

State: Arkansas **Filing Company:** UnitedHealthcare of Arkansas, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: 100-6088 UHC Admin Guide 2013
Project Name/Number: 100-6088 UHC Admin Guide 2013/100-6088 UHC Admin Guide 2013

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.
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 Author(s): Kelly Smith
 Reviewer(s): Rosalind Minor (primary)
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State: Arkansas **Filing Company:** UnitedHealthcare of Arkansas, Inc.
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The UHC 2013 Administrative Guide. This is the version posted on our provider portals such as UnitedHealthcareOnline.com (100-688 UHC Admin Guide 2013) and available by print-on-demand for provider use.

Company and Contact

Filing Contact Information

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Plaza West Building	Group Code:	Company Type: HMO
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Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

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Per Company:	No

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Company	Amount	Date Processed	Transaction #
UnitedHealthcare of Arkansas, Inc.	\$50.00	01/04/2013	66263062

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100-6088 UHC ADMIN GUIDE 2013

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Arkansas

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HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO

Product Name:

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/14/2013	01/14/2013

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Disposition

Disposition Date: 01/14/2013

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Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	100-6088 UHC ADMIN GUIDE 2013 Cover letter	Approved-Closed	Yes
Form	100-6088 UHC Admin Guide 2013	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 100-6088 UHC Admin Guide 2013

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/14/2013	100-6088 UHC Admin Guide 2013	100-6088 UHC Admin Guide 2013	OTH	Initial		56.700	UnitedHealthcare Administrative Guide - 2013.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



Physician, Health Care Professional, Facility and Ancillary Provider 2013 Administrative Guide

For Commercial and Medicare Advantage Products



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Important information regarding the use of this Guide

This 2013 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, 2013 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, 2013.

Terms used in this Guide include the following:

“Customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement with us (we sometimes refer to Customers as “members”);

- “Commercial” refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers’ compensation, TRICARE, or other governmental programs (except that “Commercial” also applies to benefit plans for government employees or students at public universities);
- “You”, “your”, or “provider” 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 covered services you provide to UnitedHealthcare Medicare Advantage Customers, including Erickson Advantage Customers but excluding UnitedHealthcare MedicareDirect Customers. 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.* If a particular section does not apply to Medicare Advantage Customers, it will be clearly indicated in this Guide.

In the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this Guide, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix.

In the event of a conflict or inconsistency between your agreement with us and this Guide, the provisions of your agreement with us will control (except that where your agreement with us 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 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 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.

* 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.”

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 supplements 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 the Additional Manuals are located and how they apply. You are subject to the Additional Manuals when providing covered services to a Customer covered under one of those benefit plans, to the extent provided in your agreement with us and in the table below. UnitedHealthcare may make changes to the Additional Manuals in accordance with the provisions of your agreement with us 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: <ul style="list-style-type: none"> • 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 up-state), some counties in PA	<p>For Commercial benefit plans: Oxford Provider Reference Manual (for Commercial plans only). OxfordHealth.com</p> <p>For Medicare Advantage benefit plans: Oxford Medicare Advantage Supplement to this Guide. UnitedHealthcareOnline.com</p>	If your agreement specifically references Oxford protocols or manuals, then the applicable Oxford Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
MDIPA	Benefit plans issued or administered by MD-Individual Practice Association, Inc.	“MDIPA”	DC, DE, MD, VA, WV, some counties in southeastern PA	<p>Mid-Atlantic Regional Supplement to this Guide. UnitedHealthcareOnline.com</p>	If your agreement specifically references MDIPA protocols or manuals, then the MDIPA Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
OCI	Benefit plans issued or administered by Optimum Choice, Inc.	“OCI”	DC, DE, MD, VA, WV, some counties in PA	<p>Mid-Atlantic Regional Supplement to this Guide. UnitedHealthcareOnline.com</p>	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.

* 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?*
OneNet	Benefit plans accessing a network administered by OneNet PPO, LLC	PPO Network: "OneNet PPO" Workers Compensation Network: ID cards are normally not utilized	DC, DE, MD, NC, PA, VA, WV	OneNet PPO Physician, Health Care Practitioner, Hospital and Facility Supplement to this Guide UnitedHealthcareOnline.com or www.onenetppo.com	If your agreement specifically references OneNet protocols or manuals, then the OneNet Additional Manual also applies, and it supersedes conflicting provisions in the rest of this Guide.
NHP	Benefit plans issued or administered by Neighborhood Health Partnership, Inc.	"Neighborhood Health Partnership"	FL	Neighborhood Health Partnership Supplement to this Guide. UnitedHealthcareOnline.com myNHP.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.
River Valley	Certain benefit plans issued or administered by <ul style="list-style-type: none"> • 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	Parts of AR, GA, IA, IL TN, WI, VA, Note: River Valley also offers benefit plans in NC, OH & SC, but the River Valley Additional Manual does not apply to those benefit plans	River Valley Entities Supplement to this Guide UnitedHealthcareOnline.com and uhcrivervalley.com .	The River Valley Additional Manual applies to you, and it supersedes this Guide if there is a conflict, if all of the following are true. <ul style="list-style-type: none"> • 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 a River Valley Medicare Advantage, Medicaid or CHIP Customer.
United-HealthOne or All Savers	Benefit plans issued or administered by: <ol style="list-style-type: none"> Golden Rule Insurance Company All Savers Insurance Company PacifiCare Life and Health Insurance Company, and American Medical Security Life Insurance Company (AMSLIC) 	<ol style="list-style-type: none"> "Golden Rule" "All Savers Insurance" "PacifiCare" "American Medical Security" 	All markets	UnitedHealthOne & All Savers Supplement to this Guide UnitedHealthcareOnline.com and myuhone.com	Additional Manual applies, but it does not supersede 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?*
United-Healthcare West or UHC West (Benefit plans referenced in this row were formerly referenced in this Guide as "PacifiCare")	Benefit plans issued or administered by any of the following entities: <ul style="list-style-type: none"> • UnitedHealthcare of California • UnitedHealthcare of Oklahoma, Inc. • UnitedHealthcare of Oregon, Inc. • UnitedHealthcare Benefits of Texas, Inc. • UnitedHealthcare of Washington, Inc. • PacifiCare of Arizona, Inc. * • PacifiCare of Colorado, Inc. * • PacifiCare of Nevada, Inc. * * These entities offer Medicare Advantage benefit plans only	"WEST"	AZ, CA, CO, NV, OK, OR, TX, WA	UnitedHealthcare West Non-Capitated Supplement to this Guide. UnitedHealthcareOnline.com and 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.
Sierra	Benefit plans issued or administered by one of the following entities: <ul style="list-style-type: none"> • 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". [As further described in the far right-hand column, these ID card references identify Sierra members who access the UnitedHealthcare network outside Nevada]	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).

* 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?*
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	<p>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.</p> <p>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.</p> <p>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.</p>
United-Healthcare 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"	Multiple states	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured uhccommunityplan.com and UnitedHealthcareOnline.com	If your agreement specifically references UnitedHealthcare Community Plan or Medicaid, CHIP, Uninsured or Other Governmental benefit plans protocols or manuals (including references to "Arizona Physicians IPA", "APIPA", or older brand names such as "AmeriChoice", "Great Lakes Health Plan", "Unison" or "Evercare"), then the UnitedHealthcare Community Plan 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?*
United-Healthcare Community Plan Medicare Advantage	Medicare Advantage benefit plans offered through the UnitedHealthcare Community Plan business unit	<p>"CP" on the back** of the card.</p> <p>**Note that UnitedHealthcare also offers Medicare Advantage benefit plans that are not subject to this Additional Manual. Those benefit plans have a reference to "UHC" (or in certain parts of the country, a reference to "OXH" or "WEST") on the back of the ID card.</p>	Multiple states	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicare uhccommunityplan.com	If your agreement specifically refer-ences UnitedHealthcare Community Plan Medicare Advantage protocols or manuals (including references to older brand names such as "AmeriChoice", "Great Lakes Health Plan" , "Unison", "Arizona Physicians IPA" or "APIPA"), then the UnitedHealthcare Community Plan Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.
TRICARE	Benefit plans for people covered by the Department of Defense's TRICARE program		TRICARE West Region (covering roughly the western half of the United States)	www.uhcmilitarywest.com	TRICARE benefit plans are not subject to this Guide and are instead subject to the 2013 TRICARE West Provider Handbook.

* 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.

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 (described in the following section of this Guide). 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.

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 per year of the "Network Bulletin", a user-friendly, online resource that includes notice to our network physicians and facilities of any protocol, policy, or program updates and changes as well as an array of other useful and interesting items. It includes information relevant across our lines of business, including Commercial, Medicaid and Medicare products. The Network Bulletin is posted and accessible online at UnitedHealthcareOnline.com → Quick Links → Network Bulletin. You can also 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 regarding the availability of the Network Bulletin for the upcoming year are mailed to all providers participating in our network in January and where required by applicable law, separately for each publication of the Network Bulletin throughout the year.

In 2013, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

January 2	March 1	May 1	July 1	September 3	November 1
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Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

General information about updates

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.

* 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.

How to contact us

Commercial & Medicare Advantage Products		
Resource	Where to go	What you can do there
UnitedHealthcare provider website	UnitedHealthcareOnline.com Note: website is applicable to Commercial, Medicare Advantage and Medicaid plans (Community Plans). Claim Status, Eligibility and certain benefits can also be retrieved for River Valley and UnitedHealthcare West.	<ul style="list-style-type: none"> • Register for UnitedHealthcareOnline.com • Review a Customer's eligibility or benefits and current Health Reimbursement Account (HRA) balances • View Patient Personal Health Records • Submit Advance Notifications or Admission Notifications • Submit referrals or check status of referrals • View claim pre-determination and bundling logic using Claim Estimator (only for professional claims for Commercial Customers) • Submit professional claims (for Commercial Customers) • 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 of payment for covered services and electronic EOBs • Request a claims adjustment or a claim 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	<ul style="list-style-type: none"> • Get help with UnitedHealthcareOnline.com
Electronic Submission (EDI Support Line)	(800) 842-1109, or online at UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions	<ul style="list-style-type: none"> • Learn about electronic transactions and submission options • Obtain Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances • Claim submission tips
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)	<ul style="list-style-type: none"> • 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

Commercial & Medicare Advantage Products		
Resource	Where to go	What you can do there
Provider Relations	UnitedHealthcareOnline.com → Contact Us → Network Contacts.	<ul style="list-style-type: none"> • Locate your Physician or Hospital Advocate • Advocates are local market and field representatives who are (1) navigational specialists who assist participating providers with services, product offerings and specific issues and (2) trusted advisors on industry best practices.
Advance Notification, Prior Authorization and Admission Notification (<i>Notification requirements</i>) apply to those Customers whose benefit plans require Prior Authorization and those whose benefit plans do not	UnitedHealthcareOnline.com → Notifications/Prior Authorizations (online submission) or Clinician Resources → Care Management → Advance & Admission Notification (policies and information) or call the United Voice Portal at (877) UHC-3210 (842-3210). See Customer's health care ID card for Customer Care contact information	<ul style="list-style-type: none"> • Notify us about the procedures and services outlined in the <i>Notification requirements</i> section of this Guide. • Communicate with us regarding utilization management issues.
Urgent Appeal Submission (Commercial Customers only) (Medicare Advantage – follow the directions in the Customer decision letter)	Fax: (801) 994-1083	<ul style="list-style-type: none"> • An expedited appeal may be available to you if the Customer's medical conditions are 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	<ul style="list-style-type: none"> • Inquire about benefits and services as indicated in this Guide, including <i>Notification requirements</i>.
Pharmacy Services (For services to Commercial Customers only)	UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → UnitedHealthcare Please refer to the <i>Commercial Pharmacy Benefit Manager Transition in 2013</i> section of this Guide for information on OptumRx™. Medco Phone: (877) 842-1508 or (877) 842-1435 MedcoFax: (888) 327-9791	<ul style="list-style-type: none"> • View the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) by drug. • Learn about pharmaceutical management procedures for notification requirements, supply limits and ProgressionRX (step therapy) protocols. • Request a copy of the PDL. • Call for medications requiring notification. • Fax for easy Rx service.
Pharmacy Services (For services to Medicare Advantage Customers only)	Go to UHC Medicare Solutions.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	<ul style="list-style-type: none"> • View the UnitedHealthcare 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	<ul style="list-style-type: none"> • Inquire about a Customer's behavioral health benefits.
Vision Services	See Customer's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> • Inquire about a Customer's vision benefits.
Transplant Services	See Customer's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> • Inquire about a Customer's transplant benefits.
Customer Care	UnitedHealthCare Commercial and Medicare Advantage Phone: (877) 842-3210	<ul style="list-style-type: none"> • Obtain information for benefit services as indicated in this Guide.
Electronic Payments and Statements (EPS)	UnitedHealthcareOnline.com → Quick Links → Electronic Payments & Statements (information) or Claims & Payments → Electronic Payments & Statements (register or logon) (866) UHC-FAST (842-3278), Option 5	<ul style="list-style-type: none"> • Learn about EPS. • Sign up for EPS. • Call for questions about EPS.

