a Participating Provider for routine obstetrical (OB) care. If the Customer is referred to a non-contracted specialist, the specialist must notify us through iEXCHANGE or by fax at the number designated on the top of the Prior Authorization Form to make sure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and 2 ultrasounds.
3. Plain film radiography that is performed by a UnitedHealthcare West Medicare Advantage Participating Provider or in the obstetrician's office in support of an authorized visit, do not require prior authorization.
4. Routine labs that are performed in the obstetrician's office, or are provided by a Participating Provider in support of an authorized visit, do not require prior authorization.
5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed.

Specialty care in a hospital setting

All specialty care performed in a hospital setting requires prior authorization. This includes all surgical procedures, diagnostic testing, or therapeutic services performed in a facility setting and other facility-based services.

Second opinions (California Commercial only)

We will authorize and provide a second opinion consultation by an appropriately qualified health care professional for Customers who meet specific criteria. A second opinion consists of one office visit for a consultation or evaluation only. Customers must return to their assigned PCPs for all follow-up care. A health care professional is defined as a PCP or specialist who is acting within the scope of practice and who possesses a clinical background, including training and expertise related to the Customer's particular illness, disease or condition.

The PCP may request a second opinion on behalf of the Customer in any of the following situations:

1. The Customer questions the reasonableness or necessity of a recommended surgical procedure;
2. The Customer questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function, or threatens substantial impairment, including, but not limited to, a serious chronic condition;
3. The clinical indications are not clear or are complex and confusing;
4. A diagnosis is in doubt due to conflicting test results;
5. The treating provider is unable to diagnose the condition;
6. The Customer's medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the Customer is requesting a second opinion regarding the diagnosis or continuance of the treatment; or
7. The Customer has attempted to follow the treatment plan or has consulted with the initial provider and has serious concerns about the diagnosis or treatment plan.

Post-stabilization care

Customers are covered for post-stabilization services following emergency services. Post-stabilization services are medically necessary, but non-emergent, services needed to make sure the Customer remains stabilized from the time the treating hospital requests authorization from Medical Management until one of the following occurs:

1. The Customer is discharged;
2. A Participating Provider arrives and assumes responsibility for the Customer's care; or
3. The treating physician and UnitedHealthcare West agree to another arrangement.

We are responsible for the cost of post-stabilization services that are:

- Pre-approved by us; and
- Medically necessary.

Post-stabilization care will be deemed approved if we do not respond within 1 hour to the request for post-stabilization care or we cannot be contacted for pre-approval.

Extension of prior authorization services

If a Customer requires services beyond the initial consult and follow-up visits in any of the situations where we require prior authorization, the specialist must request an extension of authorization through iEXCHANGE or by fax:

1. Beyond the approved visits;
2. Beyond the allotted time frame of the approval (typically 90 calendar days);
3. If a Customer requires procedures, and/or diagnostic or therapeutic testing, requiring prior authorization.

The extension must be authorized before care is rendered to the Customer. The request for extension of services must include the following information:

- Customer's presenting complaint;
- Physician's clinical findings on exam;

- All diagnostic and laboratory results relevant to the request;
- Conservative treatment that has been tried;
- Applicable CPT and ICD-9-CM codes.
- Requested services (e.g., x additional visits, procedures).

We will review the existing authorization and will mail or fax it back our response to the physician and/or make the information available on iEXCHANGE. There is no need to contact the Customer's PCP.

Inpatient authorization procedures

Preauthorization is required for all nonurgent/non-emergent inpatient services provided in an acute care hospital, rehabilitation facility and a SNF. Hospitals, rehabilitation facilities and SNFs are required to notify us of all admissions, changes in inpatient status and discharge dates daily.

Additionally, authorization is required as follows:

- Certain urgent/emergent admissions require prior authorization; please verify benefits prior to requesting authorization.
- Elective/scheduled medical admissions require prior authorization.
- For admissions or transfers after-hours or on weekends, the Customer should be admitted to the appropriate facility at the appropriate level of care. Authorization can then be obtained on the next business day.
- Authorization is not required for a consultation with a contracted in-network provider during an inpatient stay. However, consultation with a non-contracted, non-network provider requires prior authorization.
- Transfers/admissions to SNFs; a Customer can be admitted directly from the emergency room or home to a SNF.
- A referral to a non-network facility requires preauthorization from us. However, in the case of a life-threatening emergency, a non-contracted hospital may be used without prior authorization. After initial emergency treatment and/or post-stabilization, we may request that a Customer be transferred to a network hospital when medically appropriate. If a PCP directs a Customer to a non-network hospital for non-emergent care without preauthorization, the PCP may be held responsible.

Required authorizations can be obtained through iEXCHANGE or by completing and faxing the Treatment Authorization Form to the appropriate fax phone number located at the top of the Treatment Authorization Form. If the UnitedHealthcare West Prior Authorization Nurse is unable to authorize the admission or procedure; the request will be referred to our Medical Director. If the Customer's recovery requires an extension of days beyond those authorized, the Concurrent Review Nurse will contact the hospital for clinical indications for extension. Please note that issuance of a tracking number does not constitute authorization for admission.

Failure to comply with this notification requirement will result in non-payment to the hospital or SNF and their providers for all charges until notification is received and services have been authorized.

Hospital notification

Independent from prior authorization, notification by the facility is required for inpatient admissions on the day of admission for urgent/emergent, scheduled/elective, medical, surgical, out of area, hospice and obstetrical services.

Inpatient census reports

The following reports must be faxed daily to our Clinical Information department:

- Census report for all our Customers;
- Discharge report;
- Face sheets to report outpatient surgeries and SNF admissions;
- Inpatient Admission Fax Sheet to report "no UnitedHealthcare West admissions" for that day;

The census report or face sheets must include the following information:

- Primary Medical Group/IPA
- Admit date
- Customer name (first and last)
- Date of birth
- Bed type/accommodation status/level of care (LOC)
- Length of stay (LOS)
- Admitting physician
- Admitting diagnosis (ICD-9-CM)
- Procedure/surgery (CPT Code) or reason for admission
- Attending physician
- Facility
- City/State
- Policy number/Customer health care ID number
- Other insurance
- Authorization number (if available)
- Discharge report, including Customer demographic information, discharge date and disposition.

Coordination of care

Facilities are required to assist in the coordination of a Customer's care by:

- Working with the Customer's PCP;
- Notifying the PCP of any admissions; and
- Providing the PCP with discharge summaries.

Concurrent review

We will conduct concurrent review on all admissions from the day of admission through the day of discharge. Concurrent review is performed telephonically, as well as on-site at designated facilities, by clinical staff. We have established procedures for on-site concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling on-site reviews in advance; and (c) staff requirements to follow facility rules. If the clinical reviewer determines that the Customer may be treated at a lower level of care or in an alternative treatment setting, the case will be discussed with the hospital case manager and the admitting physician. If a discrepancy occurs, our Medical Director or designee will discuss the case with the admitting physician.

Variance days

If inpatient care coordination and provision of diagnostic services lack medical necessity or are not provided in a timely manner contributing to delays in care, variance days will be assigned and reimbursement adjusted accordingly. Our concurrent review staff will attempt to minimize variance days by working with the attending physicians and hospital staff. If a variance is noted in the patient's acute care process, our concurrent review staff will discuss the variance with the hospital's medical management/case management representative. If the variance exists after the discussion, our concurrent review staff will document the variance in our utilization records and submit to the Concurrent Review Manager for approval. If approved, the variance is entered into our database as a denial of reimbursement for the variance time period. A letter stating the variance type and time period will be mailed to the facility. The facility may appeal the variances in writing. Our Medical Director will review the appeal and render a decision to overturn or uphold the decision.

Medical observation status

We will authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a Customer's medical condition and determine the need for actual admission, or to stabilize a Customer's condition and typically lasts for 23-48 hours. Typical cases, when observation status is used, include ruled-out diagnoses and medical conditions that respond quickly to care. Customers under observation status may later convert to an inpatient admission if medically necessary.

Emergency and/or direct urgent admissions

If a hospital does not receive authorization from us within 1 hour of the initial call requesting authorization, the emergent and/or urgent services prompting the admission are assumed to be authorized and should be documented as such to us until we direct or arrange care for the Customer. Once we become involved with managing or directing the Customer's care, all services provided must be authorized by us.

Skilled Nursing Facilities (SNFs)

Before transfer/admit to a SNF, UnitedHealthcare West or its designee must approve the Customer's treatment plan. The Customer's network physician must perform the initial physical exam and complete a written report within 48 hours of a Customer's admission to the SNF. We will perform an initial review and subsequent reviews as we deem necessary. Federal and State regulations require that Customers at skilled level facilities be seen by a physician at least once every 30 calendar days.

Discharge planning

Discharge planning is the coordination of a Customer's anticipated continuing care needs following discharge. The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessing and documenting the Customer's needs upon admission, including the Customer's functional status and anticipated discharge disposition, if other than a discharge to home;
- Developing the discharge plan, including evaluation of the Customer's financial and social service needs and potential need for post-hospital services, such as home health, DME, and/or placement in a SNF or custodial care facility;
- Obtaining authorizations for necessary post-discharge plan;
- Organizing, communicating and executing the discharge plan;
- Evaluating the effectiveness of the discharge plan;
- Making timely referral to population-based disease management and case management programs, as indicated;

For after-hours or weekend discharges requiring home health and/or DME, the care should be arranged and authorization can be obtained, as indicated above, on the next business day.

Retrospective review/medical claim review

Medical claim review, also known as medical cost review, medical bill review and/or retrospective review, is the examination of the medical documentation and/or billing detail after a service has been provided. Medical claim review is performed to provide a fair and consistent means to retrospectively review medical claims to make sure medical necessity criteria are met, confirm appropriate level of care and length of stay, correct payer source and identify appropriate potential unbundling and/or duplicate billing occurrences.

The review includes an examination of all appropriate claims and/or medical records against accepted billing practices and clinical guidelines as defined by entities such as Medicare AMA, CPT coding and Milliman Care Guidelines depending on the type of claims submitted.

Claims that meet any of the following criteria are reviewed before the claim is paid:

- High dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Implants that are not identified on the UnitedHealthcare West's Implant Guidelines used by UnitedHealthcare West Claims Department;
- Claim check or modifier edits based on our claim payment software;
- Foreign country claims;
- Claims with LOS or LOC mismatch.

To make sure timely review and payment determinations, the physician, health care professional, facility or ancillary provider must respond to requests for all appropriate medical records within 5-7 calendar days from receipt of the request.

We may review specific claims based on pre-established retrospective criteria to make sure acceptable billing practices are applied.

For hospital providers, we may reduce the payable dollars additionally if line item charges have been incorrectly unbundled from room and board charges.

Minimum content of written or electronic notification

Written or electronic notices to deny, delay in delivery, or modify a request for authorization for health care services will, at a minimum, include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
    - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;
    - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
    - Clinical reasons for decisions regarding medical necessity; and
    - Contractual rationale for benefit denials.
- Notification that the Customer can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the Customer's physician can request a peer-to-peer review;
- Alternative treatment options offered, if applicable;
- Description of any additional material or information necessary from the Customer to complete the request, and why that information is necessary;
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
    - Information regarding the Customer's right to appoint a representative to file an appeal on the Customer's behalf,
    - The Customer's right to submit written comments, documents or other additional relevant information,
    - Information notifying the Customer and their treating provider of the right to an expedited appeal for time-sensitive situations (not applicable to retrospective review);

- Information regarding the Customer's right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
- Information that the Customer may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products only);
- For the treating provider, the name and direct phone number of the health care professional responsible for the decision.

Pharmacy formulary

Customer benefit plans may or may not include pharmacy coverage. Our Commercial and Medicare formularies include most generic drugs and a broad selection of brand name drugs. Prescription drugs/medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization in order to be covered.

In some instances, a Customer's commercial pharmacy plan may not include coverage for non-formulary prescriptions/medications. In these instances, the costs are the Customer's financial responsibility, unless the prescribing physician requests prior authorization review for the non-formulary medications and the Customer meets our criteria for coverage.

To access the formulary and changes to the formulary, go to uhcwest.com → Providers → Library → Click on the desired state → Pharmacy → Click on the desired formulary. You will then be able to search by drug name or therapeutic class. Any restriction or limitation will also be noted along with formulary alternatives, when applicable. The commercial formulary is updated twice a year, in January and July. The Medicare formulary is updated up to 6 times during a calendar year. Physician requests for formulary review of medications or preauthorization guidelines are welcome. Prior authorization guideline change request forms and formulary change request forms can be obtained by going to PrescriptionSolutions.com → HealthCare Professionals Home Page → Healthcare Provider Tools → Forms and Documents.