Commercial & Medicare Advantage Products		
Resource	Where to go	What you can do there
Outpatient Radiology Notification & Authorization – Submission and Status	UnitedHealthcareOnline.com Phone: (866) 889-8054	<ul style="list-style-type: none"> Notify us of certain advanced outpatient imaging procedures, as described in the <i>Outpatient Radiology Notification</i> and the <i>Outpatient Radiology Prior Authorization</i> sections of this Guide.
Cardiology Notification & Authorization – Submission & Status	UnitedHealthcareOnline.com Phone: (866) 889-8054	<ul style="list-style-type: none"> Notify us of certain inpatient, outpatient, and office-based cardiology procedures as described in the <i>Cardiology Notification</i> and the <i>Cardiology Prior Authorization</i> sections of this Guide.
Specialty Drug Prior Authorization Submission & Status (Medicare Part B)	UnitedHealthcareOnline.com Phone: (866) 889-8054	<ul style="list-style-type: none"> Notify us of certain outpatient and office-based Part B Specialty Drug procedures as described in the <i>Part B Specialty Drug Prior Authorization</i> section of this Guide.
Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers contracted with OptumHealth Physical Health, a UnitedHealth Group company.	myoptumhealthphysicalhealth.com Phone: (877) 842-3210	<ul style="list-style-type: none"> Verify benefits and eligibility. Check Utilization Review process requirements.

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, Advance Notification and Prior Authorization) 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

During the past two years, UnitedHealthcare has transitioned from the magnetic stripe to bar codes on health care ID cards. The bar code format allows for pharmacy information (Rx Bin, PCN and Group) 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.

For more information, visit UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → ID Cards and New Bar Code Technology

Commercial health care ID card with Medco as Pharmacy Benefit Manager (PBM)

UnitedHealthcare
 Health Plan (80840) 911-87726-04
 Member ID: 123456789 Group Number: 123456
 Member: EMPLOYEE SMITH
 Dependents: SPOUSE SMITH, CHILD1 SMITH, CHILD2 SMITH, CHILD3 SMITH
 Office: \$25 Spec: \$35 UrgCare: \$50 ER: \$100
 Customer Name Line 1: _____
 Customer Name Line 2: _____
 Payer ID: 87726
 medco
 Rx Bin: 610014
 Rx Grp: UHEALTH
 Choice plus
 Underwritten by UnitedHealthcare Insurance Company
 DOI-0501

Printed: 07/27/10
 This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites. Call for notification or preauthorization.
 For Members: www.myuhc.com 111-111-1111
 Care24: 888-887-4114
 Mental Health: 222-222-2222
 For Providers: www.unitedhealthcareonline.com 877-842-3210
 Medical Claims: PO BOX 740800, Atlanta, GA 30374-0800
 Shared Savings Logo Here
 Pharmacy Claims: PO BOX 14711, LEXINGTON KY 40512
 For Pharmacists: 800-922-1557 Members: 800-842-2042

Commercial health care ID card with OptumRx™ as PBM

UnitedHealthcare
 Health Plan (80840) 911-87726-04
 Member ID: 123456789 Group Number: 98765
 Member: EMPLOYEE SMITH
 Dependents: SPOUSE SMITH, CHILD1 SMITH, CHILD2 SMITH, CHILD3 SMITH
 Office: \$25 ER: \$100
 UrgCare: \$50 Spec: \$50
 Customer Name: _____
 Sample with Rx: _____
 Payer ID: 87726
 OPTUMRx
 Rx Bin: 610279
 Rx PCN: 9999
 Rx Grp: UHEALTH
 UnitedHealthcare Choice Plus
 Underwritten by [Appropriate Legal Entity]
 DOI-0501

Printed: 05/03/12
 This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites. Call for notification or preauthorization.
 For Members: www.myuhc.com 555-555-1234
 NurseLine: 800-848-4878
 Mental Health: 555-555-6789
 For Providers: www.unitedhealthcareonline.com 877-842-3210
 Medical Claims: PO BOX 740800, Atlanta, GA 30374-0800
 Shared Savings Logo Here
 Pharmacy Claims: OptumRx P.O. Box 29044 Hot Springs, AR 71903
 For Pharmacists: 800-788-7871

Medicare Advantage health care ID card

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.

UnitedHealthcare MedicareComplete

UnitedHealthcare Medicare Solutions
 Health Plan (80840) 911-06111-07
 Member ID: _____ Group Number: _____
 Member: _____
 Payer ID: 87726
 PCP Name: PROVIDER BROWN
 PCP Phone: _____
 Copay: Office/ Spec/ ER SXX/ \$XX/ SXX
 MedicareRx
 Prescription Drug Coverage
 Rx Bin: 610097
 Rx PCN: 9999
 Rx Grp: _____
 UnitedHealthcare MedicareComplete (HMO)

In an emergency go to the nearest emergency room or call 911.
 Customer Service: TDD 711
 NurseLine: TDD 711
 Behavioral Health: TDD 711
 For Providers: www.unitedhealthcareonline.com 1-877-842-3210
 Medical Claim Address: PO Box 31350, Salt Lake City, UT 84131-0350
 Medicare Solutions UHC
 Pharmacy Claims: RX Solutions PO Box 0082 Cypress, CA 90630-0082
 For Pharmacists: 1-877-889-6510

AARP MedicareComplete

AARP MedicareComplete
powered through UnitedHealthcare

Health Plan (80840) **911-06111-07**

Member ID: **999999999-99** Group Number **99999**

Member:
SUBSCRIBER BROWN

PCP Name:
PROVIDER BROWN

PCP Phone: (999) 999-9999

Copay: Office/ Spec/ ER
 SXX/ SXX/ SXX

H0752 PBP# 002

Payer ID
 87726

MedicareRx
Prescription Drug Coverage

RxBin: **610097**
 RxPCN: **9999**
 RxGrp: **COS**

AARP MedicareComplete (HMO)

UnitedHealthcare
PASSPORT

In an emergency go to the nearest emergency room or call 911.



This card doesn't guarantee coverage. To verify benefits, view claims, or find a physician, visit www.aarpmedicarecomplete.com or call customer service Monday - Sunday 8:00 am to 8:00 pm

Customer Service:	1-800-234-1228	TDD 711
NurseLine:	1-877-365-7949	TDD 711
Behavioral Health:	1-800-985-2596	TDD 711

For Providers: www.unitedhealthcareonline.com 1-877-842-3210
 Medical Claim Address: PO Box 31362, Salt Lake City, UT 84131-0362

Medicare Solutions UHC

Pharmacy Claims: RX Solutions PO Box 6082 Cypress, CA 90630-0082
 For Pharmacists: 1-877-889-6510

Our products

Commercial products

This table provides information about some of the most common UnitedHealthcare Commercial 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 including Medicare Advantage and/or Medicaid products that are offered in select markets. Your agreement with us determines 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 at (877) 842-3210. This product list is provided for your convenience and is subject to change from time to 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 and CORE Choice Plus provides out-of-network benefits.** Choice and CORE Choice do not (except for urgent care and emergency).	Yes, on selected procedures. See guidelines in the Notification requirements section of this Guide.
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 urgent care and emergency).	Yes, on selected procedures. See guidelines in the Notification requirements section of this Guide.
UnitedHealthcare Options PPO	Customers can choose any network physician or health care professional without a referral and without designating a primary physician.* Options PPO also provides, out-of-network benefits. **	In all states other than Colorado, 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, for selected procedures. See guidelines in the Notification requirements section of this Guide.
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[®]	For each covered family member, Customers choose a primary physician from the network of participating physicians. The primary physician makes referrals to network specialists (except that 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 the Notification requirements section of this Guide.

* 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 plans which may be identified via the health care ID card or by looking up your patient's eligibility information at UnitedHealthcareOnline.com. Each of these products include 3 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 typically 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. That 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 MedicareDirect. This product does not use a contracted provider network. For information about UnitedHealthcare MedicareDirect, 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 notification when providing certain services?
HMO and HMO-POS plans under the UnitedHealthcare or AARP brands: <ul style="list-style-type: none"> • MedicareComplete • MedicareComplete Essential • MedicareComplete Plus • MedicareComplete Plus Essential 	Customers who are Medicare eligible	Customers choose a primary physician from the network of physicians to coordinate their care. MedicareComplete Plus HMO-POS plans provide out-of-network coverage for some covered benefits * MedicareComplete. HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	A referral may or may not be required to see a specialist, depending on the plan.** For further information, call (877) 842-3210. 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 of this Guide. ***
Local PPO and Regional PPO (RPPO) plans under the UnitedHealthcare or AARP brands: <ul style="list-style-type: none"> • 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 of this Guide.
Institutional Special Needs Plans (HMO, HMO-POS, PPO) <ul style="list-style-type: none"> • 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 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.	No. A referral is not needed.	Yes. See guidelines in the Notification requirements section of this Guide.
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, (877) 842-3210. 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 of this Guide.
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 of this Guide.

* 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.

** Most services rendered to members enrolled in gatekeeper plans in the South Florida (Broward, Miami-Dade and Palm Beach counties) St. Louis, MO and Wisconsin markets require referrals and/or authorizations from the primary care physician, Physician Hospital Organization, or contracted entity such as a Managed Service Organization (MSO), dependent upon contractual arrangement.

*** For members enrolled in the Florida AARP Medicare Complete® Plan 1 HMO and AARP Medicare Complete® Plus HMOPOS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012, refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization Protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMOPOS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.

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 of this Guide. ***
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 of this Guide.
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 of this Guide.

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. The network aspect of Medicare Select allows lower premiums than those for non-Select plans.

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 or 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.

* 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.

** Most services rendered to members enrolled in gatekeeper plans in the South Florida (Broward, Miami-Dade and Palm Beach counties) St. Louis, MO and Wisconsin markets require referrals and/or authorizations from the primary care physician, Physician Hospital Organization, or contracted entity such as a Managed Service Organization (MSO), dependent upon contractual arrangement.

*** For members enrolled in the Florida AARP Medicare Complete® Plan 1 HMO and AARP Medicare Complete® Plus HMOPOS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012, refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization Protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMOPOS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.

To submit a Medicare Part A 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

<p>AARP Medicare Supplement Plans insured by UnitedHealthcare Insurance Company</p> <p>MEMBERSHIP ID 123456789-11 JOHN Q SAMPLE AARP MEDICARE SELECT PLAN C</p> <p><small>Insured by UnitedHealthcare Insurance Company (for NY residents, UnitedHealthcare Insurance Company of NY).</small></p>	<p>Claim Address: UnitedHealthcare Claim Division P.O. Box 740819 Atlanta, GA 30374-0819</p> <p>For any questions, call this toll-free number: 1-800-523-5800</p> <p>Weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time</p> <p><i>This card does not guarantee payment of benefits.</i></p>
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Notification requirements

Notification requirements at a glance

- Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification for services listed in the [Advance Notification List](#) section of this Guide.
- Facilities are responsible, prior to the date of services, for confirming the coverage approval is on file. Please see pages 18-30, below.
- Facilities are responsible for [Admission Notification](#) for inpatient services even if the coverage approval is on file. Please see page 30.
- 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 agreement with us, 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 pre-service clinical coverage review process, where applicable, and the care coordination process, which allows us to support our Customers throughout their course of treatment, including pre-service planning and coordination of home care and other discharge plans.

Is the Advance Notification process different for different Customers?

No. The list of services for which you must give Advance Notification, and the process for giving Advance Notification, is the same with regard to all Customers subject to this Advance Notification protocol.

What happens after the provider gives Advance Notification?

- In certain cases, services are subject to a pre-service clinical coverage review.
- You do not need to determine whether a coverage review is required in a given case or for a given Customer because the process for you to initiate Advance Notification is the same.
- Once you inform us of a planned service on the [Advance Notification List](#), we will inform you if a clinical coverage review is required. We will inform you what information is necessary to complete the review and 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 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.
- Subject to state regulation and Medicare Advantage policies, receipt of an Advance Notification or a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer's benefit plan, the provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare.

Who is responsible for Advance Notification?

- Physicians, health care professionals and ancillary providers are responsible for Advance Notification for those planned services on the [Advance Notification List](#).

What services require Advance Notification?

- Advance Notification is required only for those services on the [Advance Notification List](#) in this section. In some cases, clinical coverage review is required to determine whether the services will be covered.
- Certain services may not be covered by an individual Customer's benefit plan, regardless of whether Advance Notification is required by this Guide.
- The Advance Notification protocols outlined in this section do not apply to the following, each of which are addressed in separate sections later in this Guide:
 - › The required [Outpatient Radiology Notification Protocol](#) for specified Commercial plans.
 - › The required [Outpatient Radiology Prior Authorization Protocol](#) for specified Medicare Advantage Plans.
 - › The required [Cardiology Notification Protocol](#) for specified Commercial plans.
 - › The required [Cardiology Prior Authorization Protocol](#) for specified Medicare Advantage plans.
 - › The required [Part B Specialty Drug Prior Authorization Program](#) for specified Medicare Advantage plans.

When is Advance Notification or Prior Authorization Required?

- Advance Notification should be submitted as far in advance of the planned service as possible to allow for coverage review. Advance Notification is required to be submitted at least 5 business days prior to the planned service date (unless otherwise specified within the [Advance Notification List](#)). Note that [Advance Notification](#) for home health services and durable medical equipment is required within 48 hours after the physician's order. If, after submitting the original [Advance Notification](#) request, the planned service date changes, you must call us to update our records with the new planned service date.
- For services requiring urgent care, please call the telephone number on the Customer's health care 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 Submit Advance Notification?

- Notify us at [UnitedHealthcareOnline.com](#) → Notifications/Prior Authorizations → Notification/Prior Authorization Submission. We will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (also see fax numbers in the [How to submit Advance Notification or Admission Notifications](#) section of this Guide).
- If you do not have electronic access, please call us at the number on the back of the Customer's health care ID card.

Is there an expiration date on the Advance Notification of approved service(s)

- Approved Advance Notification are valid for the date of service only. If the date of service has passed and the service(s) has not been rendered, a new Advance Notification must be obtained.

When can I update an Advance Notification?

- You may make changes until a decision is made regarding the service. Once an approval has been rendered, you may update the Advance Notification with a change in *date of service only* (as long as the date has not passed). You may update the date of service on UnitedHealthcareOnline or by phone. If you do not have a definite date for rescheduling the service, you may be advised to cancel and re-notify when the date is known.

May I change the Advance Notification after the service has been delivered?

- No updates can be made to an existing Advance Notification AFTER the service has been delivered.

What information must be included in the Advance Notification?

Advance Notification must contain the following information about the planned service:

- Customer name and Customer health care ID number.
- Ordering physician, health care professional, or ancillary provider 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 in the *Clinical Coverage Review: Clinical Information* section below.

- **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 Advance 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).
- 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.

- In some cases for Medicare Advantage Customers, if clinical review is not performed, use of National Coverage Determination and Local Coverage Determination Guidelines may be leveraged to perform a clinical review when the claim is received.
- You can obtain copies of the Coverage Determination Guidelines (CDG) and Medical Policies we use for Commercial products and the UnitedHealthcare Medicare Coverage Summaries Manual used for Medicare Advantage products online at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols, and Guides.
- For Medicare Advantage Customers, we use CMS coverage documents to determine coverage, and 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.

How to submit Advance Notification or Admission Notifications

Multiple submission options are available to submit notifications and Prior Authorizations to UnitedHealthcare, including electronic methods. To avoid duplication, once a notification or prior authorization is submitted and confirmation is received, please do not resubmit.

Method	EDI 278 Transactions	UnitedHealthcare Online.com	Live Call	VoiCert	Fax
Usage	Electronic	Electronic	Non-Electronic	Non-Electronic	Non-Electronic
	Advance Notification and Prior Authorization (278A) and Admission Notification (278N)	Advance Notification and Prior Authorization and Admission Notification; Notification Status for previously submitted notifications	Advance Notification and Prior Authorization and Admission Notification; Notification Status for previously submitted notifications	Inpatient Admission Notification	Advance Notification and Prior Authorization and Admission Notification
Overview	X12 EDI submission directly to UnitedHealthcare or through a clearinghouse	Portal submission directly to UnitedHealthcare through UnitedHealthcareOnline.com	Phone submission directly to UnitedHealthcare through (877) 842-3210 (Option 3) OR dial the number provided on the back of the Customer's ID card For Erickson Advantage, call Erickson Campus Customer Service number on the Customer's ID card	Phone submission through assigned 800 number specific to facility	Fax submission, for Commercial Customers at (866) 756-9733; for Medicare Advantage Customers at (800) 676-4798; for Medicare Special Needs Plan Customers at (800) 538-1339
Business Hours (all times Eastern)	Monday through Friday: 7 a.m. to 2 a.m. Saturday: 7 a.m. to 6 p.m. Sunday: 7 a.m. to 6 p.m. Holidays: Same as above	Generally available 24 hours per day, 7 days a week. Maintenance is scheduled outside of the following hours. Monday through Friday: 6 a.m. to 12 a.m. Saturday: 6 a.m. to 7 p.m. Sunday: 7 a.m. to 5 p.m. Holidays: Same as above	Monday through Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.	VoiCert can be used 24/7, but submissions are processed the following business day: Monday through Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.	Faxes can be sent 24/7, but are processed during the following business hours: Monday through Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.

Advance Notification List

- The following list of Advance Notification requirements for physicians, other health care professionals and ancillary providers does not indicate or imply coverage. Coverage is determined in accordance with the Customer's benefit plan.
- Certain services require Prior Authorization which will lead to a medical necessity review. You do not need to know if a service requires Prior Authorization (PA). In these cases, when you submit Advance Notification, we will request clinical information, perform a coverage review based on medical necessity, and make a coverage determination. Regardless of whether Prior Authorization is required, the list of services and the process for submitting Advance Notification is the same.
- 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 Guide. Medicare Advantage and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in our network for these products. This product list is provided for your convenience and is subject to change over time.
- If a Customer presents a health care 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 or Prior Authorization requirements)*	
<ul style="list-style-type: none"> • Benefit plans for which the Customer (rather than the physician) is required to provide Advance 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 3) 	<ul style="list-style-type: none"> • UnitedHealthcare West or UHC West • Sierra • UnitedHealthcare 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.
<p>* The Advance Notification Requirements below will not apply to the listed benefit plans. However, these benefit plans may have separate Advance Notification and Prior Authorization Requirements.</p> <p>Please refer to the applicable Additional Manual table of this Guide for additional details. Please see the supplements to this guide for the plans listed above.</p>	

Florida AARP Medicare Complete® Plan 1 HMO and AARP Medicare Complete® Plus HMOPOS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012, refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization Protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMOPOS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare

A list of the most current procedure codes associated with the services defined below can be found at UnitedHealthcareOnline.com → Clinician Resources → Care Management → Advance & Admission Notification

Advance Notification List

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Bariatric Surgery	<ul style="list-style-type: none"> • Commercial • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Erickson Advantage 	<p>Bariatric Surgery and specific obesity-related whether scheduled as inpatient or outpatient.</p> <p>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.</p> <p>For Medicare Advantage Customers coverage must follow Medicare coverage guidelines. For additional information, consult the CMS Coverage Database.</p>
Behavioral Health Services	<ul style="list-style-type: none"> • Commercial • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Erickson Advantage 	<p>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.</p>

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Bone Growth Stimulator	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Use of either electronic stimulation or ultrasound to heal fractures
BRCA Genetic Testing Program	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>BRCA 1 and BRCA 2 (Breast Cancer Susceptibility) are genetic tests performing DNA sequencing to look for known gene mutations that are associated with the development of breast and ovarian cancer.</p> <p>BRCA testing requires an Advance Notification prior to performing the DNA sequencing. The ordering provider provides notice to the laboratory which would conduct the test, and the laboratory in turn provides notice to UnitedHealthcare.</p> <p>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 Advance Notification for BRCA testing from the lab, Customers will receive a letter outlining the available genetic counseling service and how to access that service.</p> <p>As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans.</p> <p>Please note: For Medicare Advantage Customers, coverage for genetic testing is based on Medicare coverage guidelines. For additional information, consult the CMS Coverage Database.</p> <p>For services listed in this section, fax to (866) 756-9733.</p>
Breast Reconstruction (Non Mastectomy)	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Reconstruction of the breast other than following mastectomy.
Capsule Endoscopy	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	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	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Erickson Advantage • Medicare Advantage 	<p>Manipulative treatment, also known as mobilization therapy or “adjustment,” refers to manual therapy employed to soft or osseous tissues for therapeutic purposes.</p> <p>Many of our benefit plans only provide coverage for chiropractic services through a designated chiropractic network 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.</p>
Clinical Trial	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	A rigorously controlled study of a new drug or a new medical device or other treatment on eligible human subjects, subject to oversight by an external Institutional Review Board (IRB) of the facility performing the clinical trial.
Cochlear Implants and Other Auditory Implants	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	A medical device (including a portion that is surgically implanted) within the inner ear and an external portion to help persons with profound sensorineural deafness to achieve conversational speech.
Congenital Heart Disease	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>Congenital Heart Disease-related services.</p> <p>For services listed in this section, call OptumHealth directly at (888) 936-7246 or the number on the back of the health care ID card.</p> <p>ICD-9-CM (or its successor): 745.0 through 747.81</p> <p>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.</p>

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Cosmetic & Reconstructive	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>Cosmetic procedures that change or improve physical appearance, without significantly improving or restoring physiological function.</p> <p>Reconstructive procedures that either treat a medical condition or improve or restore physiologic function.</p> <p>We require Advance Notification for such services whether scheduled as inpatient or outpatient.</p>
Durable Medical Equipment (DME) – greater than \$1,000	<ul style="list-style-type: none"> • Commercial • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Erickson Advantage 	<p>DME with a retail purchase cost or a cumulative rental cost over \$1,000.00</p> <p>Prosthetics are not DME (see separate <i>Prosthetics and Orthotics notification requirement</i> in this grid) for Medicare Advantage Customers.</p> <p>Some Home Health Care services may qualify under the DME requirement but are not subject to the \$1000 retail purchase or cumulative retail rental cost threshold (see separate Home Health Care Services requirement in this grid).</p> <p>Some payer groups may have different DME Advance Notification requirements imposed upon Customers through their benefit plans.</p> <p>For Medicare Advantage, Power Mobility Devices/Accessories, Lymphedema Pumps and Pneumatic Compressors require notification or prior authorization regardless of the cost.</p>
End Stage Renal Disease/ Dialysis Services	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>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 Advance Notification.</p> <p>No Advance Notification is required for end stage renal disease when a Medicare Customer travels outside of the service area.</p> <p>CPT:</p> <p>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</p> <p>Revenue Codes:</p> <p>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</p> <p>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.</p> <p>Note that your agreement with us may include restrictions on referring Customers outside the UnitedHealthcare network.</p>
Home Health Care Services	<ul style="list-style-type: none"> • Medicare Advantage 	<ul style="list-style-type: none"> • Commercial 	<p>All services which are based in the home including, but not limited to:</p> <ul style="list-style-type: none"> • Enteral Formula/Pumps • Home Infusion Therapy • Home Health Aid (HHA) • Occupational Therapy (OT) • Physical Therapy (PT) • Private Duty Nursing (T1 000) – Non covered under most plans • Respiratory Therapy (RT) • Skilled Nursing (SNV) • Social Worker (MSW) • Speech Therapy (ST) <p>For Commercial, see the Home Health Care- Nutritional, Private Duty Nursing, Skilled Nursing section on this grid.</p>

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Home Health Care – Nutritional, Private Duty Nursing, Skilled Nursing	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>The following services based in the home:</p> <ul style="list-style-type: none"> • Enteral Formula/Pumps • Skilled Nursing in the home • Private Duty Nursing <p>For Medicare Advantage, see <i>Home Health Care Services</i> section in this grid.</p>
Hyperbaric Oxygen Treatment (Outpatient)	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>Non-emergent hyperbaric oxygen treatments.</p>
Intensity Modulated Radiation Therapy (IMRT)	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>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.</p>
Infertility	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>Diagnostic and treatment services related to inability to achieve pregnancy.</p>
Injectable Medication	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>A drug capable of being injected intravenously, through an intravenous infusion, subcutaneously or intra-muscularly.</p> <p>Excludes chemo therapy drugs.</p> <p>For Medicare Advantage, see the <i>Part B Specialty Drug Prior Authorization Program</i> section of this Guide.</p>
Joint Replacement	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>Outpatient and inpatient joint replacement procedures in addition to total hip and knee.</p>
MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroid	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>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:</p> <ul style="list-style-type: none"> • The physician and/or facility must confirm coverage of the service for the Customer. • The hospital and/or facility must be contracted with 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 and Guides - Medical & Drug Policies and coverage Determination Guidelines. • The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare. <p>The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.</p> <p>For Medicare Advantage: MRgFUS is not a covered benefit</p>
Muscle Flap Procedure	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>A muscle or portion of muscle that can be transferred with its blood supply to another part of the body for reconstructive purposes.</p>
Non Emergency Transport – Other	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No applicable exclusions 	<p>Non-urgent ambulance transportation (by air, land, other) between specified locations.</p> <p>For Medicare Advantage Customers:</p> <p>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.</p>