Prior authorization/exception process

We have a prior authorization process to provide for coverage of select formulary and non-formulary/non-covered medications. We delegate prior authorization services to Prescription Solutions®. Prescription Solutions staff will adhere to plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards in reviewing each case.

Request for prior authorization of non-formulary medications

The request for prior authorization of a non-formulary drug may only be made by the physician or his or her designee, who is located in the physician's office or other site where the Customer is receiving medical services. The prior authorization functions may not be delegated to a third-party who is not located at the physician's office or other site where the Customer is receiving medical services. However, clinical pharmacists who work in a medical management capacity within a medical group, and who are directly employed by or contracted with that medical group may also make requests.

You can request an authorization by:

- **Phone:** Toll-free: (800) 711-4555
- **Written request:** Fax: (800) 527-0531 for oral medications and (800) 853-3844 for injectable/specialty medications. You can obtain a Prior Authorization Medications Request Form at uhcwest.com after login or through PrescriptionSolutions.com → Prior Authorizations.
- **Online:** PrescriptionSolutions.com → Healthcare Professionals → Prior Authorizations. This new online service enables physicians and health care professionals to submit a real-time Prior Authorization request any time of the day or night, any day of the week. After logging on at prescriptionsolutions.com with his or her unique National Provider Identifier (NPI) number and password, a physician or health care professional can submit patient details

securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly. With just a few mouse clicks, physicians can submit information that previously had to be collected by phone or fax. Also, physicians and health care professionals can use the new service to check on the status of a Prior Authorization request, even if it was not submitted online. This new online service applies to oral drugs as well as specialty medications.

The prior authorization request must include specific information related to the Customer's medical condition and course of treatment, as requested by Prescription Solutions. Prescription Solutions will not process the request until all necessary information has been submitted. Prescription Solutions will communicate with the physician or designated employee or other individual under the direction and control of the physician regarding whether the non-formulary drug will be covered. Once all requested necessary information has been received, Prescription Solutions will make its determination within the applicable time frame as defined by federal and/or state regulations. No decision will be made on requests that are incomplete.

Non-formulary medications and/or other medications that require prior authorization may be authorized in accordance with benefit design, provided the Customer's benefit restrictions (applied to both the requested agent(s)/therapeutic class, and the prior authorization process) are not exceeded, and when any of the following criteria are met:

- The requested non-formulary medication has limited efficacy and relatively high incidence of side effects, but indication for specific disease management meets criteria outlined in the National Pharmacy & Therapeutics Committee (NPTC) Guidelines;
- Documented failure of a therapeutic trial of a formulary agent(s);
- The Formulary alternative(s) is/are contraindicated for treatment;
- The Customer is currently maintained and stabilized on a non-formulary medication previously approved by the plan that is not excluded from coverage;
- The Customer experienced allergic reaction(s) to the formulary alternative (e.g., rash, urticaria, drug fever, anaphylactic type, or established adverse effects as published in the package insert of respective product relating to the pharmacological properties of the medications, formulations or differences in absorption, distribution, or elimination of the medications);
- The Customer meets established medical necessity criteria per clinical guidelines and/or standards, and
- No other formulary agent is appropriate to meet the Customer's condition.
- The prescriber provides compelling medical evidence supporting the use of the requested non-formulary medication over the formulary agent where the requested therapeutic class is necessary for medical management.

The following information is required to evaluate each case prior to issuance of an authorization:

- Customer's name
- Customer's health care ID number
- Customer's date of birth
- Customer's gender
- Prescriber's name
- Prescriber's specialty
- Prescriber's address
- Prescriber's phone/fax number
- Name and dosage strength of the requested medication
- Directions for use
- Diagnosis

- Date Customer was started on the non-formulary medication
- Name of specific drugs tried and failed
- Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice
- Any other compelling medical information that would support the use of the non-formulary medication over a formulary alternative

A written communication of case resolution is faxed to the provider for each case serviced. If prior authorization is approved, the medication will be covered for the applicable cost sharing. If prior authorization is denied, the Customer is responsible for paying the cost of the prescription.

Denial determinations require a letter to be sent to both Customer and prescriber stating the reason why the non-formulary medication is being denied and outlining the process for filing standard and expedited appeals.

Additional information (applies only to Medicare Advantage)

For Medicare Advantage Customers, Prescriptions Solutions' Prior Authorization staff will follow the coverage determination timelines as established by the Centers for Medicare & Medicaid Services (CMS). Standard coverage determinations must be completed within 72 hours. Expedited coverage determinations must be completed within 24 hours. Prescription Solutions will communicate with the physician or his or her designee, and the Customer regarding whether or not the non-formulary drug will be covered and/or whether the cost-sharing exception is approved.

For Medicare Customers, under certain circumstances and on an individual basis, Customers or physicians may request a reduction in the copayment or coinsurance amount for a drug on the formulary. A Tier 3 non-preferred drug may be requested for a Tier 2 copayment/coinsurance instead of the higher Tier 3 copayment/coinsurance amount or a Tier 2 generic drug may be requested for a Tier 1 generic drug copayment/coinsurance instead of the higher Tier 2 copayment/coinsurance amount. Prescription Solutions will not grant an exception to the copayment/coinsurance amount for Tier 5 drugs.

Criteria for cost share reduction are: 1) whether the Customer has failed or has contraindications or intolerance to all equivalent formulary drugs in lower preferred tiers (i.e., Tier 1 and Tier 2); and 2) whether the drug is FDA approved for the condition being treated; and 3) the providers supporting statement must indicate that the preferred drug for the treatment of the enrollee's condition: a) would not be as effective as the requested non-preferred drug; and/or b) would have adverse effects, or its use is supported by a citation in one of the following compendia:

- AHFS (American Hospital Formulary Service) Drug Information;
- USPDI (United States Pharmacopeia-Drug Information); (or its successor publication)
- DRUGDEX Information System from Micromedex.

Non-formulary/non-covered products that are approved through the exceptions process are not eligible for further cost-sharing reductions to Tier 1 or Tier 2 levels.

Authorizing and dispensing injectable/infusion medications

Customers may use the Prescription Solutions Specialty Pharmacy or a participating network retail pharmacy to obtain covered self-injectable and injectable/infusion medications. A list of participating retail pharmacies is available at prescriptionsolutions.com. All medications are subject to the Customer's benefit plan and delegation of medical/physician groups.

The physician must submit the following information to request a covered injectable and/or self-injectable medication for a Customer:

- Complete Prior Authorization Medications Request Form (the requesting physician's signature is required to allow the vendor to accept the document as a legal prescription);
- Recent history and physical

- Copies of any pertinent laboratory results
- Copies of any reports by consultant providers

Submit requests to the Prescription Solutions Specialty Pharmacy at (800) 711-4555, or fax requests directly to (800) 853-3844.

Prescription Solutions will verify the Customer's eligibility, notify the physician of the determination, and if appropriate, contact the physician's office to coordinate delivery of the medication(s). In the case of approved self-injectables, the vendor will contact the Customer to coordinate delivery of the medication(s).

For those self administered drugs that may be covered by Medicare Part D, please refer or download a copy of the formulary online at uhcwest.com, AARPMedicarePlans.com, or UHCMedicareSolutions.com.

Claims processing

Claims adjudication

UnitedHealthcare West uses industry claims adjudication and/or clinical practices, state and federal guidelines, and/or UnitedHealthcare West policies, procedures and data to determine appropriate criteria for payment of claims. To find out more about this information, please contact your Network Account Manager, Physician Advocate or Hospital Advocate, as applicable, or visit our website at uhcwest.com.

Complete claims requirements

We follow the UnitedHealthcare complete claims requirements, as found in the beginning of this Guide.

National Provider Identification (NPI)

UnitedHealthcare West is able to accept the 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 TIN. For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy.

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

- **Website:** uhcwest.com → Provider → Electronic Data Interchange (EDI)/NPI. Here you will find complete details regarding NPI.
- **Phone:** (877) 842-3210 through 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.

Level of care documentation and claims payment

Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, UnitedHealthcare West will pay only the authorized level of care, and the Customer shall not be billed for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, will pay the provider based on the lower level of care, which was determined by provider to be the appropriate level of care for the Customer.

Customer financial responsibility

Reference the applicable Commercial and Medicare Advantage Copayment Guideline Grids at uhcwest.com → Login → Library → Guidelines & Interpretation Manuals for more information about interpretation of copayments.

Services provided to ineligible Customers

In the event that UnitedHealthcare West provides eligibility confirmation indicating that a Customer is eligible at the time the health care services are provided and it is later determined that the patient was not in fact eligible,

UnitedHealthcare West will not be responsible for payment of services provided to the Customer, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the Customer (to the extent permitted by law) or from any other source of payment.

Authorization guarantee procedure (California Commercial only)

Authorization Guarantee provides for reimbursement to the Participating Provider for covered services provided to an Customer for which (1) an authorization has been provided, (2) who is determined to have been ineligible with UnitedHealthcare West on the date the authorized services were rendered and (3) where the Customer's lack of eligibility is only determined after authorized services have been rendered. The Authorization Guarantee does not apply to self-insured or Medicare Advantage benefit plans.

Provider's responsibility to monitor eligibility

UnitedHealthcare West makes available current Customer eligibility information through the United Voice Portal, UnitedHealthcare West Provider Portal, and our Customer Service Center. The Provider is responsible for checking Customer eligibility within 2 business days prior to the date of service. Provider shall be eligible for reimbursement under the Authorization Guarantee program described herein for authorized services provided that Provider has checked and confirmed eligibility within 2 business days prior to the date of service.

Authorization guarantee and reimbursement procedure

Currently, our systems automatically deny claims for services provided to patients who are not eligible regardless of prior authorization. We will review all fee–for-service claims denials that were based on lack of eligibility to determine whether services are eligible for reimbursement. UnitedHealthcare West will overturn denials that are payable under the Authorization Guarantee program without any action by provider. Additionally, the provider must submit the following information to the UnitedHealthcare West Provider Dispute Resolution Team (at: Provider Disputes, PO BOX 6098 Cypress, CA 90630) for Authorization Guarantee reimbursement consideration:

- Coversheet: uhcwest.com → Provider → After Login → Library → Provider Policy & Procedures Manual → Policies and Procedures (2011) → "Authorization Guarantee Claims Submission" Form.
- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within 2 business days prior to the date of service;
- A copy of the authorization for the services rendered; and
- A record of any payment received from any other responsible payer, and amount due based on Provider's contract with us, less any payment received from any other responsible payer.

For services covered by the Authorization Guarantee program, UnitedHealthcare West will reimburse Provider in the amount that would have been due to Provider had the same services been provided to an eligible Customer.

Note: If, before or after UnitedHealthcare West makes a payment under the Authorization Guarantee program, the Provider receives payment for the same services from another source, the Provider shall refund the amount received from the other source to us, not to exceed the amount paid by us, within 45 business days.

Claims status follow up

If, after submitting a claim within timely filing guidelines, you have not received an Explanation of Payment (EOP) within the time frames in accordance with state and federal law, the provider may follow-up on the status of a claim using one of the following methods:

- Online at uhcwest.com → Provider → Login → Check Eligibility. The website provides real-time data and is the quickest method for retrieving claim status information or call the provider line at the toll-free number found on the back of the Customer's health care ID card.

- You may also submit an Electronic Transaction (HIPAA 276/277). Please contact your EDI clearing house for additional information.
- United Voice Portal now provides access to claim status information by calling the toll-free number found on the back of the Customer's health care ID card, and simply following the prompt instructions over the phone. This system provides a fax of the claim status detail information that is available.

Claims submission requirements

Claims shall be submitted to UnitedHealthcare West on industry standard forms (CMS-1500s, UB-04s) and forwarded to the address listed Customer's ID card. Refer to the EDI section of this Guide for more information about electronic claims submission and other Electronic Data Interchange (EDI) transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g. PMG, MSO, Hospital), you should bill that entity directly for reimbursement.

Claims submission requirements for reinsurance claims for hospital providers

If contracted covered services fall under the reinsurance provisions set forth in your agreement with us, you shall abide by the terms of the agreement in making sure that:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
- Only those inpatient services specifically identified under the terms of the reinsurance provision(s) may be used to calculate the stipulated threshold rate;
- Applicable eligible Customer copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;
- The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;
- The reinsurance is applied to the specific, authorized acute care confinement;
- Claim submitted in accordance with the required time frame, if any, as set forth in the agreement.

In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms Agreement and/or this Supplement, you shall:

- Indicate if a claim meets reinsurance criteria; and
- Make medical records available upon request for all related services identified under the reinsurance provisions (e.g. , ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, UnitedHealthcare West shall continue to process the claim at the appropriate LOC per diem rate in the agreement. In order to compute specific reinsurance calculations and to properly review reinsurance claims for covered services, an itemized bill is required.

Interim bills

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The process outlined below will increase efficiencies for both us and the Hospital/SNF business offices:

- 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).

- 114 Interim – Last Claim: Review admit to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

Reciprocity agreements

You shall cooperate with our contracting/participating providers and other UnitedHealthcare entities and agree to provide services to Customers enrolled in benefit plans and programs of UnitedHealthcare affiliates and to assure reciprocity of providing health care services.

Without limiting the foregoing, if any Customer who is enrolled in a benefit plan or program of any UnitedHealthcare West affiliate, receives services or treatment from you and your sub-contracted providers (if applicable), you and your sub-contracted providers (if applicable), agree to bill the UnitedHealthcare West affiliate at billed charges and to accept the compensation provided pursuant to your agreement, less applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare affiliate and this agreement for reimbursement of such services or treatment.

Overpayments

If you identify a claim for which you were overpaid by us, or if we inform you of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If refund or dispute is not made within 45 calendar days of our request, we shall recoup the amount of overpayment through other means, which may include 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 us, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter.

Please include appropriate documentation that outlines the overpayment, including Customer'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 us. 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 or other contracting/participating health care professional. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim reconsideration, or as provided by applicable law. 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 must submit the dispute, in writing, to the recovery agent requesting the overpayment. The agent's name and address is located on the recovery request letter.

If you dispute the refund request, the recovery of claims overpayment will not occur until after you have exhausted our appeals process. (See *Claim Appeals* section of this Supplement.)

Medicare opt-out providers

UnitedHealthcare West abides by, and requires its providers to abide by, Medicare's physician/practitioner opt-out policy. Physicians/practitioners who opt-out of Medicare (this may include physicians/practitioners not participating in Medicare) are not allowed to bill Medicare or its Medicare Advantage plans for 2 years from the date of official opt-out. UnitedHealthcare West and its delegated entities will not contract with, or pay claims to, providers who have opted-out of Medicare for Medicare Advantage membership.

Exception: In an emergency or urgent care situation, a physician/practitioner who opts-out of Medicare may treat a Medicare beneficiary with whom he or she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a non-participating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with the physician/practitioner.

End-stage renal disease

If a Customer has (or develops) end stage renal disease (ESRD) while covered under an employer's group plan, the Customer must use the benefits of the plan for the first 30 months after becoming eligible for Medicare, based on ESRD. After the 30 months elapse, Medicare is then the primary Payer. However, if the employer group plan coverage were secondary to Medicare when the Customer developed ESRD, Medicare would be the primary Payer.

Medicaid (applies only to Medicare Advantage)

Qualified Medicare Beneficiaries (QMB) are held harmless for Medicare cost-sharing under applicable CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copayments included under Medicare Advantage Plans.

Physicians and health care professionals will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Customer who is eligible for both Medicare and Medicaid, or said Customer's representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g. copays, deductibles, coinsurance) when the State is responsible for paying such amounts. Physicians and health care professionals 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.

Time limits for filing claims

All physicians and health care professionals are required to submit to clean claims for reimbursement no later than the time specified in the provider's participation agreement or the time frame specified in the state guidelines, whichever is greater.

If a provider fails to submit clean claims within the foregoing time frames, UnitedHealthcare West reserves the right to deny payment for such claim(s). Claim(s) which are denied for untimely filing cannot be billed to a Customer.

We have established internal claims processing procedures to make sure timely claims payment to its physicians and health care professionals. UnitedHealthcare West is committed to paying claims for which it is financially responsible within the time frames required by state and federal law.

For purposes of determining the date of UnitedHealthcare West's or its delegate receipt of a claim, the date of receipt shall be deemed to be the business day when a claim, by physical or electronic means, is first delivered to UnitedHealthcare West's specified claims payment office, post office box, designated claims processor or to UnitedHealthcare West's capitated provider for that claim. The following date stamps may be used to determine date of receipt.

- UnitedHealthcare West Claims Department date stamp
- Primary Payer claim payment/denial date as shown on the EOP
- Delegated Provider date stamp
- TPA date stamp
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender

Note: Date stamps from other health plans or insurance companies are not valid received dates for timely filing determination.

Provider appeals

Claims research and resolution (applies to only commercial in Oklahoma & Texas)

The Claims Research & Resolution (CR&R) process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was UnitedHealthcare West, the delegated Medical Group/IPA or other delegated payer, or the capitated hospital/provider. You are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

We will research the issue to identify the payer who holds financial risk of the services and will abide by federal and state legislation on appropriate timelines for resolution. We will work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim reconsideration requests (does not apply in California)

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). You should submit your request to us in writing by using the Claims Rework Request form (available at uhcwest.com → Providers → Login → Library → Select State Forms. All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines.

Please refer to the chart titled UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section for the address to which your request should be sent.

Submission of bulk claim inquiries

The Claims Project Management (CPM) Team handles bulk claim inquiries. You should contact the CPM team at the address below to initiate a bulk claim inquiry:

UnitedHealthcare West bulk claims rework reference table		
Provider's state	**Contact information**	**Notes**
Arizona	UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078	Submit requests for 20 or more claims.
California	Claims Research Projects P.O. Box 30968 CA1 20-0360 Salt Lake City, UT 84130-0968	Submit requests for 19 or more claims.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 52064. Phoenix, AZ 85072-2064	Submit requests for 20 or more claims.
Nevada	For Medicare Advantage claims UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638	The Nevada delegated payer handles bulk claim inquiries received from physicians and health care professionals of service. The provider of service should submit the bulk claims with a cover sheet indicating "Appeal" or "Review" to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for 10 or more claims.
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	Submit requests for 20 or more claims.
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.

UnitedHealthcare West bulk claims rework reference table		
Provider's state	**Contact information**	**Notes**
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	Submit requests for 20 or more claims.
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.

UnitedHealthcare West's response

We will respond to issues as quickly as possible.

- **Reworks/disputes requiring medical determination:** Individuals with clinical training/background who were not previously involved in the initial decision will review all clinical rework/dispute requests. A letter will be sent to the provider outlining the outcome of the determination and the basis for the decision.
- **Reworks/disputes requiring claim process determination:** Individuals not previously involved in the initial processing of the claim will review rework/dispute request.
- **Response details:** If claim requires an additional payment, the EOP will serve as notification of the outcome on the review. If the original claim status is upheld, the provider will be sent a letter outlining the details of the review.
- **Applies to California only:** If claim requires an additional payment, the EOP itself is insufficient to serve as notification of the outcome of the review. A letter will be sent to the provider with the determination. In addition, payment must be sent within 5 calendar days of such determination based on the date on the determination letter.

We will respond to the provider within the applicable time limits set forth by Federal and State agencies. After the applicable time limit has passed, the provider may contact Provider Relations at (877) 847-2862 to obtain a status.

Provider Dispute Resolution (PDR) (applies to commercial in CA, OR and WA)

A provider dispute is a dispute of a claim for which a determination has previously been issued by us. You must submit a provider dispute in writing and accompanied by additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless other filing guidelines contained in your participation agreement or State law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of provider disputes, in accordance with State and Federal regulations. We will not discriminate, retaliate against or charge you for submitting a provider dispute. The PDR process is not a substitution for arbitration and will not be deemed as arbitration.

What to submit

As the provider of service, you should submit the dispute with the following information:

- Customer's name;
- Customer's health care ID number;
- Claim number;
- Specific item in dispute;
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved;
- Submitting provider's contract information.

Note: Physicians and health care professionals who do not submit the appropriate supporting documentation when requesting review of a previously processed claim will not have the dispute reviewed.

For California physicians and health care professionals: A Provider Dispute Resolution form can be obtained online at

uhcwest.com → Library → Select "Provider Disputes". The dispute resolution form is not required; however, the minimum requirements outlined in AB1455 must be met.

Where to submit

State-specific addresses and other pertinent information regarding the PDR process may be found in the UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section.

Accountability for review of a provider dispute

The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/provider.

Excluded from the PDR process

The following are examples of issues that are excluded from the PDR process:

- Dates of service prior to January 1, 2004.
- Instances in which a Customer has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the Customer's appeal will take precedence. You can submit a Provider Dispute after the Customer appeal decision is made. If you are appealing on behalf of the Customer, the appeal will be processed as a Customer appeal.
- An Independent Medical Review initiated by a Customer through the Customer Appeal Process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply "good cause" for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/provider and does not involve an issue of medical necessity or medical management.

UnitedHealthcare West provider rework or dispute process reference table

Provider's state	Contact information	Notes
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	• First Review: Request for reconsideration of a claim is considered a Grievance. Physicians and health care professionals are required to notify us in writing of any request for reconsideration within 1 year from the date the claim was processed. • Second Review: Request for reconsideration of a Grievance determination is also considered a Grievance. Physicians and health care professionals are required to notify us in writing of any second level Grievance within 1 year from the date the first level Grievance resolution was communicated to the provider.
California	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	• UnitedHealthcare of California will acknowledge receipt of the dispute within 15 business days of receipt of the dispute for disputes submitted by paper and within 2 business days of receipt of the disputes submitted electronically. We will issue a written determination to the provider within 45 business days. Also, we will return the provider dispute if additional information is required within 45 business days.

UnitedHealthcare West provider rework or dispute process reference table		
Provider's state	**Contact information**	**Notes**
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team 4601 E. Hilton Ave. Phoenix, AZ 85034	• Upon receipt of a dispute, PacifiCare of Colorado will: • Send the provider a written acknowledgement of receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conduct a thorough review of the provider's dispute and all supporting documentation; • Supply the provider with a written determination, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Process payment, if necessary, within 5 business days of the written determination; • Return the dispute to the provider of service within 30 calendar days if additional information is required; • If additional information is required, we will hold the dispute request for 30 additional calendar days.
Nevada	For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638	• All Nevada Medicare Advantage HMO claims are processed by a delegated payer. Therefore, the provider appeals are reviewed primarily by the delegated payer.
Oklahoma	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Oregon	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	• UnitedHealthcare of Oregon will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. • We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. • In the case of billing disputes, we will render a decision within 60 calendar days of the complaint.
Texas	UnitedHealthcare West Claims Department P. O. Box 400046 San Antonio, TX 78229	
Washington	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	• UnitedHealthcare of Washington will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. • We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. • In the case of billing disputes, we will render a decision within 60 calendar days of the complaint.

Access & availability to medical & behavioral health services

We monitor Customers' access to medical and behavioral healthcare to make sure that we have an adequate provider network to meet the Customers' healthcare needs. We use Customer satisfaction surveys and other feedback to assess performance against standards.

UnitedHealthcare has established the following national standards for access to care. Exceptions or additions to these national standards are shown in the table below.

Type of Care	Guideline
Regular or routine	14 calendar days Exceptions: California Commercial HMO Customers are offered appointments for non-urgent PCP within 10 business days of request, for non-urgent specialist within 15 business days of request; Texas within 3 weeks for medical conditions
Preventive care	4 weeks Exceptions: Texas within 2 months for child and within 3 months for adult. Medicare Advantage within 30 days
Non-urgent, but in need of attention (applies to Medicare Advantage only)	Within 1 week
Urgent exam (PCP or specialist)	Same day (24 hours) Exceptions: California Customers are offered appointments within 48 hours when no prior authorization required, within 96 hours when prior authorization required
Emergent exam	Immediately (exception: only if open 24 hours a day/7 days a week).
In-office wait time	Less than 15 minutes from the time of the appointment until the Customer is with the physician in the exam room. Exceptions: California Customers in-office wait time is less than 30 minutes
Referral process	Notification to the Customer should be completed in a timely manner, not to exceed 5 business days of a request for non-urgent care or 72 hours of a request for urgent care.
Non-urgent ancillary (diagnostic)	15 business days
Behavioral health care for a non-life-threatening emergency	6 hours
Behavioral health urgent care	24 hours
Behavioral health routine office visit	10 business days

* A physician's office after-hours line should provide a Customer access within 30 minutes to someone who can direct the Customer in determining/securing necessary care. The after-hours line may be monitored by an answering service that pages or contacts the on-call physician, or an answering machine with clear instructions and a second number to call to reach a physician or another person to page the physician. Regardless of the method, the after-hours communication must instruct the Customer to call 911 or go to the nearest emergency room if the Customer is experiencing an emergency.

1. Customers must have access to all physicians and support staff that work for the physician and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.
2. Customers must have access to appointments during all normal office hours and will not be limited to appointments on certain days or during certain hours.
3. Customers must have access to time slots that are the same as all other patients seen by the physician who are not UnitedHealthcare West Commercial Customers.
4. The physician must work cooperatively with our Medical Management department toward:
   - Managing inpatient and outpatient utilization;
   - Customer Care and Customer satisfaction;

   As an "authorization representative" of the health plan, physicians are responsible to notify the Customer about the prior authorization determination, unless State regulation requires otherwise.