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Orthognathic Surgery	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No applicable exclusions 	Treatment of maxillofacial (jaw) functional impairment.
Orthotics – greater than \$1,000	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No applicable exclusions 	Orthotics with a retail purchase cost or a cumulative rental cost over \$1000.
Out-of-Network Services	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No applicable exclusions 	<p>A recommendation from a network physician, or health care provider to a hospital, physician, or other health care provider who is not contracted with us.</p> <p>Please note that your agreement with UnitedHealthcare may include restrictions on directing Customers outside the UnitedHealthcare network. Customers who use non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses or no coverage.</p> <p>For Commercial Customers:</p> <p>Advance 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.</p> <p>For Medicare Advantage Customers:</p> <p>Advance Notification is required for Medicare Advantage members when:</p> <ol style="list-style-type: none"> 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. <p>Advance 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.</p> <p>Advance Notification is not required for Medicare Advantage National PPO Customers, regardless of whether an in-network provider is available.</p>
Part B Occupational Therapy (OT), Speech Therapy (ST) or Physical Therapy (PT) provided in a SNF	<ul style="list-style-type: none"> • Erickson Advantage Customers residing in a long-term care facility. 	<ul style="list-style-type: none"> • Commercial • Medicare Advantage (other than Erickson Advantage) 	
Physical Therapy/ Occupational Therapy (PT/ OT)	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>For Commercial:</p> <ul style="list-style-type: none"> • Required when services are performed at an outpatient clinic contracted with OptumHealth Physical Health. Since the Customer's benefit plan may require a pre-service coverage review, please call number on the Customer's health care ID card to fulfill the requirement. • NOT required when services are performed at an in network Hospital. • NOT required for in network outpatient clinics not contracted with OptumHealth Physical Health. <p>For Medicare Advantage, Advance Notification is only required when services are performed in the home. Also see the <i>Home Health Care Services</i> section of this grid.</p>
Potentially Unproven Services	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Prosthetics – greater than \$1,000	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Prosthetics with a retail purchase cost or a cumulative rental cost over \$1000.
Proton Beam Therapy	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Focused radiation therapy that uses beams of protons (tiny particles with a positive charge).
Septoplasty/Rhinoplasty	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Treatment of nasal functional impairment and septal deviation.
Sleep Apnea Procedures & Surgeries	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea.</p> <p>Applies to inpatient or outpatient, including but not limited to: Palatopharyngoplasty - oral pharyngeal reconstructive surgery includes laser-assisted uvulopalatoplasty (laup).</p> <p>Not applicable to diagnostic procedures related to sleep studies. For sleep studies, see the <i>Sleep Studies</i> section of this grid.</p>
Sleep Studies	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>Sleep laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders.</p> <p>Excludes sleep studies performed in the home. Not applicable to sleep apnea procedures and surgeries. For those services, see the <i>Sleep Apnea Procedures and Surgeries</i> section of this grid.</p>
Specific Medications as Indicated on the Prescription Drug List (PDL)	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>Effective January 1st, 2013, some groups will have prescriptions managed through OptumRx. Please refer to the Customer's health care ID card for the Customer service number, or the Commercial Pharmacy Benefit Manager Transition in 2013 section of this Guide for information on OptumRx.</p> <p>Call (877) 842-1435 when prescribing medications that require Advance Notification. These medications are so designated on the PDL.</p> <p>To view the Prescription Drug List PDL, visit UnitedHealthcareOnline.com → Notifications/Prior Authorizations → OptumRx Prior Authorization Submission & Status → Login.</p>
Speech Therapy Services	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>For Commercial:</p> <ul style="list-style-type: none"> • Required when services are performed at an outpatient clinic contracted with OptumHealth Physical Health. Since the Customer's benefit plan may require a pre-service coverage review, please call number on the Customer's health care ID card to fulfill the requirement. • NOT required when services are performed at an in network Hospital. • NOT required for in network outpatient clinics not contracted with OptumHealth Physical Health. <p>For Medicare Advantage: Advance Notification is only required when services are performed in the home. Also see the <i>Home Health Care Services</i> section of this grid.</p>
Spinal Stimulator for Pain Management	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Spinal cord stimulators when implanted for pain management.
Spinal Surgery	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Inpatient and outpatient spinal surgeries.
Transplant of tissue or organs	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	<p>For transplant services, call OptumHealth directly at (888) 936-7246 or the notification number on the back of the health care ID card.</p> <p>Request for transplant or transplant-related services prior to pre-treatment or evaluation.</p>
Vagus Nerve Stimulation	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Implantation of a device that sends electrical impulses into one of the cranial nerves.

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
Vein Procedures	<ul style="list-style-type: none"> • Commercial • Medicare Advantage 	<ul style="list-style-type: none"> • No Applicable Exclusions 	Removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins of the extremities.
Ventricular Assist Devices	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow.</p> <p>Call OptumHealth directly at (888) 936-7246 or the notification number on the back of the health care ID card.</p>

Other Advance Notification & Prior Authorization Programs

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
<p>Cardiology Notification Program</p> <p>(See additional information in the Cardiology Notification Protocol section of this Guide)</p>	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>Advance Notification is required for participating physicians for inpatient, outpatient, and office-based diagnostic catheterizations and electrophysiology implants prior to performance.</p> <p>Physician-to-physician review may be required, based on the Cardiology Notification Program Clinical Criteria, to help support physicians in their decision-making process.</p> <p>Rendering provider must obtain the required Notification number by contacting UnitedHealthcare through any of the following:</p> <ol style="list-style-type: none"> 1. Online: Via UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status 2. Phone: (866) 889-8054 <p>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.</p>
<p>Cardiology Prior Authorization Program</p> <p>(See additional information in the Cardiology Prior Authorization Protocol section of this Guide)</p>	<ul style="list-style-type: none"> • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Commercial Erickson Advantage 	<p>Prior Authorization required for participating physicians for inpatient, outpatient, and office-based and electrophysiology implants prior to performance.</p> <p>Prior Authorization required for participating physicians for outpatient and office-based diagnostic catheterizations, echocardiograms, and stress echos prior to performance.</p> <p>Prior Authorization may be submitted by the rendering physician in 1 of 2 ways:</p> <ol style="list-style-type: none"> 1. Online: Via UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization – Submission & Status 2. Phone: (866) 889-8054 <p>For additional details, including a list of the CPT codes for which Prior Authorization is required, please visit UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Medicare Advantage Cardiology Prior Authorization Program.</p>
<p>Radiology Notification</p> <p>(See additional information in the Outpatient Radiology Notification Protocol section of this Guide)</p>	<ul style="list-style-type: none"> • Commercial 	<ul style="list-style-type: none"> • Medicare Advantage 	<p>For Commercial benefit plans, we require Advance Notification for certain CT, MRI, MRA, PET scan, Nuclear Medicine, and Nuclear Cardiology procedures. The advanced imaging procedures for which Advanced Notification is required are referred to as “Advanced Outpatient Imaging Procedures.”</p> <p>The physician/health care professional ordering an Advanced Outpatient Imaging Procedure is responsible for obtaining a Notification number prior to scheduling the procedure.</p> <p>Ordering physicians/health care professionals must obtain the required Notification number by contacting UnitedHealthcare through any of the following:</p> <ol style="list-style-type: none"> 1. Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status 2. Phone: (866) 889- 8054 <p>Additional details regarding this Notification requirement, including a list of the CPT codes for which Notification is required are available online at: UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification → Notification Resources: Reference Materials.</p>

Procedures & services	Plan inclusions	Plan exclusions & exceptions	Explanation
<p>Radiology Prior Authorization</p> <p>(See additional information in the Radiology Prior Authorization Protocol section of this Guide)</p>	<ul style="list-style-type: none"> • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Commercial • Erickson Advantage 	<p>For Medicare Advantage benefit plans, we require Prior Authorization for certain CT, MRI, MRA, PET scan, Nuclear Medicine and Nuclear Cardiology procedures. The advanced imaging procedures for which Prior Authorization is required are referred to as “Advanced Outpatient Imaging Procedures.”</p> <p>The physician/health care professional ordering an Advanced Outpatient Imaging Procedure is responsible for obtaining a Prior Authorization number prior to scheduling the procedure.</p> <p>Ordering physicians/health care professionals must obtain the required Prior Authorization number by contacting UnitedHealthcare through any of the following:</p> <ol style="list-style-type: none"> 1. Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization – Submission & Status. 2. Phone: (866) 889-8054 <p>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</p>
<p>Part B Specialty Drug Prior Authorization</p> <p>(See additional information in the Part B Specialty Drug Prior Authorization Program section of this Guide)</p>	<ul style="list-style-type: none"> • Medicare Advantage (except Erickson Advantage) 	<ul style="list-style-type: none"> • Commercial • Erickson Advantage 	<p>For Medicare Advantage benefit plans, we require Prior Authorization for the medical use of certain specialty drugs. A complete list of the specialty drugs requiring Prior Authorization is available online at:</p> <p>UnitedHealthcareOnline.com → Clinician Resources → Specialty Drugs</p> <p>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.</p> <p>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.</p> <p>Ordering Providers must obtain authorization.</p> <p>Servicing Providers must confirm that an approved authorization is on file.</p> <p>Ordering physicians/health care professionals must obtain the required authorization number by contacting UnitedHealthcare through any of the following:</p> <ol style="list-style-type: none"> 1. Online: UnitedHealthcareOnline.com - Notifications/Prior Authorizations - Specialty Drug Prior Authorization Submission & Status (Medicare Part B) 2. Phone: (866) 889-8054 <p>Additional details regarding this Prior Authorization requirement are available online at: UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug</p>

Voluntary Notification for Case and Disease Management Enrollment

Voluntary Notification is requested from physicians other healthcare professionals and ancillary providers for the purpose 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 service 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
Healthy Pregnancy	Commercial	Medicare Advantage	<p>Upon confirmation of pregnancy, notification is requested from physicians or other health care professionals who provide obstetrical care to a pregnant Customer for:</p> <ul style="list-style-type: none"> • ICD-9-CM (or its successor) • V72.42 or any other diagnosis code related to pregnancy <p>Notification provides OptumHealth with an opportunity to enroll pregnant members in the Healthy Pregnancy Program prior to the delivery of the baby.</p> <p>Notification is needed 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.</p>

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 identified below) 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 cases where it is determined that the service will not be covered, the Customer can then 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 agreement with us, 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 or Prior Authorization request AND that coverage review ultimately determines the service to have been a covered service under the Customer's benefit plan, 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)*	
<ul style="list-style-type: none"> • Benefit plans for which the Customer (rather than the physician) is required to provide notification, such as UnitedHealthcare Options PPO and UnitedHealthcare Indemnity • AMSLIC, PLHIC or All Savers • MDIPA, OCI, or OneNet • NHP • Oxford • Benefit plans subject to the River Valley Entities Supplement (as further described on page 3) • Sierra 	<ul style="list-style-type: none"> • UnitedHealthcare West or UHC West • Erickson Advantage • UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (please refer to the Additional Manual table). Some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide including these Admission Notification requirements. • Other benefit plans, such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage.
<p>* 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 table of this Guide for additional details.</p>	

Florida AARP Medicare Complete® Plan 1 HMO and AARP Medicare Complete® Plus HMOPOS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012, refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization Protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMOPOS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at [UnitedHealthcareOnline.com](#) → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.*

* For state specific variations, please refer to [UnitedHealthcareOnline.com](#) → Tools and Resources → Policies, Protocols, and Guides → Advance and Admission Notification

- 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 (notice required within 24 hours of the mother's discharge)
- Unless otherwise indicated, 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.
- 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.
- Receipt of an Admission Notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's participation agreement with UnitedHealthcare.
- Admission Notifications must contain the following details regarding the admission:
 - › Customer name and Customer health care 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.