5. The physician will use best efforts to refer Customers to UnitedHealthcare West network providers.

The physician must use only UnitedHealthcare West network laboratory and radiology providers, unless specifically authorized.

Timely access to non-emergency health care services (applies only to Commercial in California)

- The timeliness standards require licensed health care providers to offer Customers appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Customer.
- Triage or screening services by phone must be provided by licensed staff, 24 hours per day, 7 days per week. Under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise or make any decision regarding the condition of an Customer or determine when an Customer needs to be seen by a licensed medical professional.
- UnitedHealthcare of California SignatureValue HMO Customers have access to free telephonic triage and screening services 24 hours a day, 7 days a week through OptumHealth's Nurseline at (866) 747-4325.

California Language Assistance Program (California Commercial only)

Consistent with California law, UnitedHealthcare of California Signature Value HMO Customers, who have limited English proficiency, have accessibility to translated written materials and oral interpretation services, free of charge, to assist such Customers in obtaining covered services. For more information, call (800) 752-6096.

Customer complaints & grievances

We acknowledge that Customer disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. UnitedHealthcare West respects the rights of its Customers to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All Customers receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

Oxford Medicare Advantage Supplement

(May apply to providers in CT, NJ, NY; refer to your agreement for applicability)

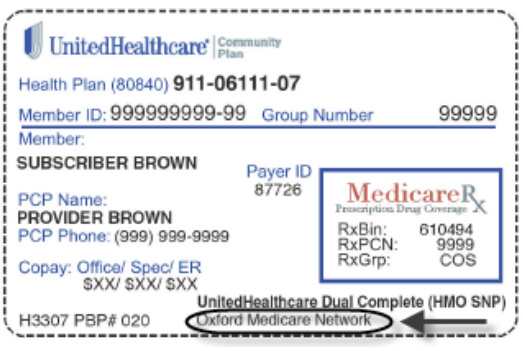
Important information regarding the use of this Supplement

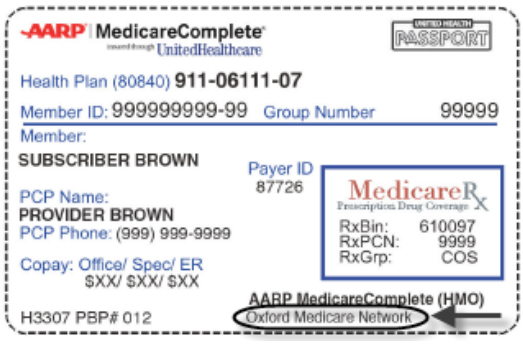
This Oxford Medicare Supplement (Supplement) applies to services provided to Customers enrolled in UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic*, and UnitedHealthcare® Medicare Advantage brands. This Supplement applies to Customers enrolled in the plans described above. Customers under those plans will present a health care identification (ID) card displaying the UnitedHealthcare logo in the top left corner and indicating either "Oxford Medicare network" or "Oxford Mosaic Network" in the lower right corner.

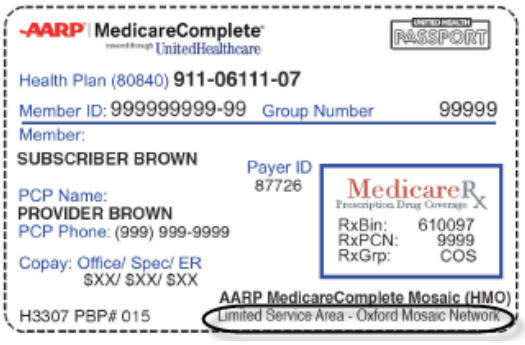
In the event of any inconsistency between the Guide and this Supplement, the Supplement and all Protocols and Payment Policies found on UnitedHealthcareOnline.com will apply.

Health care ID cards

Customers enrolled in AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic*, and UnitedHealthcare® Medicare Advantage plans on the current Oxford Health Plan benefit plans will present with a plastic health care ID card. Be sure to use the telephone numbers and addresses noted on these health care ID cards effective 1/1/2012.







* AARP® MedicareComplete® Mosaic (HMO) is a Limited Service Area and includes only the following four counties: Kings, Queens, New York and Bronx.

How To Contact Us

Resource	Where to go	What you can do there
Online services	**Use UnitedHealthcareOnline.com**	• Register for UnitedHealthcareOnline.com • Review a Customer's eligibility or benefits • Electronic Referral System › Submit notifications and precertifications › Check status of or update existing notifications and precertifications › View claim pre-determination and bundling logic using claim Estimator › Submit claims online CMS 1500 only › 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, 10 codes at a time with the exception of capitated arrangements › Review/print a current copy of this Supplement › View health plan protocols and policies › View current and past issues of our Network Bulletin › Access and review clinical program information and patient safety resources
Electronic Claim Submission (EDI Support Line)	(800) 842-1109 To obtain information on HIPAA Transactions code sets go to hipaa.uhc.com → Uniprise → Companion Document Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions	Use our payer ID 87726

Claims process

All claims should be submitted electronically to our Payer ID 87726. For claims appeals, please send your letter of appeal to the address on the back of the Customer's health care ID card or follow the instructions on the Provider Remittance Advice (PRA) or on the correspondence received from UnitedHealthcare. Instructions are also available on the UnitedHealthcareOnline.com under the Patient Eligibility and Benefits Section.

Health services

To notify us of the procedures and services outlined in the Preauthorization and Precertification section, please fax, call or go online to:

- Non Urgent precertification requests only fax (800) 303-9902;
- Hospital Notification only fax (800) 699-4712;
- General Provider Phone Number (877) 842-3210;
- UnitedHealthcareOnline.com
- Submit via EDI

Services requiring precertification

The appearance of an item on this list is not a guarantee of coverage. Precertification requirements and covered services may vary depending on the Customer's plan of coverage. Precertification and payment of covered services are subject to the terms, conditions and limitations of the Customer's contract or certificate, eligibility at time of service, and approval by our Medical Management Department. This list may be changed by us, and any changes will be communicated on the first business day of each month online at UnitedHealthcareonline.com.

In addition, precertification requirements may differ by individual physician or other health care professional. If additional precertification requirements apply, the physician or other health care professional will be notified in advance of the precertification rules being applied.

Inpatient and outpatient care

As a general rule, any service rendered in an inpatient facility or an outpatient facility requires precertification. These settings include, but are not limited to: acute care centers, skilled nursing facilities, freestanding ambulatory surgery centers, radiology centers, radiation therapy centers, hospice centers, and rehabilitation centers.

Exceptions to this rule include emergency room visits not resulting in an admission and urgent care delivered at a participating urgent care facility.

Emergency admissions do not require precertification. However, we must be notified within 24 to 48 hours of an emergency admission.

If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, the provider must notify us within 24-48 hours of when the surgery is performed.

Elective admissions require prior authorization at least 14 days prior to the date of admission for the following: acute care, skilled nursing facility care, acute intensive rehabilitation care, and hospice care.

Transfer from one facility to another requires precertification prior to the transfer, unless the transfer is due to a life-threatening medical emergency.

Hospital notification of admissions

Hospitals are required to notify us of inpatient admissions. We may deny part or all of an inpatient admission if the hospital fails to:

- Notify of any admission
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required, including ambulatory surgery resulting from an emergency room or urgent care visit
- Notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required
- Provide records as reasonably requested by us
- Cooperate with inpatient concurrent review

If we deny part or all of an inpatient admission for one of the reasons noted above, the hospital will have 48 hours (72 hours for New Jersey hospitals) to submit a request to Medical Management for reconsideration of the denied days (excluding case rates). If during the reconsideration process, we determine the previously denied days were medically necessary and appropriate, we will pay the hospital for the covered services at the allowable rates.

Performing services at contracted hospitals

- All participating physicians and other health care professionals are responsible for obtaining precertification when hospital services (inpatient, outpatient or emergency admissions), out-of-network services and other specific services are to be delivered.
- All services require precertification 14 days prior to the scheduled date of service, with the exception of emergency room service, or unless the need is defined as a medical emergency.

Discharge planning and concurrent review

Upon admission, Medical Management will accept concurrent review information as well as the discharge plan provided by the admitting physician or other health care professional and/or the hospital's Utilization Review department. If a Customer requires an extended length of stay or additional consultations, please call our Medical Management Department at (877) 842-3210 to update the precertification. For Behavioral Health, all calls related to inpatient precertification for UnitedHealthcare Community Plan Customers should be directed to (800) 496-5841 and all calls for all other Medicare Customers should be directed to (800) 985-2596.

Our concurrent review process uses approved criteria to determine the medical necessity of a Customer's continued hospitalization; it also allows for changes and updates to discharge plans.

Inpatient concurrent review – day-of-service decision-making program

We provide hospitals with day-of-service decision-making for continued and ongoing care. To achieve this goal, our processes are consistent with the Milliman Care Guidelines® for inpatient medical and surgical care, home care and recovery facility care.

When issuing a precertification for an inpatient admission or concurrent review approval, the number of approved days or other types of services will be based on these guidelines. We provide concurrent and prospective certification for all services via the Hospital Communication Log (HCL). The HCL lists all our Customers currently known to be in that facility. We must be made aware of each Customer's admission, and the facility involved must provide timely necessary clinical information to demonstrate medically appropriate covered care. Our intention is to eliminate most, if not all, retroactive denials. The following are more specifics about these processes.

Hospital responsibilities

Concurrent inpatient stays (notification prior to discharge):

- The hospital will verify a patient's status, since no payment will be made for services rendered to persons who are not our Customers.
- The hospital is required to notify us of any patient that changes level of care, including but not limited to NICU, ICU, etc.
- The Customer must be enrolled and effective with us on the date the service(s) are rendered; once the hospital verifies a Customer's eligibility with us, that determination will be final and binding; however, if the Centers for Medicare & Medicaid Services (CMS) or an employer or group retroactively disenrolls the Customer up to 90 days following the date of service, then we may deny or reverse the claim; if there is a retroactive disenrollment for these reasons, the hospital may bill and collect payment for those services from the Customer or another payer.
- The hospital must provide a daily inpatient census log by 10 a.m.; the daily inpatient census log will reflect all admits and discharges through midnight the day prior; this will be considered the hospital's official record of our Customers under its care.
- The hospital must provide notification of all admissions of our Customers at the time of, or prior to, admission; the hospital must notify us of all emergencies (upon admission or on the day of admission); the hospital must also notify us of "rollovers" (i.e., any patient who is admitted immediately upon receiving a precertified outpatient service); the hospital also must notify us of any transfer admissions of Customers.

- The hospital must precertify any transfer admissions of Customers prior to the transfer unless the transfer is due to a life-threatening medical emergency.
- The hospital must communicate necessary clinical information on a daily basis, or as requested by our Case Manager, at a specified hour that allows for timely generation of our HCL. If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will be given only if clinical information is received within 48 hours (72 hours for New Jersey facilities).
- The hospital is responsible for verifying the accuracy of the admission and discharge dates for our Customers listed on the HCL. If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to Customers, their medical records, the emergency room, hospital staff, and other information reasonably necessary to:
    - Conduct utilization review activities
    - Make coverage decisions on a concurrent basis
    - Consult in rounds and discharge planning in both inpatient and emergency room settings
- It is the responsibility of all physicians and other health care professionals to deliver letters of non-coverage to the Customer before discharge; this includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

Please note: Appeals will be considered if the hospital can demonstrate that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.

Retrospective review of inpatient stays (notification of admission after discharge)

A retrospective review may be initiated only within the above guidelines and when the Customer is not held financially liable. All information must be received within 10 business days of the initial request for retrospective review.

AARP® MedicareComplete® Mosaic preauthorization and precertification

Certain services require preauthorization or precertification for AARP® MedicareComplete® Mosaic Customers. Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon Customer eligibility and benefits.

The following preauthorization requirements apply to AARP® MedicareComplete® Mosaic Customers. Be sure to submit your request at least 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 Customer's benefit plan. If you have any questions, please contact the Provider Services Department at the number on the back of the Customer's health care ID card.

Physical and Occupational Therapy Services

OptumHealth CareSolutions (OptumHealth), a UnitedHealth Group company, administers the physical and occupational therapy benefit for UnitedHealthcare's Oxford products..