State-Specific Variations from the Standard Notification Requirements

For Maryland Facilities:

If prior authorization or Advance Notification is required for the requested elective inpatient procedure, it is the physician's responsibility to obtain the relevant approval. It is the responsibility of the facility to notify UnitedHealthcare within 24 hours (or the following business day if the admission occurs on a weekend or holiday) of the elective admission. If the physician has obtained prior authorization or Advance Notification, the initial day of the inpatient admission will be paid unless:

1. The information submitted to UnitedHealthcare regarding the service to be delivered to the Customer was fraudulent or intentionally misrepresentative;
2. Critical information requested by UnitedHealthcare regarding the service to be delivered to the Customer was omitted such that UnitedHealthcare's determination would have been different had it known the critical information;
3. A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or
4. On the date the service was authorized or approved service issued through Advance Notification was delivered the Customer was not covered by UnitedHealthcare and the provider could have verified the Customer eligibility status by utilizing UnitedHealthcare's automated eligibility verification system (VETTS) or by accessing UnitedHealthcareOnline.com 24 hours a day, 7 days a week. Note that the online verification must indicate that the Customer is not covered by UnitedHealthcare.

If Advance Notification is obtained and Admission Notification is not made by the facility in a timely manner, payment reductions will be limited to hospital room and board charges when applicable.

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)

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).

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.

3. Reimbursement reductions will not be imposed for maternity admissions.

- 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.

Cardiology Notification Protocol for Covered Services to Commercial Customers

The UnitedHealthcare Cardiology Notification protocol for Commercial Customers does 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* table of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following Cardiology Notification requirements)
<ul style="list-style-type: none"> • UnitedHealthcare Options PPO • UnitedHealthcare Indemnity
<p>The following benefit plans:</p> <ul style="list-style-type: none"> • UnitedHealthOne or All Savers • MDIPA, OCI, or OneNet • NHP • Oxford • Benefit plans subject to the River Valley Entities Supplement (as further described on Page 3) • Sierra • UnitedHealthcare West or UHC West
Other Excluded Plans
<p>The UnitedHealthcare Cardiology Notification protocol does not apply to non-Commercial benefit plans such as Medicare Advantage Medicaid, CHIP and Uninsured.</p>

Except as noted above, the Cardiology Notification protocol requirements described below apply to all participating physicians (“Providers”) who perform diagnostic catheterizations and electrophysiology implant procedures on UnitedHealthcare Customers. Even Providers 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, Prior Authorization or medical necessity determination unless applicable state law dictates otherwise. Notification under this protocol is required for services rendered in all settings (e.g., outpatient, inpatient and office-based).
- 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. 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 Provider’s participation agreement with us.
- The procedures subject to this Notification requirement include:
 - › Diagnostic catheterization procedures including, for example, coronary arteriogram, left heart catheterizations, and combined left-right heart catheterizations.
 - › Electrophysiology implants including, for example, pacemaker and automated implantable cardio defibrillators.

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.

State roll-out schedule

As of the date of publication of this Guide, the Cardiology Notification protocol has been implemented in 35 states and the District of Columbia. To see the states in which the protocol applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification Program for the latest information. If additional states are added, you will receive notification if you participate in that state.

Process for Provider

To receive payment for services rendered, prior to performing the stated diagnostic catheterization or electrophysiology implant procedure, the rendering Provider must:

- Contact us and follow the notification process:
 - › Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification Submission and Status.
 - › Phone: (866) 889-8054

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

Customer's information

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

Provider information

- Provider name, TIN, specialty, address, and phone number
- The contact person at the Provider'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 Provider believes will help in evaluating the request including, but not limited to, prior diagnostic tests, consultation reports, etc.
- If the requested procedure is consistent with evidence-based clinical guidelines, a Notification number will be issued to the ordering Provider.

OR

- If the procedure requested for the Customer is not consistent with the Cardiology Notification protocol Clinical Criteria or if further information is needed to assess the request, we will inform you that the Provider (or his or her designee such as a covering provider, provider'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 Provider (or their Provider designee) will confirm the procedure ordered and a Notification number will be issued. The rendering Provider maintains final decision authority for the performance of the procedure.

The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on evidence-based clinical guidelines. This discussion is not a Prior Authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

- Please note that Notification is required from the rendering Physician. However, Notification will be accepted on behalf of the rendering Provider from either the Provider's office staff or the facility if the staff or facility has relevant clinical information to complete the Notification process.

Note: The receipt of a Notification number does not guarantee or authorize payment, but simply confirms that Notification was made. Medical coverage and payment authorization is a separate process determined by the Customer's benefit plan and the Provider's participation agreement with UnitedHealthcare. Services required on an emergent basis should be performed without waiting for the Notification process, and Notification should be given retrospectively, as further described below in the *Retrospective Notification process* section.

Urgent requests during regular business hours

The Provider may request a Notification number on an "urgent" basis if the Provider determines it to be medically required. Urgent requests should be requested via telephone by calling (866) 889-8054. The 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 after our receipt of all required information.

The Notification number is valid for 45 days. When a Notification number is entered for a cardiac procedure, UnitedHealthcare will use the date the Notification was issued as the starting point for the 45-day period in which the cardiac procedure must be rendered. If the procedure is not rendered within 45 days, a new Notification number must be obtained.

Urgent requests outside of regular business hours

If the 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 UnitedHealthcare will issue a Notification number retrospectively following the Retrospective Notification Process described below.

Retrospective Notification process

- A Provider 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 pneumonia, and a cardiac consult indicates that a diagnostic catheterization or electrophysiology implant is required, the Provider 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 an explanation of the circumstances under which the service was provided during an inpatient admission.
- Rendering Providers must follow the same online or phone 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 or urgent request outside of UnitedHealthcare's normal business hours.

Note: Please be aware that there may be changes to this protocol in 2013. If the protocol applies to additional states or we make any other changes to the protocol, we will communicate that information to impacted Providers. As in the past, all up-to-date information regarding the Cardiology protocols can be found at UnitedHealthcareOnline.com → Clinician Resources → Cardiology.

Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers

The UnitedHealthcare Medicare Advantage Cardiology Prior Authorization protocol does 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 2-6 of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following Cardiology Prior Authorization requirements)

- Florida: AARP Medicare Complete Plan 1, HMO and AARP Medicare Complete Plus, HMO-POS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012.
Refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMO-POS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.
- New York: AARP Medicare Complete Plan 1 - Group 66074, AARP Medicare Complete Plan 2 - Group 13012, AARP Medicare Complete Essential - Group 66075, AARP Medicare Complete Mosaic - Group 66076. Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- UnitedHealthcare 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 Prior Authorization protocol.
- 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 Cardiology Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured, that are not Medicare Advantage

Prior Authorization for diagnostic catheterizations, echocardiograms and stress echos is required for outpatient and office-based services only. Prior Authorization for electrophysiology implants is required for outpatient, office-based and inpatient services. Cardiac procedures rendered in and appropriately billed with any of the following places of service do not require Prior Authorization: emergency room, urgent care center or inpatient setting (except for electrophysiology implants).

Compliance with this protocol is required.

Failure to complete the Medicare Advantage Cardiology Prior Authorization process 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 provider will receive a denial notice with the appeal process outlined. Providers who render cardiac procedures within the scope of the protocol must confirm that Prior Authorization has been obtained, or payment for their services may be denied.

To see the states in which this protocol applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Medicare Advantage Cardiology Prior Authorization protocol. If additional states are added to the protocol, we will communicate that information to impacted providers.

Process for Provider:

Ordering Provider:

The provider ordering the cardiac procedure is responsible for obtaining a Prior Authorization number prior to any rendering of the cardiac procedure. A provider may obtain the required Prior Authorization number by contacting us via:

- Online: [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com/notifications/prior-authorization) → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status, 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 Provider information

- Ordering provider's TIN
- Ordering provider's last name
- Ordering provider's phone number
- Ordering provider's fax number
- Ordering provider's email address
- Contact person at the ordering 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 provider believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.

Rendering Provider information (if different)

- Rendering provider's last name, first name
- Rendering provider's address
- Rendering provider's phone number
- Rendering provider's fax number

A Prior Authorization number will be issued to the ordering provider when the Prior Authorization process is completed. The Prior Authorization number will be communicated by fax and phone or online. If the rendering provider is different from the ordering provider, to help ensure proper payment is made, the Prior Authorization number should be obtained and communicated by the ordering provider to the rendering provider scheduled to render the cardiac procedure.

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 provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare.

Urgent requests during regular business hours

The ordering provider may request a Prior Authorization number on an “urgent” basis if the 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 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 after our receipt of all required information.

Urgent requests outside of regular business hours

If the provider determines that care is medically required on an urgent basis, and Prior Authorization cannot be requested 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 cardiac procedure is required on an urgent basis or Prior Authorization cannot be requested because it is outside of our normal business hours, the service may be performed and Prior Authorization requested retrospectively.

- Retrospective Prior Authorization requests must be made within 2 business days after rendering the cardiac procedure.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why Prior Authorization could not be requested during UnitedHealthcare’s normal business hours.
- The ordering Provider should follow the same Prior Authorization process outlined above for a standard request.

Rendering Provider (if different)

To receive payment for services rendered, prior to rendering the cardiac procedure, the rendering Provider must validate with UnitedHealthcare that an approved Prior Authorization number is on file by contacting UnitedHealthcare via:

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

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

If the rendering Provider determines there is no Prior Authorization number on file, and the ordering Provider does not participate in UnitedHealthcare’s network and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process. If the rendering Provider does not obtain a Prior Authorization number for the cardiac procedure ordered by a non-participating Provider, the rendering 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 Providers can 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.

Cardiology Crosswalk Table

Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, Physicians/Providers are not required to contact the Medicare Advantage Cardiology Prior Authorization protocol to modify the existing Prior Authorization record. A complete listing of applicable CPT code combinations is available at UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Medicare Advantage Cardiology Prior Authorization protocol.

However, for code combinations not listed on the CPT Code Crosswalk Table, Physicians/Providers must follow the Cardiology Prior Authorization protocol process set forth above for additional procedures.

Outpatient Radiology Notification Protocol for covered services to Commercial Customers

The UnitedHealthcare Outpatient Radiology Notification protocol for Commercial Customers 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* table of this Guide for additional details.

Excluded Plans (benefit plans not subject to the following Outpatient Radiology Notification requirements)

Excluded Plans (benefit plans not subject to the following Outpatient Radiology Notification requirements)
<ul style="list-style-type: none">• UnitedHealthcare Options PPO• UnitedHealthcare Indemnity
<p>The following benefit plans:</p> <ul style="list-style-type: none">• 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 3)• Sierra• UnitedHealthcare West or UHC West• Benefit plans sponsored or issued by certain self-funded employer groups
Other Excluded Plans
The UnitedHealthcare Radiology Notification protocol does not apply to non-Commercial benefit plans such as Medicare Advantage, Medicaid, CHIP and Uninsured.

The Outpatient Radiology Notification protocol requirements apply to all participating physicians, health care professionals, facilities and ancillary providers (“Providers”) that order or render any of the following advanced imaging procedures: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology. Please note that only certain of these advanced imaging procedures require Notification. The advanced imaging procedures for which Notification is required are referred to herein as “Advanced Outpatient Imaging Procedures.”

This protocol is a prior notification requirement, not a precertification, prior authorization, or medical necessity determination unless applicable state law dictates otherwise. 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; observation unit; urgent care; or inpatient stay.

Compliance with this protocol is required and will be monitored 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 for Advanced Outpatient Imaging, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification. Please be aware that there may be changes to this protocol in 2013. If the protocol applies to additional states or we make any other changes to the protocol, we will communicate that information to impacted Providers.

Ordering Provider

- The Provider ordering the imaging service is responsible for obtaining a notification number prior to scheduling any Advanced Outpatient Imaging Procedures. The process required by this protocol for ordering Providers is as follows:
- Obtain the required notification number by contacting us:
 - › Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status
 - › 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 health care 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)

Provider information

- › Ordering Provider's name, TIN/NPI, specialty, address, and phone number
- › Provider to whom the Customer is being referred, if specified, address and phone number
- › Rendering 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 Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical 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 Provider.

OR

- If the requested imaging study is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will inform you that the ordering 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 Provider will confirm the procedure ordered and a Notification number will be issued.

The ordering 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 evidence-based clinical guidelines. This discussion is not a Prior Authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

The Notification number will be issued to the ordering Provider when the Notification process is completed. The Notification number will be communicated by fax, phone, or online, consistent with how the request was initiated. To help promote proper payment, the Notification number must be communicated by the ordering Provider to the rendering 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 plan and your agreement with us.

Urgent requests during regular business hours

The ordering Provider may request a Notification number on an urgent basis if the 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 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 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 process

- 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 Providers must follow the same Notification process outlined above for a standard request.

Rendering Provider

To be eligible to receive payment for covered services rendered, the rendering 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 Provider determines there is no Notification number on file, and the ordering Provider participates in UnitedHealthcare's network, we will use reasonable efforts to work with the rendering Provider to obtain the Notification number from the participating ordering Provider prior to the rendering of services.

If the rendering Provider determines there is no Notification number on file, and the ordering Provider does not participate in UnitedHealthcare's network, and is unwilling to complete the Notification process, the rendering Provider is required to complete the Notification process. If the rendering Provider does not provide Notification for services ordered by a non-participating Provider, the rendering 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.

Note: Non-participating Providers can provide Notification either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054.

Provision of additional Advanced Outpatient Imaging Procedures

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering 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 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 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 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.

Outpatient Radiology Prior Authorization Protocol – for Covered Services to Medicare Advantage Customers

The UnitedHealthcare Medicare Advantage Radiology Prior Authorization protocol 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* table 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 and AARP Medicare Complete Plus, HMO-POS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012.
Refer to the “UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMO-POS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only” posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.
- New York: AARP Medicare Complete Plan 1 - Group 66074, AARP Medicare Complete Plan 2 - Group 13012, AARP Medicare Complete Essential - Group 66075, AARP Medicare Complete Mosaic - Group 66076. Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- UnitedHealthcare 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 protocol.
- 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 protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured, that are not Medicare Advantage.

The Medicare Advantage Radiology Prior Authorization protocol requirements apply to all participating physicians, health care professionals, facilities and ancillary providers (Providers”) that order or render any of the following advanced imaging procedures Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology.

Please note that only certain of these advanced imaging procedures require Prior Authorization. For a complete list of CPT Codes for advanced imaging procedures that require Prior Authorization, please visit UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization protocol. The advanced imaging procedures for which Prior Authorization is required are referred to herein as “Advanced Outpatient Imaging Procedures.”

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

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

Compliance with this protocol is required.

Failure to complete the Radiology Prior Authorization process will result in an administrative claim denial. Claims denied for failure to complete Prior Authorization may not be billed to the Customer. If we receive a Prior Authorization request and determine that the services do not meet clinical coverage criteria, the claim will be denied for lack of medical necessity; 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 Provider will receive a denial notice with the appeal process outlined. Providers that render Advanced Outpatient Imaging Procedures must confirm that Prior Authorization has been

obtained through the process described below under the “Rendering Provider” section, or payment for their services may be denied (for both technical and professional components).

To see the states in which this protocol applies and obtain the latest information on this protocol, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization protocol. If additional states are added to the protocol, we will communicate that information to impacted Providers.

Ordering Provider:

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

- Online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status, or
- By calling 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 Provider information

- Ordering Provider’s TIN and NPI
- Ordering Provider’s last name
- Ordering Provider’s phone number
- Ordering Provider’s fax number
- Ordering Provider’s email address
- Contact person at the ordering 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 Provider 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 Provider information

- Rendering Provider’s last name, first name
- Rendering Provider’s address
- Rendering Provider’s phone number
- Rendering Provider’s fax number

The Prior Authorization number will be issued to the ordering Provider when the Prior Authorization process is completed. The Prior Authorization number will be communicated by fax, phone or online, consistent with how the request was initiated. To help ensure proper payment, the Prior Authorization number should be obtained and communicated by the ordering Provider to the rendering Provider scheduled to perform the Advanced Outpatient Imaging Procedure. Please note that receipt of a Prior 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 coverage on the date of service, the provider being eligible for payment, any claim processing requirements, and the Provider's participation agreement with us.

The Prior Authorization number is valid for 45-days. When a Prior Authorization number is entered for a Advanced Outpatient Imaging Procedure, UnitedHealthcare will use the date the Prior Authorization was issued as the starting point for the 45-day period in which the Advanced Outpatient Imaging Procedure must be rendered. If the procedure is not rendered within 45-days, a new Prior Authorization number must be obtained.

Urgent requests during regular business hours

The ordering Provider may request a Prior Authorization number on an "urgent" basis if the Provider determines rendering the services urgently is 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 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 receipt of all required information.

If the Provider determines an Advanced Outpatient Imaging Procedure must be rendered before a Prior Authorization number can be issued on an urgent basis, the procedure 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 Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and Prior Authorization cannot be rendered because it is outside of UnitedHealthcare's normal business hours, the service may be performed and a Prior Authorization number must be requested 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 requested because it is outside of our normal business hours, the service may be performed and Prior Authorization requested retrospectively.

- Retrospective Prior 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 requested during UnitedHealthcare's normal business hours. The ordering Provider must follow the same Prior Authorization process outlined above for a standard request.

Rendering Provider

To receive payment for services rendered, prior to performing an Advanced Outpatient Imaging Procedures, the rendering Provider must validate with UnitedHealthcare that an approved Prior Authorization number is on file by contacting UnitedHealthcare as follows:

- 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 Provider participates in UnitedHealthcare's network, we will use reasonable efforts to work with the rendering Provider to request that the participating ordering Provider obtain Prior Authorization prior to the rendering of services.

If there is no Prior Authorization number on file and the ordering Provider does not participate in UnitedHealthcare's network and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process. If the rendering Provider does not obtain a Prior Authorization number for services ordered by a non-participating provider, the rendering 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 Providers can 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 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 already been obtained, a new Prior Authorization 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 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, Provider 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 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 Provider must obtain a new Prior Authorization number. A test for a different, noncontiguous body part will be considered a new request.

Part B Specialty Drug Prior Authorization Program for Covered Services to Medicare Advantage Customers

The UnitedHealthcare Medicare Advantage Part B Specialty Drug Prior Authorization Program will not apply to the following benefit plans. However, these benefit plans may have separate specialty drug Notification/Prior Authorization requirements. Please refer to the applicable *Additional Manual* table 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 and AARP Medicare Complete Plus, HMO-POS Gatekeeper benefit plans Group 26000, Group 26016, Group 26018, Group 26019, Group 26020 and Group 26021 and UnitedHealthcare Group Medicare Advantage (HMO) plan group 54011 and group 54012.

Refer to the "UnitedHealthcare Medicare Advantage Gatekeeper Plans Referral/Authorization Protocol for Physicians, Facilities, Ancillaries and Other Health Care Professionals, HMO and HMO-POS Medicare Advantage Gatekeeper Plans in Broward, Miami-Dade and Palm Beach Counties Only" posted at UnitedHealthcareOnline.com → Tools and Resources → Welcome Kit for New Physicians and Providers → Medicare → Florida Medicare.

- New York: AARP Medicare Complete Plan 1 - Group 66074, AARP Medicare Complete Plan 2 - Group 13012, AARP Medicare Complete Essential - Group 66075, AARP Medicare Complete Mosaic - Group 66076. Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- UnitedHealthcare 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 Part B 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 Part B Specialty Drug Prior Authorization requirements in this Program apply to all participating physicians, health care professionals, facilities and ancillary providers ("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 Drugs.

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 Prior Authorization: emergency room, urgent care center or during an inpatient stay.

Compliance with this Program is required.

Failure to complete the Part B Specialty Drug Prior Authorization Program will result in administrative denial. Claims denied for failure to complete Prior Authorization may not be billed to the Customer. If we receive a Prior Authorization request and determine that the services do not meet clinical coverage criteria, the claim will be denied 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 Provider will receive a denial notice with the appeal process outlined. Providers who 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 Drugs. If additional states are added to the program, we will communicate that information to impacted Providers.

Ordering Provider:

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

- Online: [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com/notifications/prior-authorizations/specialty-drug-prior-authorization-submission-status) → 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 Provider information

- Ordering Provider's TIN and NPI
- Ordering Provider's last name
- Ordering Provider's phone number
- Ordering Provider's fax number
- Ordering Provider's email address
- Contact person at the ordering 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 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 Provider information (if different)

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

A Prior Authorization number will be issued to the ordering 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 Provider is different from the ordering Provider, to help ensure proper payment, the Prior Authorization number should be obtained and communicated by the ordering Provider to the rendering Provider scheduled to render the specialty drug.

Please note that receipt of an authorization for Medicare Advantage 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 Provider being eligible for payment, any claim processing requirements, and the 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 Provider.

When a Prior Authorization number is approved for a specialty drug, the date 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 Provider may request a Prior Authorization number on an “urgent” basis if the 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 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 after our receipt of all required information.

Urgent requests outside of regular business hours

If the Provider determines that care is medically required on an urgent basis and Prior Authorization cannot be requested 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 requested 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 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 requested during UnitedHealthcare’s normal business hours.
- The ordering Provider must follow the same Prior Authorization process outlined above for a standard request.

Rendering/Provider (if different)

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

- Online: [UnitedHealthcareOnline.com](https://www.unitedhealthcare.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 Provider determines there is no Prior Authorization number on file, and the ordering Provider participates in UnitedHealthcare’s network, UnitedHealthcare will use reasonable efforts to work with the rendering Provider to request that the participating ordering Provider obtain Prior Authorization prior to the rendering of services.

If the rendering Provider determines there is no Prior Authorization number on file, and the ordering Provider does not participate in UnitedHealthcare’s network and is unwilling to complete the Prior Authorization process, the rendering

Provider is required to complete the Prior Authorization process. If the rendering Provider does not obtain a Prior Authorization number for a specialty drug ordered by a non-participating Provider, the rendering 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 Providers can 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, Providers are not required to contact the Part B 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 Drugs: Reference Materials.

However, for code combinations not listed on the CPT Code Crosswalk Table, Providers must follow the Part B 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

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
- UnitedHealthcare 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 a situation where a provider is planning to perform a non-emergent procedure in a non-participating ambulatory surgical center). The use of 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.
 - › Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent
 - › Home Healthcare Providers
 - › Laboratory Service Providers – for specimens collected in the physician's office and sent out to a non-participating laboratory for processing.
 - › Outpatient Dialysis Providers
 - › Specialty Drug Vendors

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 services from any of the nonparticipating provider types listed above, 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 and Guides → Protocols](https://www.unitedhealthcare.com/Tools-Resources/Policies-Protocols-and-Guides/Protocols).

Participating physicians and other healthcare professionals must keep the signed Member Advance Notice Form on file and provide it to us upon request. A separate Member Advance Notice Form is required for each service that involves one of the non-participating provider types listed above.

As previously noted, 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 from us to use a non-participating physician, facility or other healthcare provider. Lastly, this protocol does not apply when the participating provider involves non-participating provider types that are not listed above in a Customer's care. 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 Member Advance Notice Form at any time. Compliance with this protocol will be reviewed by UnitedHealthcare and failure to comply with the protocol, including failure to completely respond to our requests for copies of the signed Member Advance Notice Form, may result in appropriate action under your agreement with us, which may include, but is not limited to, ineligibility for performance based compensation or termination of your agreement.

Note: This protocol does not apply to Commercial Customers in the state of New York at this time and will not apply to these Customers until impacted providers are notified.

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](https://www.unitedhealthcare.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 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:

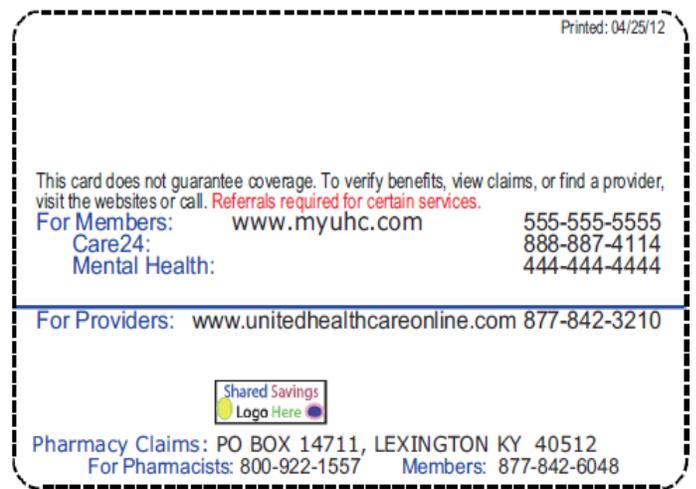
- Loss of eligibility for the Practice Rewards programs;
- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

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

Commercial Navigate®, Navigate Balanced® and Navigate Plus (Specialist Referral Requirements)

The Navigate portfolio of products includes a gatekeeper feature, and Prior Authorization by UnitedHealthcare for selected services as listed in the [Advance Notification](#) section in this Guide. Customers are required to select a primary physician.

The primary physician performs primary care services. In addition, the primary physician generates referrals to network specialists. The Navigate product name and Customer's primary physician are indicated on the Navigate Customer's health care ID card. Reference to referrals being required is on the back of the ID card.