Utilization review process

All physical therapy and/or occupational therapy visits require utilization review and an authorization, including the initial evaluation. A Patient Summary Form must be submitted to OptumHealth by the treating physician or health care professional. Once the required form is completed, it should be submitted by fax, mail or through the OptumHealth website at myoptumhealthphysicalhealth.com. Forms may be obtained through these channels:

Fax: (866) 695-6923

Mail: OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

myoptumhealthphysicalhealth.com

Patient Summary Forms should be sent within 3 days of initiating treatment and must be received within 10 days from the initial date of service indicated on the Patient Summary Form. Patient Summary Forms received outside of this 10-day submission requirement will reflect an adjustment to the initial payable date. This date will be calculated starting 10 days prior to the date OptumHealth received your Patient Summary Form.

Once the forms are received, OptumHealth will review the services requested for medical necessity, and will make any denial determinations. If a patient's care requires additional visits, an updated Patient Summary Form with updated clinical information must be submitted after the initially approved visits have occurred.

Laboratory services

In-office laboratory testing and procedures list

The in-office laboratory testing list provides a list of laboratory procedural/testing codes that we will reimburse its network physicians to perform in their offices. This list represents the only procedures/tests that Oxford network physicians can perform in their offices that will be reimbursed. All other lab procedures/tests must be performed by one of the participating laboratories in Oxford's network.

Certain physician contracts allow for additional tests to be reimbursed in the office. Refer to your physician contract for additional coverage guidelines.

Note: Reimbursement for some of the procedures/tests is limited to physician's specialties.

Primary Care Physicians and Specialists

CPT Code	Test Description
*81000	Urinalysis, non-automated, with microscopy
*81001	Urinalysis, automated, with microscopy
*81002	Urinalysis, non-automated, without microscopy
*81003	Urinalysis, automated, without microscopy
81025	Urine pregnancy test, by visual color comparison methods
*****82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)
*****82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources
*****82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82948	Glucose; blood, reagent strip
82962	Glucose, blood sugar by glucometer
83014	Helicobacter pylori, breath test analysis; drug administration (Note: Dianon is providing test kit free of charge – call 800-328-2666)
83026	Hemoglobin; by copper sulfate method, non-automated
83655	Lead
***85013	Blood count; spun microhematocrit
***85018	Blood count; hemoglobin (Hgb)
85651	Sedimentation rate, erythrocyte; non-automated
****86403	Particle agglutination, screen, each antibody
86485-86580	Skin tests; various
**87070	Culture, bacterial; any other source but urine, blood or stool, with isolation and presumptive identification of isolates.
**87081	Culture, bacterial, screening only, for single organisms
87177	Ova and parasites, direct smears, concentration and identification.
87210	Smear, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination for fungi (e.g., KOH slide)
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
****87880	Infectious agent detection by immunoassay-streptococcus group A
89100	Duodenal intubation and aspiration; single specimen plus appropriate test
89105	Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube
89130-89141	Gastric intubation and aspiration; various
89350	Sputum, obtaining specimen, aerosol-induced technique
99195	Phlebotomy, therapeutic (separate procedure)
*** 85025	For Stat Purposes Only Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

Those labs marked with *, **, ***, ****, ***** will be limited to one procedure (within the same family of asterisks) per visit. For example, all labs that are marked with one * will only be allowed to have one lab test performed out of all of the codes designated with the single *.

Dermatologists / Dermatopathologists

CPT Code	Test Description
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

Rheumatologists

CPT Code	Test Description
89060	Crystal Identification by light microscopy with or without polarizing lens analysis; tissue or any body fluid (except urine)

Urologists

CPT Code	Test Description
#89264	Sperm identification from testis tissue, fresh or cryopreserved
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)

Customer must have the infertility benefit.

Pediatricians

CPT Code	Test Description
82247	Bilirubin, Total

Pulmonologists

CPT Code	Test Description
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)

Hematologists / Oncologists / Pediatric Hematologists

CPT Code	Test Description
***85007	Blood count; automated differential WBC count blood smear, microscopic examination with manual differential WBC count
***85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
***85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85097	Bone marrow; smear interpretation only, with or without differential cell count
86077	Blood bank physician services; difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report
86078	Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report
86079	Blood bank physician services; authorization for deviation from standard blood-banking procedures, with written report
86927-86999	Transfusion medicine

Those labs marked with *, **, ***, ****, ***** will be limited to one procedure (within the same family of asterisks) per visit. For example, all labs that are marked with one * will only be allowed to have one lab test performed out of all of the codes designated with the single *.

Obstetricians/Gynecologists/Reproductive Endocrinologists/Infertility

CPT Code	Test Description
82670	Estradiol
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
84144	Progesterone
84702	Gonadotropin, chorionic (hCG); quantitative
#89250	Culture of oocyte(s)/embryo(s), less than 4 days
#89251	Culture of oocyte(s)/embryo(s), less than 4 days, with co-culture of oocytes(s)/ embryos
#89253	Assisted Embryo hatching, microtechniques (any method)
#89254	Oocyte identification from follicular fluid
#89255	Preparation of embryo for transfer (any method)
#89257	Sperm identification from aspiration (other than seminal fluid)
#89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
#89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
#89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed
#89325	Sperm antibodies
#89329	Sperm evaluation; hamster penetration test
#89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test

Customer must have the infertility benefit.

Endocrinologists / Infertility

CPT Code	Test Description
#89264	Sperm identification from testis tissue, fresh or cryopreserved
#89268	Insemination of oocytes
#89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
#89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
#89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
#89352	Thawing of cryopreserved; embryo(s)

Customer must have the infertility benefit.

Specimen Handling and Venipuncture:

- If specimen handling and venipuncture codes are billed in conjunction with a lab code, only the lab and venipuncture codes will be reimbursed (and only if that lab code is on the above Lab Exception List).
- If specimen handling and venipuncture codes are billed without a lab code on Oxford's In Office Laboratory Testing and Procedures List or with other non laboratory services, the specimen handling and venipuncture codes will be paid per the Oxford fee schedule.

River Valley Entities Supplement

Important information regarding the use of this Supplement

This River Valley Entities Supplement applies to covered services rendered to River Valley Entities Customers—other than Medicare Advantage, Medicaid and CHIP Customers- by physicians, health care professionals, facilities and ancillary providers in either of the following categories:

- Their UnitedHealthcare participation agreement includes a reference to the River Valley or John Deere Health protocols or manuals, or they have directly contracted with one or more of the River Valley Entities to participate in networks maintained for River Valley Entities Customers; and
- They are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Whiteside, Lee, Mercer, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford and McLean.

River Valley Entities Customers are Customers whose benefit plans are sponsored, issued or administered by one of the following "River Valley Entities":

- UnitedHealthcare Services Company of the River Valley, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of the River Valley

River Valley Entities Customers can be identified by a reference to www.uhcrivervalley.com on the back of their ID card.

Please Note: Physicians, health care professionals, facilities and ancillary providers whose participation agreements do not subject them to the River Valley Entities Supplement (including, but not limited to, providers in Ohio and South Carolina) can disregard the information in this Supplement and work with us when providing services to River Valley Entities Customers in the same way as you do when providing services to other UnitedHealthcare Customers. Information regarding a River Valley Entities Customer, including but not limited to eligibility information and claims status information, can be obtained by calling the telephone number on the back of the Customer's ID card.

Please Note: This Supplement does not apply to Medicare Advantage, Medicaid or CHIP benefit plans. Refer to the UnitedHealthcare Community Plan administrative guides available on **www.uhcrivervalley.com → Provider Manuals → UnitedHealthcare Community Plan Provider Manuals** for policies and procedures relating to the TennCare, hawk-i, and Secure Plus Complete Medicaid Plans.

How to contact us

Physicians, health care professionals, facilities and ancillary providers that practice in Illinois, Iowa and Wisconsin should refer to the "Midwest" references in the following grid. Physicians, health care professionals, facilities and ancillary providers that practice in Arkansas, Georgia, Tennessee and Virginia should refer to the "Southeast" references in the following grid.

How to contact us	Where to go	What you can do there
Provider Web site	**www.uhcrivervalley.com/10Provider**	• Find electronic claims submission guidelines • Review a Customer's eligibility or benefits • Check claims status • Access provider e-Services • Find the Coverage Policy Library • Find clinical practice guidelines • Find the Prescription Drug List (PDL)/Generic Drugs • Obtain home health authorization forms • Obtain out-of-network request forms • Obtain demographic change forms • Obtain recoupment request forms to refund overpayments • Find the provider directory • Find newsletters • Find other forms
Electronic claims submission	(866) 509-1593 or **uhcrv_edi_support@uhc.com**	• Enroll in electronic data interchange (EDI) or ask questions regarding electronic claims submission requirements
Claims submission on paper	UnitedHealthcare of the River Valley Commercial PO Box 5230 Kingston, NY 12402-5230	• Submit paper claims in hard copy (as outlined in the *Claims* section of this Supplement)
Tax ID numbers (TIN)/ Provider ID numbers	(866) 509-1593 or **uhcrv_edi_support@uhc.com**	• To update your NPI and related information online, login to www.uhcrivervalley.com/10Provider → Additional Services → demographicchangeform • Contact our e-Business department for technical assistance about Tax or Provider ID numbers, or for more information go to uhcrivervalley.com
Claims payment reconsideration requests	**Phone:** Midwest: (800) 747-1446 Southeast: (800) 224-6602 UnitedHealthcare of the River Valley 3800 Avenue of the Cities, Suite 200 Moline, Illinois 61265	• Get help with questions regarding claims payment, or submit a reconsideration request. • A copy of the claim and supporting documentation will be required for Reconsideration review. Please mark the claim as a "Payment Reconsideration" to ensure the claim is routed to the appropriate area for review.
United Voice Portal (UVP)	**Phone:** Midwest: (800) 747-1446 Southeast: (800) 224-6602	• Determine Customer eligibility and benefits • Check claim status • Update facility/practice data • Obtain information about the appeal submission process
Preauthorization for procedures and services, except for those otherwise referenced in this grid below, including preauthorization for certain Durable Medical Equipment (DME)	**Fax:** Midwest: (888) 242-9058 Southeast: (888) 242-9078 **Phone:** (800) 747-1446 Ext: 65208 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265	• Request preauthorization for procedures and services including DME, orthotics, prosthetics, and other supply items (may need to be obtained through a contracted vendor)

How to contact us	Where to go	What you can do there
Mental health, substance abuse, vision, or transplant services	See the back of the Customer's health care ID card for the contact numbers	• Inquire about a Customer's behavioral health, vision, or transplant services • Most mental health and substance abuse services must be approved (preauthorized) through the contracted mental health/or substance abuse vendor.
Skilled/extended Care	**Phone:** Midwest: (800) 747-1446 Southeast: (800) 224-6602 **Fax:** Midwest: (888) 534-3258 Southeast: (800) 880-5403	• Request preauthorization for skilled/extended care
Pharmacy services / prescription drugs requiring preauthorization	**Phone:** (800) 903-6224 **www.uhcrivervalley.com/10Provider**	• Request preauthorization for prescription drugs as outlined in this Supplement • View the prescription drug list (PDL)
Preauthorization for end-of-life care and home health care including infusion services	**Phone:** (800) 747-1446 Ext: 65287 **Fax:** (800) 340-2184 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265	• Request preauthorization for home health care services by downloading a Home Health Authorization Form: www.uhcrivervalley.com/10Provider
Out-of-network referrals	**Fax:** (800) 299-3779 **Phone:** (800) 747-1446 Ext: 65287 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265	• Request an out-of-network (OON) referral by downloading an OON Request Form, at: www.uhcrivervalley.com/10Provider
Notification of inpatient admissions	**Phone:** Midwest: (800) 747-1446 Southeast: (800) 224-6602 **Fax:** Midwest: (888) 534-3258 Southeast: (800) 880-5403	• Notify us of inpatient admissions
Disease Management	**Toll-Free Phone Number:** (800) 369-2704, Option # 4 **Toll-Free Fax Number:** (866) 950-7759, Attn: CMT Coordinator **E-mail:** MailWebCDM@uhc.com **Online: uhcrivervalley.com → Providers → Health Programs**	• Request Disease Management services for your patients • Provide information to the Care Management Tool (CMT) Coordinator
Case Management	**Phone:** (800) 369-2704 Ext. 2 for Case Management	• Request Case Management services for your patients

Claims

Claims format

All claims for medical or hospital services must be submitted using, as applicable, the CMS-1500 or UB-04, their successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims. The use of black ink is recommended when completing a CMS-1500 claim. Black ink on a red CMS-1500 claim will allow for optimal scanning into our claims processing system.

Electronic claims submission and billing

You should submit your claims electronically. Specific exceptions to this requirement are set forth below.

For electronic claims submission requirements, please see the River Valley Entities' HIPAA Transaction Standard Companion Guide. The River Valley Entities' HIPAA Transaction Standard Companion Guide is located at www.uhcrivervalley.com/10Provider → Providers → HIPAA Information → Companion Documents. This document should be shared with your software vendor. Please note that we update the Companion Guide from time to time and you should routinely review the Companion Guide to ensure you have the most current information about our requirements.

To obtain more information regarding electronic claims, please refer to the EDI section of this Supplement or the provider section of uhcrivervalley.com.

Exceptions to electronic claims submission guidelines

The following claims require attachments and, therefore, must be submitted on paper:

- Claims submitted for dental pre-treatments for crown lengthening, periodontics, implants and veneers
- Claims submitted for timely filed reconsideration requests
- Claims submitted for Correct Coding Initiative (CCI) edit reconsideration
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field

Except as provided above, please do not send claims on paper or with claim attachments unless we request it.

Please note: No special rules apply to electronic claims that append Modifier 59 or for claims for dental pre-treatment; however, as noted above certain pre-treatment claims must be submitted on paper.

Claims with special rules for electronic submission

- **Corrected Claims:** must include the words "corrected claims" in the notes field. Your software vendor can instruct you on correct placement of all notes.
- **Unlisted Procedure Code Claims:** must include a sufficient description in the notes field. If you are not able to do so you must submit a paper claim.
- **Claims That Require Dates of Service by Line Item:** Claims for occupational therapy, speech therapy, physical therapy, dialysis, mental health or substance abuse services require the date of service by line item. We do not accept span dates for these types of claims.
- **Secondary Coordination Of Benefits (COB) Claims:** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount
  - **Professional:** Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (Amount that the payer paid to the Customer not the provider)

- **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount (contractual discount amount of other payer), Patient Paid Amount (Amount that the payer paid to the Customer not the provider)
- **Span Dates:** Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS-1 500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission

Requirements for claims (paper or electronic) reporting revenue codes

- All claims reporting Revenue Codes require the exact dates of service if they are span dates.
- If Revenue Code 270 is submitted by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.
- If you report Revenue Code 274, you are required to provide a description of the services or a valid CPT or HCPCS code.
- Claims reported with Revenue Codes 250-259 require an itemized statement if the charges exceed $1,000.
- All claims reporting the Revenue Codes on the list below require that your report the appropriate CPT and HCPCS codes.

Revenue codes requiring CPT® and HCPCS codes

260	IV Therapy(General Classification)
261	Infusion Pump
262	IV therapy/pharmacy services
263	IV therapy/drug/supply delivery
264	IV Therapy/Supplies
269	Other IV therapy
290	Durable Medical Equipment (other than renal) (General Classification)
291	Durable Medical Equipment/Rental
292	Purchase of new DME
293	Purchase of used DME
300	Laboratory(General Classification)
301	Chemistry
302	Immunology
303	Renal Patient(Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other laboratory
310	Laboratory -Pathology(General Classification)
311	Cytology
312	Histology
319	Other Laboratory Pathological
320	Radiology –diagnostic (General Classification)
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
329	Other Radiology -Diagnostic
330	Radiology –Therapeutic and/or Chemotherapy Administration (General Classification)
331	Chemotherapy Administration-Injected
332	Chemotherapy Administration-Oral
333	Radiation Therapy
335	Chemotherapy Administration-IV
339	Other Radiology-Therapeutic
340	Nuclear Medicine (General Classification)
341	Diagnostic Procedures
342	Therapeutic Procedures
350	CT Scan (General Classification)
351	CT- Head Scan
352	CT - Body Scan
359	CT-Other
360	Operating Room Services (General Classification)
361	Minor Surgery
362	Organ Transplant- Other Than Kidney
367	Kidney Transplant
369	Other Operating Room Services
400	Other Imaging Services(General Classification)
401	Diagnostic Mammography
402	Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
410	Respiratory Services(General Classification)
412	Inhalation Services
419	Other Respiratory Services
460	Pulmonary Function(General Classification)
469	Other-Pulmonary Function
470	Audiology (General Classification)
471	Audiology/Diagnostic
472	Audiology/Treatment
480	Cardiology (General Classification)
481	Cardiac Cath Lab
482	Stress Test
483	Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care (General Classification)
499	Other Ambulatory Surgical Care
610	Magnetic Resonance Technology (General Classification)
611	MRI – Brain/Brain Stem
612	MRI -Spinal Cord/Spine
614	MRI - Other
615	MRA – Head and Neck
616	MRA – Lower Extremities
618	MRA Other
618	Other MRT
623	Surgical Dressing
624	FDA Investigational Devices
634	Erythropoietin (EPO) < 10,000 units
635	Erythropoietin (EPO) >10,000 units
636	Drugs Requiring Detail Coding
730	EKG/ECG (Electrocardiogram) (General Classification)
731	Holter Monitor
732	Telemetry
739	Other EKG/ECG
740	EEG (Electroencephalogram) (General Classification)
750	Gastro-Intestinal (GI) Services(General Classification)
790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921	Peripheral Vascular Lab
922	Electromyelogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
929	Additional Diagnostic Services
940	Other Therapeutic Services (General Classification)
941	Recreational Therapy
942	Education/Training (Diabetic Education)
949	Other Therapeutic Services (HRSA approved weight los providers)

Electronic Data Interchange (EDI)

You may use Electronic Data Interchange (EDI) to conduct business with us electronically, including submitting claims, receiving remittances, and transferring funds. To enroll, please call EDI Customer service at (866) 509-1593 or send an email to **uhcrv_edi_support@uhc.com.**

Claims transmission

You should inform your office software vendor that you want to begin electronic transmission of claims to the River Valley Entities, Payer ID # 95378. All claims are received through our clearinghouse, Ingenix Connectivity Solutions, ENSHealth.com. The clearinghouse sets up all claims as commercial. Your EDI software vendor is responsible for establishing your connectivity to the clearinghouse. Your vendor can advise you of the specific requirements that apply to claims transmissions to the River Valley Entities.*

Electronic Remittance Advice (ERA)

To enroll for 835 ERA, your software vendor should go to our clearinghouse website at ENSHealth.com and click on "ERA Information." Using our Payer ID (95378), the vendor can complete the short enrollment form. ERAs will be returned through the clearinghouse.

Electronic Funds Transfer (EFT)

To initiate EFT, please send an email to: JDHPDemo@uhc.com, with "EFT Enrollment" as the subject line. Please include a contact name, your TIN, your telephone and fax numbers and your e-mail address. A representative will send you the EFT enrollment documents.

EDI acknowledgment/status reports

Your software vendor will provide you with a report that shows only that an electronic claim left your office. It does not confirm that claims have been received or accepted at the clearinghouse or by us.

Clearinghouse acknowledgment reports do show the status of your claims. They are returned after each transmission so you are able to confirm immediately whether a claim reached us for payment or was rejected because of an error, because additional information is needed or for any other reason. This allows you to correct any errors and retransmit a claim the same day so there will be no delay in processing.

You will also receive various Status Reports from the River Valley Entities that provide additional information on the status of claims including copies of Explanations of Benefits (EOBs) and denial letters that may request additional information.

It is very important that you carefully review all Vendor Reports, Clearinghouse Acknowledgment Reports and the River Valley Entities' Status Reports as soon as you receive them. You will know the status of each claim you have submitted and you will be able to correct any errors promptly.

Provider e-Services

The River Valley Entities' provider e-Services can be accessed at uhcrivervalley.com. You will find the following tools that will allow you to quickly and efficiently obtain important and up-to-date information you need when providing services to our Customers:

* For River Valley Customers, Providers are not able to submit claims via the "Connectivity Director" or UnitedHealthcareonline.com All-Payer Gateway.™ The tools for preparing, submitting and managing claims found on UnitedHealthcareonline.com, including the Claim Estimator are also not available with respect to River Valley Customers.

Claim status review

You may locate specific claims using either your provider ID or a specific Customer's ID and obtain a claim summary or line-item detail about claims status including whether we have received the claims and whether they have been paid, pended or denied.

Benefits and eligibility

You may verify the eligibility of your patients before you see them and obtain information about their benefits including required co-payments and any deductibles, out-of-pockets maximums or co-insurance for which your patients are responsible.

PCP roster

You may find a list of all Customers who have designated you as their Primary Care Physician.

Registration for provider e-Services

Before you may use Provider e-Services, your office is required to designate a Security Administrator. The Security Administrator (1) will be the primary contact with the River Valley Entities and (2) is responsible for maintaining access for all users in your office. An officer of your organization who has authority for the Tax IDs seeking access to Provider e-Services should complete the Security Administrator Form identifying the Security Administrator. You may submit the form online at: www.uhcrivervalley.com/10Provider → Providers → Provider eServices → register.

You also may download a hard copy of the form at: uhcrivervalley.com. You may submit the form to us via fax (888) 246-5506, or e-mail: (UHCRVE-ConnSupport@uhc.com) or by United States mail:

UnitedHealthcare
ATTN: UHC - Solutions Support and Services Portal Security
1300 River Drive, Suite 200
Moline, IL 61265

Within 7 to 10 days after submission, the Security Administrator will receive a User ID and Password in separate letters via US mail.

For additional information on the registration process, go to uhcrivervalley.com, and in the section entitled "e-Services" select "Register Now" or the link for providers under "Why use e-Services"?

For technical assistance or information, you may contact our e-Business department from 8:00 a.m. – 4:30 p.m. CT by telephone at (866) 509-1593.

Payment policies

In accordance with your agreement with us, reimbursement of claims is subject to Payment Policies, among other things. You may find these policies at uhcrivervalley.com/10provider → Coverage Policy Library. Change in our payment policies are generally announced in the Network Bulletin found on UnitedHealthcareOnline.com.

We also apply coding edits procedures, based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS' Outpatient Code Editor (OCE). You may find the NCCI edits and the OCE at www.cms.gov/NationalCorrectCodInitEd/.

River Valley's Utilization Management Program

Program components

The River Valley Entities' Utilization Management Program (UM) has several components. These include but are not limited to: (1) preauthorization for various procedures, medical services, treatments, prescription drugs and durable medical equipment; (2) review of the appropriateness of inpatient admissions and ongoing coverage of in-patient care (3) prior approval for referrals to out-of-network providers, if applicable under a Customer's benefit plan; and (4) case management. Our goal is to encourage the highest quality of appropriate care, in the most appropriate setting from the most appropriate provider.

Providers must cooperate with our UM program. You will allow us access, in the form we request, to information on covered services provided to our Customers and you will allow us to collect data that will facilitate UM reviews and decisions.

Medical policies, drug policies and coverage determination guidelines

The River Valley Entities have adopted Medical Policies (also referred to as "Coverage Policies" in the River Valley Entities' Coverage Policy Library), Drug Policies and Coverage Determination Guidelines to assist us in making coverage determinations which includes evaluating whether a particular treatment or service is medically necessary and appropriate in a particular case. The Policies and Guidelines are developed and approved by a committee that includes physicians and other medical professionals representing multiple specialties and are based on current clinical practices, current peer-reviewed medical literature, evidence-based medicine and other relevant factors. You may find and obtain copies of the current Policies and Guidelines at www.uhcrivervalley.com/10Provider → Resource Tools → Coverage Policy Library.

Coverage determinations are also based on other factors including but not limited to a Customer's eligibility, the Customer's benefit plan document (such as a summary plan description), applicable state or federal law benefit mandates, and evidence-based guidelines which may include Milliman® Care Guidelines®. Our Clinical Coverage Criteria are generally reflected in the Medical Policies and Coverage Determination Guidelines. Our Clinical Coverage Criteria are based on current clinical principles and processes and evidence-based practices. Clinical coverage criteria are available upon request. You may also find them at www.uhcrivervalley.com/10Provider → Preauthorization.

Our Medical Policies, Drug Policies and Guidelines are developed as needed and are regularly reviewed and modified as necessary to ensure that they reflect changes and advances in healthcare treatment. We announce new policies, retired policies and amendments to existing policies in the Network Bulletin. The Network Bulletin is available at UnitedHealthcareOnline.com and through uhcrivervalley.com/10Provider → Newsletters.

Preauthorization

Services that require preauthorization

"Preauthorization" means a process of evaluating and authorizing coverage for services using clinical coverage review criteria. The River Valley Entities require preauthorization for certain procedures, items of durable medical equipment (DME), prescription drugs and other services. Many of these are posted at www.uhcrivervalley.com/10Provider → Preauthorization. If you have questions about whether a procedure, DME, prescription drug or service requires preauthorization, contact a UnitedHealthcare Customer Service Representative for the most current information. We reserve the right to remove a procedure, DME, drug or other service from the preauthorization list before notice is provided to you.