Note: Sample health care ID cards (above) are for illustration only; information on ID cards may vary by payer, benefit plan design and/or other requirements.

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 who is not practicing under the same TIN as their primary physician. If Customers seek care from a network physician outside of their primary care physician's TIN without a referral, there is no benefit for that physician's services and related facility services, and the member is responsible for the billed amount (subject to the services that do not require a referral as listed in this section).
- **Navigate Balanced:** A 2-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 not practicing under 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 network benefits (subject to the services that do not require a referral as listed below).
- **Navigate Plus:** A 3-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 not practicing under 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 network benefits (subject to the services that do not require a referral as listed below). Non-network benefits are available for services from non-network providers at a lower level of benefit.

Changing Primary Physicians – Navigate

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 – Navigate

When billing services as a covering physician, modifiers *Q2* (substitute physician) and *QS* (locum tenens) can help make sure that your claim is recognized as submitted by a covering physician.

Specialist Referrals – Navigate

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 not practicing under the same TIN as the primary physician. Retroactive referrals and referrals to non-network physicians are not accepted.

If a network specialist to whom the Customer has been referred identifies the need for a Customer to see another specialist, the Customer's primary physician must be contacted for the primary physician's consideration of an additional referral. Only the Customer's primary physician or a physician practicing under the same TIN can write a referral to a network specialist. A specialist cannot enter a referral.

Services Not Requiring a Referral – Navigate

- Referrals are not required for the following services provided by a network physician:
 - › Services from a network Obstetrician/Gynecologist, including any type of ob-gyn (e.g., perinatologist).
 - › Services from a pathologist, radiologist or anesthesia physician.
 - › Services from a physician practicing under the same TIN as the primary physician.
 - › A routine refractive eye exam from a network provider.
 - › Mental health/substance use disorder services with network behavioral health clinicians.
 - › Services rendered in any emergency room, emergency ambulance, network urgent care center, or network convenience clinic.
 - › Physician services for emergency/unscheduled admissions.

- › Services from inpatient consulting physicians.
- › Any other services for which applicable law does not allow us to impose a referral requirement.
- Referrals are not required for any non-physician type of network services which include but are not limited to:
 - › Outpatient lab, x-ray, or diagnostics.
 - › Physical therapy, DME, home health, prosthetic devices, hearing aids.
 - › Rehab services with the exception of manipulative treatment and vision therapy (i.e., physician services).

Referral Submission Requirements – Navigate

- Referrals must be submitted by the Customer’s primary physician on our secure website at UnitedHealthcareOnline.com → Notification/Prior Authorizations → Referral Submission. Referrals cannot be accepted via phone, fax or paper.
- Referral submissions require first time user registration for UnitedHealthcare Online to submit online transactions. If you are not a registered user, simply click the ‘New User’ link in the upper right hand corner on the UnitedHealthcareOnline.com home page and follow the prompts. If you have questions about the website registration, call (866) UHC-FAST (866)-842-3278, and select Option 2.
- Users must have the Referral Submission functional role selected on their user profile to be granted security rights to submit and update referrals. For more information on access and roles, refer to the Roles Function Quick Reference Guide at [UnitedHealthcareOnline](http://UnitedHealthcareOnline.com) → Help → Quick Reference → User ID & Password Management → Roles Function Quick Reference.

Maximum Referral Visits – Navigate

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 additional 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.

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
27Z00; 27Z0;27Z01	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.

Referral Status – Navigate

Specialists are expected to confirm the existence of a referral when Navigate Customers are scheduling appointments. Facilities are also encouraged to confirm the existence of a referral for planned services given that Navigate Customers have no, or significantly reduced, benefits for care provided without a referral. 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.

Each physician has the responsibility to follow the Advance Notification or Prior Authorization procedures for any services they render or order. 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 agreement with us.

UnitedHealthcare Nursing Home Plan: A Medicare Advantage Institutional Special Needs Plan benefit plan 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 our 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.

UnitedHealthcare Nursing Home Plan Customer: A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and is enrolled in a UnitedHealthcare Nursing Home 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 (PCP): 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 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 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 when a change in the Primary Care Team is necessary.
7. Provide UnitedHealthcare 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 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 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'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 plan 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 a 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. If contact information is not available, please contact the local office or coordinate communication through the local nursing facility clinical staff.
9. Provide UnitedHealthcare a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.

Pharmacy Services

Commercial Pharmacy Benefit Manager Transition in 2013

As you may have heard, UnitedHealth Group will consolidate and manage its pharmacy benefit programs internally through OptumRx. In 2013 we will transition all services for our Commercial Customers currently handled by Medco to OptumRx.

We are preparing to begin a staged, orderly migration of over 12 million Customers in early 2013 onto a highly capable and robust delivery platform. More than \$200 million in infrastructure enhancements have been made as OptumRx continues to expand capacity and strengthen operations – in key areas such as technology, operations, tools and staffing.

You and Your Patients

Most existing mail service prescriptions will transfer to OptumRx. Prescriptions for certain medications, such as controlled substances (like opioids and stimulants), and prescriptions without refills will not transfer, and the Customer will receive a letter from UnitedHealthcare instructing them to contact your office for a new prescription.

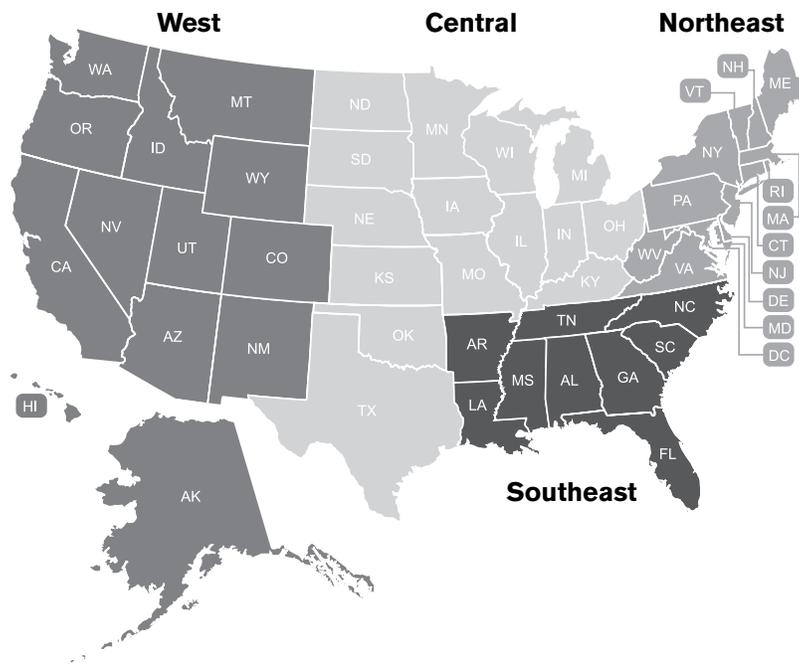
If you have not worked with OptumRx before, their Online Prior Authorization tool (available through UnitedHealthcareOnline.com) offers real-time approvals and is easy to use. The majority of online prior authorizations are approved in real time, and an auto-population feature provides 95% of a Customer’s information to save you and your staff valuable time. Provide Prior Auth TFN: (800) 711-4555. The current active prior authorizations will be transferred to OptumRx and you will not need to obtain a new authorization due to the UnitedHealthcare migration.

If you E-prescribe through Sure Scripts, the NCPDP ID for OptumRx is #0556540.

Timing Considerations

The transition will occur on a staged basis, starting in 2013. This phased approach will ensure that Customers experience no breaks in service, quality or access to the full range of pharmacy benefits and service support they enjoy now. We’ve provided the general timing of the transition below for your convenience. Customers will get a new ID card once they migrate and we have asked them to provide you a copy. As you interact with your patients you may want to inquire about a new health care ID card and remember this migration happens throughout 2013 so you may want to ask at periodic intervals.

Date	Region See map	Plans
1/1/2013	UnitedHealth Group Employees and select clients	UnitedHealthcare Employer & Individual, Harvard Pilgrim
4/1/2013	West region and Northeast region	UnitedHealthcare Employer & Individual, Medica, Harvard Pilgrim
6/1/2013	Central region	UnitedHealthcare Employer & Individual, Medica, Harvard Pilgrim
7/1/2013	National Account clients across all regions	UnitedHealthcare Employer & Individual, Medica, Harvard Pilgrim
9/1/2013	Southeast region	UnitedHealthcare Employer & Individual, Medica, Harvard Pilgrim
10/1/2013	All regions	Oxford, Sierra, River Valley, UnitedHealth One, Neighborhood Health Plan



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

Acquisition for administration 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[®], Supartz[®], and Orthovisc[®] 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)
- Orthovisc (sodium hyaluronate)

Note: This protocol does not apply to Euflexxa[®], Synvisc[®] and Synvisc-One[®]. Euflexxa, Synvisc and Synvisc-One may continue to be purchased and directly billed to UnitedHealthcare. Health care providers may continue to “buy and bill” Euflexxa, Synvisc and Synvisc-One. As of publication of the 2013 Provider Administrative Guide protocol, Gel-One is only sold directly to hospital; in the event it is made available for use in any other setting, including providers’ offices, you must acquire Gel-one from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare.

UnitedHealthcare has contracted for the national distribution of Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan, Supartz and Orthovisc. 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, Supartz and Orthovisc 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 Supartz and Orthovisc should be submitted to the participating specialty pharmacy using the applicable enrollment request forms that are available at UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → Prescription Enrollment Forms, Protocols & Administrative Guides. 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 the enrollment forms online (see path above).

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

UnitedHealthcare anticipates that all participating physicians and other health care professionals will be able to procure Synagis, Xolair, Botox, Dysport, Myobloc, Xeomin, Hyalgan, Supartz and Orthovisc from a participating specialty pharmacy provider.

The 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 may result in a denial of the claim in whole or in part. In addition, you may be subject to other administrative actions as provided in your agreement with us.

Please contact your local UnitedHealthcare Network Manager if you have any questions.

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.

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.

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, that are typically 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.

Specialty Drug Prior Authorization Process (for Commercial Customers only)

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

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

Compliance with this process is required.

- Failure to follow the Specialty Drug Prior Authorization process may 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 or on drug policy criteria for proven indicators in accordance with the Customer's benefit document. Upon issuance of the denial, the Customer and Provider will receive a denial notice with the appeal process outlined.

To see the drugs in which this Program applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Specialty Drug → Commercial Drug List. If additional drugs are added to the program, we will communicate that information via Network Bulletin.

Ordering Provider:

The Provider ordering the specialty drug is responsible for obtaining a prior authorization number, Service Request Number (SRN) prior to any rendering of the specialty drug. A Provider may obtain the SRN by contacting us via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization - Submission & Status (Commercial), or
- Phone: Toll-free (877) 842-3210

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 Provider information

- Ordering Provider's TIN
- Ordering Provider's last name
- Ordering Provider's phone number
- Ordering Provider's fax number
- Contact person at the ordering 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 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 Provider information (if different)

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

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

Please note that receipt of a coverage authorization means that the service met our criteria for medical necessity and/or met coverage and drug policy criteria. 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 Provider participation agreement with UnitedHealthcare. The length of time for which a prior authorization will be valid will vary by request.

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.

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 Provider should follow the same prior authorization process outlined above for a standard request.

Rendering Provider (if different)

To receive payment for services rendered, prior to rendering the stated specialty drug, the rendering Provider must validate with UnitedHealthcare that an approved Service Request Number (SRN) is on file by contacting us via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization - Submission & Status (Commercial).
- Phone: (877) 842-3210 - Select the appropriate option for Commercial Customers.

If the rendering Provider determines there is no SRN on file, and the ordering Provider participates in our network, we will use reasonable efforts to work with the rendering Provider to request that the participating ordering Provider obtain prior authorization prior to the rendering of services.

If the rendering Provider determines there is no SRN on file, and the ordering Provider does not participate in our network and is unwilling to complete the prior authorization process, the rendering Provider is required to complete the prior authorization process.

If the rendering Provider does not obtain a prior authorization number for a specialty drug ordered by a non-participating Provider, the rendering 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 Providers can still submit prior authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (877) 842-3210 and selecting the option for Commercial Customers.

Our claims process

Reimbursement policies

UnitedHealthcare reimbursement policies are available online at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides. Reimbursement policies may be referred to in your agreement with us 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 to ensure that you submit the claim to the correct payer.

There are 3 options for checking eligibility:

- › On UnitedHealthcareOnline.com, **using bar code or swipe card technology or keying in the Customer's information.**
- › Via electronic data interchange (EDI) using the Eligibility & Benefit Inquiry & Response (270/271).
- › 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.