Preauthorization: physician responsibility for submitting adequate clinical documentation

It is your responsibility to request preauthorization when it is required. It is important that you provide complete clinical information and medical documentation to support the services you are requesting at the time you submit your request so that we may promptly determine whether the services are covered and medically necessary. We make these determinations based upon the information available to us at the time we are required to make a decision. We will consider additional information provided within the time period allowed for review, but delayed submissions increase administrative time and work for you and for us.

The preauthorization request also must include the documentation needed to evaluate each particular procedure, device, drug and service for which you seek authorization. You should refer to our Medical Policies in determining what documentation and information you should provide.

How to request preauthorization when required

Submitting a request

Please refer to the *How to Contact Us* section at the beginning of this Supplement for information regarding how to submit a request for preauthorization when required.

Failure to obtain preauthorization when required may result in denial of a claim and you cannot bill the Customer for such denied services.

Preauthorization review hours

The River Valley Entities' staff is available for review of preauthorization requests from Monday through Friday from 8:00 a.m. CT to 4:30 p.m. CT with the exception of national holidays and the day after Thanksgiving. Medical Directors are available to discuss clinical policies or decisions by calling the toll-free number on the back of the Customer's health care ID card. Simply ask to speak with a River Valley Entities' Medical Director.

Clinical review of a preauthorization request

When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the submitted clinical information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate in a particular case. River Valley Entities' nursing staff may make decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a Medical Director, or other appropriate reviewer such as a Board-Certified Physician in the applicable specialty or a Registered Pharmacist, to evaluate circumstances or conditions that the criteria do not address. Only physicians and other appropriate practitioners may issue a medical necessity denial for coverage.

The River Valley Entities' staff, their delegates and physicians who make these decisions are not rewarded for denying coverage. The River Valley Entities and its delegates do not offer incentives to physicians to encourage underutilization of care or services.

The treating physician has the ultimate authority for the medical care of the patient. The medical management process does not override this responsibility. If there is disagreement regarding whether care or treatment is medically necessary, the treating physician may care for the patient without any encumbrances from the utilization management process.

Timing of utilization management decisions

We make our utilization management decisions within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee on Quality Assurance (NCQA) standards.

We also provide notice of our decisions to providers and Customers in the form and manner required by applicable state and federal law and in accordance with NCQA standards and River Valley Entities' policy. Among other things, all denial letters outline a Customer's appeal rights, including, where applicable, the right to an expedited and/or external review, as well as the requirements for submitting an appeal and the requirements for our response. A Customer may designate a health care professional to appeal a decision on the Customer's behalf. A copy of the Customer's written consent is required and must be submitted with the appeal.

Facility Utilization Review

Notification of inpatient admission required

Facilities are required to notify us of an inpatient admission within 24 hours of the admission or on the next business day following a holiday or weekend admission. The notification should include the Customer's name, identification number, admitting diagnosis, and the name of the attending physician.

Failure to notify

If the facility does not notify us of an inpatient admission as required, claims will be returned to the facility as not allowed (not allowed to bill the Customer for the services). The facility must contact our Utilization Management department with case information and a Medical Director will determine the appropriateness of the admission and length of stay. The facility will be responsible for all hospital charges deemed not allowed by our Medical Director. The facility will need to resubmit the claims.

Inpatient review

Inpatient review is a component of our utilization management activities. The Medical Director and other clinical staff review Customer hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are medically appropriate and consistent with evidence-based guidelines. Where appropriate, the River Valley Entities also use Milliman Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions, on a case by case basis, in many health care settings, including acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. Criteria other than Milliman Care Guidelines may be used in special situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.

Inpatient review also gives us the opportunity to contribute to decisions about discharge planning and case management. In addition, we may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs.

We usually begin our review on the first business day following admission. If a nurse reviewer believes that an admission or continued stay does not meet criteria you will be asked for more information concerning the treatment and case management plan. The nurse will then refer the case to our Medical Director. If our Medical Director determines that an admission or continued stay at the facility, being managed by a network physician, is not medically necessary, the facility and the physician will be notified.

If you wish to speak with our Medical Director, you will be allowed that opportunity within 1 business day of the request. When complex decisions require expertise outside the scope of the usual physician advisor, we will have a board-certified physician of the relevant specialty (or similar specialty) review the case. External independent review will be obtained when we determine it is appropriate or by Customer request according to applicable law.

If our conclusion does not change after additional review and discussion, and you do not agree that the Customer should be discharged, the Medical Director will determine what action, if any, to take under the *River Valley Provider Sanction Policy* section (the *Sanction Policy*) discussed below. Among other sanctions, the Medical Director may assess a monetary penalty and determine that the Health Plan will not reimburse you for the days of the hospital stay found not to be medically necessary. You have a right to appeal the sanction as described below. Non-reimbursable charges are not billable to the Customer.

The facility and the attending physician have sole authority and responsibility for the medical care of patients. Our medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform you of our determination.

Admission to other facilities

Admission to Rehabilitation Units

All rehabilitation confinements require authorization for admission and are reviewed concurrently for continued services at this level of care. Please refer to the *Skilled/Extended Care* row in the *How to Contact Us* section at the beginning of this Supplement for information on how to submit a request for preauthorization.

Admission to skilled nursing units

A Customer may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

- Preauthorization is required for all admissions to a Skilled Nursing Facility (or skilled level of care within an acute facility). Please refer to the *How to Contact Us* section at the beginning of this Supplement for information regarding how to submit a request for preauthorization.
- The facility must submit the documented plan of care including treatment goals, summary of services to be provided, expected length of stay (LOS), and initial discharge plan.
- Initial certification for admissions will be authorized consistent with the level of care required based upon the anticipated treatment plan.

Concurrent review is conducted at least weekly, or more often if indicated.

- The skilled facility provider is responsible for providing appropriate/adequate documentation, including changes in the level of care.
- Approval for additional days of authorized coverage must be obtained prior to the expiration of the authorization.
- Determinations regarding levels of care must consider not only the level of service but also the medical stability of the Customer.
- Disagreements regarding the level of care required will be addressed by our Medical Director in consultation with you (as the physician managing the Customer in the skilled facility, not the transferring attending physician). The appeal procedure can be initiated as desired by the Customer and/or authorized representative when coverage is not authorized.

We determine whether the admission and subsequent stay and care are covered and medically necessary based upon the following clinical guidelines among others:

- Services must be ordered by a physician and be reasonable and necessary for the treatment of the Customer's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, particular medical needs, and accepted standards of medical practice.
- The Customer must be clinically stable with clinical and lab findings improving/unchanged for the last 24 hours and diagnosis and initial treatment plan established prior to admission to the skilled nursing facility.
- The services must also be reasonable in terms of duration and quantity. The Customer must require skilled services on a daily basis (i.e., available on a 24-hour basis, 7 days/week). If skilled rehabilitation services are not available on a 7 day-a-week basis, a Customer whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when he/she needs and receives those services at least 5 days a week. Skilled services, however, are required and provided at least 3 times per day. Note that the frequency with which a service must be performed does not, by itself, make it a skilled service.

- The nature and complexity of a service and the skills required for safe and effective delivery of that service are considered in determining whether a service is skilled. Skilled care requires frequent patient assessment and review of the clinical course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care is goal-oriented to progress the Customer toward functional independence, and requires the continuing attention of trained medical personnel.

Admission for observation

We may review observation services concurrently or post-discharge to determine whether the use of hospital services was appropriate and medically necessary. Inappropriate use of observation services may result in physician education, sanction, or payment denial or any other action permitted under your participation agreement.

Observation services are a means to evaluate and determine a Customer's need for hospital admission. Observation may be appropriate when determining response to treatment, or monitoring/diagnosing a medical condition when such diagnostic testing or treatment exceeds usual outpatient care. Observation is generally used when 48 hours or less is needed for evaluation of a Customer's condition. In rare and exceptional cases, observation services may span more than 48 hours. Transition to inpatient admission status from observation is generally indicated when:

- A condition is diagnosed requiring a long-term (usually greater than 48 hours) stay (e.g., acute MI)
- Long-term (usually greater than 48 hours) treatment or monitoring are needed for a condition (e.g., persistent severe asthma)

Notice of termination of inpatient benefits

We may determine that an admission and/or a continued stay in a Hospital, Rehabilitation Unit or Skilled Nursing Facility (SNF) are not covered benefits for a number of reasons including, but not limited to the following:

- A Medical Director determines that an admission or continued stay, which was not preapproved at an out-of-network facility, is not medically necessary at the level of care the facility provides;
- Preauthorization was not obtained for a procedure or service subject to that requirement and/or the procedure or service is not a covered benefit under the Customer's benefit plan;
- A Medical Director determines that the Customer's condition is custodial, and is a non-covered benefit;
- A Medical Director and the attending physician determine that continued acute inpatient/Acute Inpatient Rehabilitation/SNF level of care is no longer medically necessary but the patient refuses discharge;
- The Customer has exhausted all existing inpatient or skilled care benefits under his or her benefit plan.

If a non-coverage determination is made, written notification will be provided to the physician, the Customer and facility on the day the determination is made.

Referrals

An out-of-network (OON) referral means a written authorization provided by a participating physician and approved by the River Valley Entities for services from a non-participating provider. OON referrals must be requested by the Customer's primary care physician (PCP). If an OON referral is obtained, services received from a non-participating provider are covered at an in-network level of benefits under the Customer's benefit plan. An OON referral is needed when services are not available from a participating provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance abuse services. To determine whether an OON referral is necessary under a Customer's benefit plan, contact Customer Care at the number on the back of the Customer health care ID card. Additional information regarding OON referrals is provided in a section below.

An in-network referral allows a Customer enrolled in a primary care coordinator (PCC) plan to access care from a participating provider other than a primary care physician (for instance, a specialist) at the in-network benefit level. Additional information regarding in-network referrals for PCC benefit plans is provided in the sections below.

Referrals are required when we are the primary or secondary payer. Please note that a referral does not guarantee payment of a claim.

In-network referral process for primary care coordinator (PCC) plans

An in-network referral allows a Customer to access care from a participating provider other than a primary care physician (for instance, a specialist) at the in-network benefit level. Referral requests must originate from the Customer's network PCP. The final decision concerning a referral will be the sole responsibility of the contracted PCP. Specialist-to-specialist referrals are not allowed. If the treating specialist feels it is necessary for the Customer to see another specialist, he/she must contact the Customer's PCP, who will be responsible for making all new referrals.

Standard exceptions to the in-network referral process:

- Female Customers are allowed direct access to network OB/GYN providers without a referral.
- Customers are allowed direct access to network ophthalmologists or contracted vision providers for an annual diabetic dilated eye exam, without a referral.
- Customers with a split copayment (where the Customer has one copay amount for PCP visits and a higher copay amount for specialty visits) do not require a referral to see an in-network specialist.

Process to facilitate in-network referrals for the Customer:

- The PCP determines the need for an in-network referral to a network specialist, communicates this to the Customer, and sends a letter of referral or phones/faxes a referral to the consulting specialist. The PCP indicates in the referral what services he/she is requesting that the specialist provide.
- Service requests must be a covered benefit under the Customer's plan and must be made to contracted providers.
- To facilitate continuity and coordination of care, the referring PCP should provide timely communication of clinical information to the specialist. Likewise, the specialist should provide written communication to the Customer's PCP, providing a description of health services rendered to the Customer at the referrals visit(s).
- A specialist submits claim(s) for services, providing PCP's name and UPIN/NPI number in boxes 17 & 17a of the CMS-1500 form. The River Valley universal referral number 2009061 RV is placed in Box 23 of the HCIF 1500 form to serve as authorization for payment at the Customer's in-network benefit level.

Out-of-network referral approval

When services are not available from a contracted provider, an out-of-network referral to a non-participating provider must be approved by us prior to services being rendered by the non-participating provider. We must be advised of all requests for out-of-network referrals (except emergencies). A Medical Director will review requests not meeting approval criteria. In the case of emergencies, we must be notified the first business day following the referral. Prior approval for modified or expired out-of-network referrals must also occur as described herein. Prior approval for referral extensions must also occur as described above. Prior approval of a out-of-network referral is required for each follow up visit unless we indicate otherwise.

- Requests for prior approval may be obtained by completing an out-of-network service approval request form and faxing it with documentation for consideration. A copy of the out-of-network referral request form can be accessed at www.uhcrivervalley.com/10Provider → Resource Tool → UnitedHealthcare out-of-network referral Request-Midwest Form OR UnitedHealthcare out-of-network referral Request-Southeast Form. Physicians who practice in Illinois, Iowa and Wisconsin should use the "Midwest" referral form. Physicians who practice in Arkansas, Georgia, Tennessee and Virginia should use the "Southeast" referral form.
- Decisions will be made within 3 business days of receiving the referral request. A letter confirming our approval or denial of a referral will be sent to the Customer and your office.
- If a Customer requests approval after the fact, please advise the Customer that this is contrary to policy and refer the Customer to the Customer Care number on the back of their health care ID card if they have further questions.

- Contracted physicians may not refer their own family members to non-contracted physicians/facilities due to the inherent conflict of interest.

Please Note: If the physician denies a referral to the Customer, the physician must inform the Customer that he/she should refer to his/her benefit document for any appeal rights or call the number on the back of his or her Customer health care ID card.

Services obtained outside the River Valley Entities' service area

- The River Valley Entities' Clinical Services Department processes service requests for treatment authorizations as directed by you and the out-of-area (OOA) attending physician.
- The River Valley Entities' Clinical Services Department in conjunction with you and the OOA attending physician coordinates a Customer's transfer back to the Service Area when medically feasible and appropriate.
- We provide coverage for OOA services for urgent or emergent stabilization services in accordance with the Customer's benefit plan. This will include the time he/she is stabilized in the emergency room, prior to admission as an inpatient or discharge from the facility.
- We also provide coverage for post-stabilization care services. Post-stabilization care services are those that are provided after a Customer is stabilized in order to maintain the stabilized condition.
- Coverage from OOA inpatient services continues only as long as the Customer's condition prevents transfer to a contracted hospital. Transfers should occur within 48 hours of the determination that a transfer is medically feasible and appropriate. Payment for preventive or non-emergent/urgent services performed outside of the network varies according to the benefit plan. Determinations on benefit coverage may include, but are not limited to: non-covered; covered at a reduced level of benefit; or covered at the in-network level of benefit with a referral. Please contact our Customer service department for specific questions.

Special requirements for certain referral requests

Durable Medical Equipment (DME)

- Preauthorization is required for some DME. Please refer to the *How to Contact Us* section at the beginning of this Supplement for information on how to submit a request for preauthorization.
- Subject to the exceptions noted below, all DME, orthotics, prosthetics and supply items must be obtained from a contracted vendor. If an item is not available from a contracted vendor, whether or not preauthorization is required, you must obtain an out-of-network referral or payment for the item will be denied unless the Customer has an out-of-network benefit for DME.
- Note: Even when medically necessary, certain items, for example orthotic devices, may not be covered under a Customer's benefit plan. Others, for example prosthetic devices, may be subject to benefits limits.
- Contact a Customer Service representative for information about a Customer's benefit plan and about any additional requirements that may for DME, procedures, prescription drugs or other services require preauthorization.

Prescription drugs

- Preauthorization is required for some prescription drugs. Please refer to the *How to Contact Us* section at the beginning of this Supplement for information on how to submit a request for preauthorization.
- Some drugs have special rules and require special management services. These include drugs with therapy prerequisites, quantity limitations and/or a multiple co-pay requirement. A list of some of the drugs that that require preauthorization or have special rules may be found at uhcrivervalley.com → providers → preauthorization → drugs. There are links for the list of drugs with special rules.

- If you order and/or administer any medication that requires preauthorization or special clinical management services, you may be required to acquire those medications from a participating specialty pharmacy, unless we authorize a non-specialty pharmacy in a particular situation.
- Certain drugs are available in quantities up to 90 or 100 day supplies, depending on plan benefit design. A list of many of the drugs on the three-month supply list is available at uhcrivervalley. com → provider → Pharmacy → 90 and 100 day supply lists. This list is subject to change at any time without notice.
- The River Valley Entities' Prescription Drug Lists (PDLs), which identify those drugs that currently have special rules are located at uhcrivervalley.com → Pharmacy, and can be found by clicking on the links for: "2011 4-Tier PDL", "2011 Traditional PDL", and "2011 Advantage PDL". You may also find them at www.uhcrivervalley. com/10Provider/Resource Tools and select from the drop down box.

Please Note: Not all drugs on a PDL are covered under a Customer's pharmacy benefit. You may determine whether a medication is covered by viewing the Online Pharmacy found at uhcrivervalley.com/Pharmacy.

Polysomnography and portable monitoring for sleep related breathing disorders

- Preauthorization is required for polysomnongraphy treatment and for the site of service (Sleep lab v. portable home monitoring).
- You must submit a completed "Sleep Test Patient Information Worksheet" with your request. You may find and download that form in the Medical Policy found in the Coverage Policy Library at UHCrivervalley.com/10provider → Coverage Policy Library. Upon request, you may also be required to submit contemporaneous office notes supporting the information in the form.

Home health care including home infusion services

- Preauthorization is required for Home Health Care including but not limited to Home Infusion Services.
- You must complete a specific Home Health Authorization Form which you may find at www.uhcrivervalley. com/10Provider, in the drop down box. Please refer to the *How to Contact Us* section at the beginning of this Supplement for information about how to submit this form.
- If requested services are required after business hours please notify us within 24 hours or the next business day following a holiday or weekend. The notification should include the Customer's name, identification number, diagnosis, the name of the attending physician, and requested services.
- If you do not notify us, your claims will be denied and you may not bill the Customer for the service.

Assisted reproduction program

- Most River Valley Entities' benefit plans specifically exclude coverage for infertility evaluation or treatment. Some employer groups have a variation or rider to cover evaluation and/or treatment of infertility. Certain states, such as Illinois, have mandated treatment for infertility for some groups. For questions relating to assisted reproduction benefits or to obtain preauthorization for services, contact a Registered Nurse at (800) 747-1446, Ext. 65209.

Transplants

- Transplants require preauthorization. Please contact the OptumHealth transplant case manager at (888) 936-7246. The transplant case manager will request medical records necessary to review the Customer's individual appropriateness for a potential transplant. All information is sent to a physician expert in that particular field of transplantation for review prior to authorization.
- If authorized, the case manager coordinates all referrals, assists in selecting a transplant center based upon the Customer's needs, and provides information about the value of our transplant management program.
- If a transplant candidate is in need of home care or is actively involved with a contracted center, services will be arranged by the transplant case manager.

- Any post transplant lab or pathology that cannot be performed/interpreted by a network physician can be sent to the transplant center for interpretation. Please notify the transplant case manager if assistance is needed in making arrangements. Most of these services are covered under the transplant contract. It is cost effective to use the transplant center when appropriate. It is important that the transplant center be involved in the continuing care of the transplant patient.

Post transplant care

- Preauthorization is required for all follow-up care. Requests should be made using the standard River Valley Entities' preauthorization process
- One year post transplant, Customers will be transferred back to their respective local physician for any additional care management services required.

End of life care

- Some Customers have end of life care benefits which may include hospice services. Preauthorization is required for these services. Approved care is coordinated by the River Valley Entities' care managers. Requests for end of life care may be faxed to the Home Health Department at (800) 340-2184.

Provider Education – Sanction Policy

The Provider Education/Sanction Policy has been developed to promote your compliance with medical management processes. All network providers including all practitioners, facilities, home health agencies, ambulatory surgery centers and ancillary providers, including durable medical equipment suppliers, are subject to the education/sanction process. Providers may be subject to sanctions for non-compliance with administrative requirements and/or inappropriate utilization of services including provision of services that are determined to be medically unnecessary.

The River Valley Entities' Medical Directors or Senior Medical Director, Health Services Central Region determine whether a sanction is warranted. They have the authority and discretion to impose monetary and non-monetary sanctions, to place a provider on focused review and/or to require appropriate education. Quality of care issues that meet established criteria are forwarded to and managed by the appropriate UnitedHealthcare department. When appropriate, certain sanctions are reported to regulatory agencies.

Sanctions for inappropriate utilization of services, including the provision of medically unnecessary services, may include denial of payment in whole or part. The practitioner/provider may not bill the Customer for such services unless the Customer knows that we have determined that a service is not medically necessary, agreed in writing, before the services are provided to be responsible for payment of charges for those services.

Other measures that may be imposed with sanctions include but are not limited to:

- Notification and education regarding the occurrence(s);
- A documented plan for improvement from the provider;
- Focused review of the provider's practice;
- Additional training and/or mandatory Category 1 Continuing Medical Education (CME). Specific CME will be determined by the Medical Director(s) or Chief Medical Officer (CMO). All expenses associated with training and CME will be the responsibility of the provider;

Providers who are determined to be noncompliant with required medical management processes and provision of services will notified in writing of the areas of noncompliance, including a description of all specific incidents that lead to the determination, the sanction to be imposed and the potential consequences of future non-compliance. A physician will also be notified in writing of any sanction issued to a mid-level professional under the physician's supervision.

Provider appeal rights

Providers also are notified in writing of their right to appeal via the Network Provider Appeal Process for Sanctions, which includes the opportunity to discuss the determination and sanction with a physician reviewer. If you elect to appeal a sanction, you must notify the issuer of the sanction in writing within 30 calendar days of the date of notification of the sanction. If the initial reviewer does not approve the appeal request, it will be presented to another reviewer of same or similar specialty for the decision. A decision will be made within 30 calendar days of receipt of all information you submit. You will be notified in writing of the appeal decision.

If you disagree with the appeal decision, you have 60 calendar days from the date of the decision on the appeal to notify River Valley Entities of a request for arbitration. The request should be submitted to River Valley Entities in writing. Upon receipt of the request, River Valley will send you information regarding how to initiate arbitration with the American Arbitration Association (AAA).

A request for arbitration must be made to AAA within 180 calendar days of the decision on the appeal. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. The expenses associated with the arbitration will be shared equally by both parties. Arbitration shall be final and binding on all parties.

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved	01/23/2012
Bypass Reason:	UHC Admin Guide 2012 = 56.7 readability		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/23/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	01/23/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	01/23/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	100-6088 UHC ADMIN GUIDE 2012. Updated 1.6.2012 Cover letter	Approved	01/23/2012
Comments:			

SERFF Tracking Number:	*UHLC-128004618*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	
Company Tracking Number:	*100-6088 UHC ADMIN GUIDE 2012*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*
Product Name:	*100-6088 UHC Admin Guide 2012. Updated 1.6.2012*		
Project Name/Number:	*100-6088 UHC Admin Guide 2012/100-6088 UHC Admin Guide 2012*		

Attachment:

100-6088 UHC Admin Guide 2012.AR Cover Letter.pdf

UnitedHealthcare®
A UnitedHealth Group Company

January 4, 2012

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas, Inc.
NAIC No. 95446

2012 Administrative Guide: 100-6088 UHC Admin Guide 2012

Flesch Score: 56.7

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed 2012 Administrative Guide for your Department's review and approval. This is the version posted on our provider portals such as UnitedHealthcareOnline.com (100-688 UHC Admin Guide 2012) and available by print-on-demand for provider use.

The following is a summary of changes incorporated into the 2012 UHC Administrative Guide:

Supplements to the 2012 UnitedHealthcare Guide - Two new Supplements have been added to the 2012 Guide.

- River Valley Entities (formerly the 2010 River Valley Entities Provider Manual)
- Oxford Health Plan Medicare Advantage (Formerly part of the 2010 Oxford Provider Reference Manual)

Re-branding
UnitedHealth Group's benefit businesses-Commercial, Medicare and Medicaid- are aligning to support a single brand. Through this brand transition, UnitedHealthcare, UnitedHealthcare Community Plan, UnitedHealthcare Medicare Solutions and UnitedHealthcare Military & Veteran Services are now sharing the UnitedHealthcare brand name.The branding transition began in late 2010 and will continue into 2012, including the Medicare transition on January 1st, 2012.

UnitedHealthcare Navigatesm - This commercial benefit plan will require members to choose a primary care physician participating in the UnitedHealthcare network, who will then be responsible for managing the individual's health care needs.

Notification Requirements – Certain Notification requirements have been revised, including the following items:

- The *Advance Notification List* has been modified and includes product level or place of service applicability changes for the following service categories:
  - Cochlear Implants
  - Surgical Treatment of Obstructive Sleep Apnea
  - Capsule Endoscopy
  - Hyperbaric Oxygen Treatment (Outpatient)
  - Joint Replacement (hip, knee, other)
  - Orthopaedic and Spine Surgeries
- Facilities will be responsible for confirming that the coverage approval is on file prior to the date of service for any service on the Advance Notification list.
- Facilities will continue to be responsible for Admission Notification for inpatient services; the reimbursement reduction for failure to give such Notification has been modified.
- A new protocol for *Specialty Drug Prior Authorization Program* is added for Medicare Advantage Plans.

- Easier-to-read applicability tables are now included in the *Cardiology Notification, Outpatient Radiology Notification (Commercial),* and *Radiology Prior Authorization (Medicare Advantage)* sections.

New Protocol- Participating providers are required to provide advance notice to Commercial Customers when the provider refers or directs the Customer to a non-participating provider for certain types of services.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Kelly Smith
Manager, Regulatory Affairs

Kelly_smith@uhc.com
Phone: 240-632-8061