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 Advantage plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. When applicable, notify us in accordance with the Advance and Admission Notification Requirements section in this Guide. Please see the [Notification requirements](#) section of this Guide for services that require notification as well as submission options.

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 UnitedHealthcare group's clearinghouse vendor (OptumInsight™, 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 non participating physicians, health care professional, facility and ancillary provider claims are accepted electronically, using UnitedHealthcare's primary Payer ID (87726). A complete list of Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances 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. **Enroll in Electronic Payments and Statements (EPS) to receive payments 5-7 days faster.**

When you enroll in EPS, payments are electronically deposited into one or more bank 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 and is not available for Community 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, UnitedHealthcareOnline.com'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 and check the status online before sending second submissions or tracers. Check the status online at UnitedHealthcareOnline.com → Claims & Payments → Claim Status. If you do need to submit a second submissions or tracers, be sure to submit them electronically no sooner than 45 days after original submission.

Complete claims include the information listed below under the Complete Claims Requirements in this section. 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 only 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).
- Charge 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 enable 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, the appropriate revenue and CPT or HCPCS codes.
- For outpatient services, the 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..

ICD-10 - One-Year Delay to October 1, 2014

On August 24, 2012, the Department of Health and Human Services (DHHS) announced a one-year delay of the implementation of the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Code Set to October 1, 2014. The final rule has been published in the November 5, 2012, Federal Register and is final 60 days after publication in accordance with federal law. Learn more about ICD-10 at UnitedHealthcareOnline.com. Select the ICD-10 quick link in the top right section of the screen where you'll find education, tools and resources designed to support ICD-10 transition efforts.

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:

- UnitedHealthcareOnline.com: To update your NPI and related information online, login and go to “Practice/Facility Profile” and select the TIN. Click “continue”, then select the “View/Update NPI Information” tab.
- Fax: For all UnitedHealthcare business, you can 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.
- 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 → Tools & Resources → National Provider Identifier (NPI). Also, see definitions in the UB-04 Data Specifications Manual. Updated information for HIPAA 837P, 837I 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 ICD 9-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 will be a provider’s liability, the 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.

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 to the provider 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 such as eyeglasses and hearing aids. 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.

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 Commercial professional claim predeterminations through [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) → Claims & Payments → Claim Estimator. 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 Customers with UnitedHealthcare HRAs or HSAs, please verify Customer eligibility and benefits coverage online at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) → Customer Eligibility & Benefits. Alternatively, you can call the Customer Service number on the back of your Customer's health care ID card.

Special note regarding UnitedHealthcare HRA enrollees: Once logged into the Customer Eligibility section of [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com), the "HRA Balance" field will be displayed if the Customer 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 Customer 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 your clearinghouse or [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com). A complete list of Payer IDs for UnitedHealthcare, Affiliates and Strategic Alliances can be found at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. Alternatively, you may submit claims to the address on the back of the Customer's health care ID card.

Please wait until after a claim is processed and you receive your EOB before collecting funds from your Customer because the Customer responsibility may be reimbursable through their HRA account and paid directly to you. The EOB will indicate any remaining Customer balance. UnitedHealthcare will not automatically transfer the HSA balance for payment; however, the Customer 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. Providers may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses; such non-qualifying expenses include, but are 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

An expense can be defined as a “qualified medical expense”, but might not be covered under a Customer’s benefit plan. 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 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 and Guides → 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 unless precluded 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 the 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 and 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 → Quick Tips → Secondary/COB or Tertiary Claims, 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 claims 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 form located on UnitedHealthcareOnline.com.

Claim reconsideration and appeals process and resolving disputes

Step 1: Claim Reconsideration. You must submit your Claim Reconsideration within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).

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 form that is 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 health care ID number as well as the provider name, address and TIN on the Claim Reconsideration form to prevent processing delays.

- Alternatively, you can call (877) 842-3210 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 (or as required by law or your participation agreement), 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 notification or claim appeal processes described in this Guide, we both 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. For disputes regarding payment of claims, you must timely complete the claim reconsideration and appeal process as set forth in this Guide prior to initiating arbitration.

If we have a concern or complaint about your compliance with your agreement with us, we will 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.

AL	Jefferson County, AL
AK	Anchorage, AK
AZ	Maricopa County, AZ
AR	Pulaski County, AR
CA	Los Angeles County, CA San Diego County, CA San Francisco County, CA
CO	Arapahoe County, CO
CT	Hartford County, CT New Haven County, CT
DE	Montgomery County, MD
DC	Montgomery County, MD
FL	Broward County, FL Hillsborough County, FL Orange County, FL
GA	Gwinnett County, GA
HI	Honolulu County, HI
ID	Boise, ID Salt Lake County, UT
IL	Cook County, IL
IN	Marion County, IN
IA	Polk County, IA
KS	Johnson County, KS
KY	Fayette County, KY

LA	Jefferson Parish, LA
ME	Cumberland County, ME
MD	Montgomery County, MD
MA	Hampden County, MA Suffolk County, MA
MI	Kalamazoo County, MI Oakland County, MI
MN	Hennepin County, MN
MS	Hinds County, MS
MO	St Louis County, MO Jackson County, MO
MT	Yellowstone County, MT
NE	Douglas County, NE
NV	Clark County, NV Washoe County, NV Carson City County, NV
NH	Merrimack County, NH Hillsboro County, NH
NJ	Essex County, NJ
NM	Bernalillo County, NM
NY	New York County, NY Onondaga County, NY
NC	Guilford County, NC
ND	Hennepin County, MN

OH	Butler County, OH Cuyahoga County, OH Franklin County, OH
OK	Tulsa County, OK
OR	Multnomah County, OR
PA	Allegheny County, PA Philadelphia County, PA
RI	Kent County, RI
SC	Richland County, SC
SD	Hennepin County, MN
TN	Davidson County, TN
TX	Dallas County, TX Harris County, TX Travis County, TX
UT	Salt Lake County, UT
VT	Chittenden County, VT Washington County, VT Windham County, VT
VA	Montgomery County, MD
WA	King County, WA
WV	Montgomery County, MD
WI	Milwaukee County, WI Waukesha County, WI
WY	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. For Commercial

Customers, the consent must comply with the following: 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.

For Medicare Advantage Customers, you must follow the protocol outlined in the section below and use the Advanced Notice of Non-Coverage Form referenced in that section. 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 the 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, or 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 written consent under this protocol.

NOTE: We highly recommend that you use the Advance Notice of Non Coverage (ANN) for Medicare Advantage Members Form to obtain written consent from Medicare Advantage Customers in order to seek and collect payment from such Customers for services that are not covered under the applicable benefit plan. A copy of the ANN Form and instructions for use can be found at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols.

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 only for professional Commercial claims).

Some claims can be processed (adjudicated) in real time while the Customer 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 against 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 and applicable state and federal requirements. For Commercial Customers, this includes the contract the Customer's employer plan sponsor 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 the 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 regulations and guidelines.
- 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.
- Hiring, promoting or terminating practitioners or other individuals are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Preventive Care

The Department of Health and Human Services has released regulations that require a non-grandfathered group health plan and a health insurance issuer offering group or individual health insurance coverage to provide coverage for preventive care without any cost-sharing (copayments, coinsurance or deductible) requirements as long as services are rendered by physicians and other health care professionals who participate in the plan's network.

UnitedHealthcare has updated its Preventive Care Services Coverage Determination Guideline (CDG) to help physicians identify and correctly code preventive services they deliver to UnitedHealthcare members. The CDG is updated when new guidance is received about services that should be covered as preventive services and whenever the applicable codes are revised. The United States Preventive Services Task Force is one of the primary references driving changes to the CDG. Items that have an "A" or "B" rating must be covered without cost-share by non-grandfathered plans.

This preventive services provision applies to both fully insured and self-funded plans. While grandfathered plans are not required to implement these changes, some grandfathered plans have chosen to cover preventive care services at no cost-share.

The provision applies to members with UnitedHealthcare commercial plans, including Oxford, UnitedHealthcare of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Washington, Inc., MD Individual Practice Association, Inc. (M.D. IPA), OptumChoice, Inc., MAMSI Life and Health Insurance, Neighborhood Health Partnership, UnitedHealthcare Plan of the River Valley, Inc., Arnett Health Plans and IBA Health Plans. The Provision does not apply to members enrolled in government health plans (Medicare/Medicaid) including UnitedHealthcare Medicare Solutions Medicare Advantage plans. For information

on Medicare coverage of preventive services, please see the UnitedHealthcare Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, available on UnitedHealthcareOnline.com.

For more information please visit:

Benefit Verification: You can verify the benefits and coverage of UnitedHealthcare Customers at UnitedHealthcareOnline.com.

Healthcare Reform: www.uhc.com → News Releases → United for Reform Resource Center → Health Reform Provisions → Preventive Services.

Coverage Determination Guide: UnitedHealthcareOnline.com → Medical & Drug Policies and Coverage Determination Guidelines → Preventive Care Services or Preventive Care Services Coding Guideline Summary.

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 pre payment 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 state 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.

Non Hospital Audits – Extrapolation

As part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may conduct a systematic review of paid claims. In cases where reviewing all medical records for a particular code would be burdensome on you, we may select and audit a statistically valid random sample (SVRS) of claims, or a smaller subset of the SVRS, in order to obtain an estimate of the proportion of claims that were, in fact, paid in error. The estimated proportion— referred to as the error rate—may then be projected across the relevant universe of claims to determine any overpayment, as permitted by law or regulation. You may appeal the initial Overpayment findings or alternatively, if only a subset of the SVRS sample was reviewed, cooperate by supplying the full sample of medical records represented in the SVRS. Should you request a more comprehensive audit, we will select a larger sample of claims, re-estimate the error rate based on the payments made in that sample, and extrapolate our findings across the relevant universe of claims to determine the amount of Overpayment, if any. Any Overpayment Disputes will be handled as outlined in this Guide and in your agreement with us.

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 Customer 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. You must use the standard CMS approved notice entitled, “Notice of Medicare Non- coverage” (NOMNC). The standardized form and instructions regarding the NOMC may be found on the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html> 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 and Health Management Program information:

Complex Case and Disease Management programs

Health Management Programs

UnitedHealthcare offers case and disease management programs to support physicians’ treatment plans and assist Customers in managing their conditions. Using medical, pharmacy and behavioral health claims data, our predictive model systems help us identify Customers who are at high risk and directs them to our programs. Patients can also be identified at time of hospital discharge via a Health Risk Assessment, Nurseline referral, or Customer or caregiver referral. If you have patients who are UnitedHealthcare Customers who would benefit from case or disease management, you can refer them to the appropriate program by calling the number on the back of the Customer’s health insurance ID card. Participation in these programs is voluntary. Upon referral, each Customer is assessed for the appropriate level of care for their individual needs. Programs vary depending on the Customer’s benefit plan.

Case Management

At the core of case management is identifying high-cost, complex, at-risk Customers who can benefit from these services. We partner with Customers and their physicians or other health care professionals to facilitate health care access and decisions that can have a dramatic impact on the quality and affordability of their health care.

Specifically, our programs are designed to assist in ensuring individuals:

- Receive evidenced-based care
- Have necessary self-care skills and/or caregiver resources
- Have the right equipment and supplies to perform self-care
- Have requisite access to the health care delivery system
- Are compliant with medications and the physician’s treatment plan

Our case managers are registered nurses who engage the appropriate internal, external or community-based resources needed to address Customers’ health care needs. When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, behavioral health, employee assistance and disability. Case management services are voluntary and a Customer can opt out at any time.

Disease Management Programs

We offer disease management programs designed to provide Customers with specific conditions assistance in managing their health. Eligibility for programs and services provided may vary according to the Customer’s benefit plan, and may include:

- Coronary Artery Disease
- Diabetes
- Heart Failure
- Asthma
- Chronic Obstructive Pulmonary Disease

- Cancer
- High Risk Pregnancy
- Kidney Disease
- Transplant
- Hemophilia*

Our programs include:

- Screening for depression and helping Customers access the appropriate resources.
- Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes care and stress management, as appropriate
- Helping Customers understand and manage their condition and its implications.
- Education on how to reduce risk factors, maintain a healthy lifestyle, and adhere to treatment plans and medication regimens.

For some programs, Customers may receive:

- A comprehensive assessment by specially-trained registered nurses to help determine the appropriate level and frequency of interventions.
- 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.
- Information on gaps in care and encouragement to discuss treatment plans, goals and results with their physician. Physicians with patients in moderate intensity programs may receive information on their patient's care opportunities.
- Transitional case management when high risk patients are discharged from a hospital.
- Outbound calls for the highest risk individuals to address particular gaps in care. You will be notified when patients are identified for the high-risk program.

These programs complement the physician's treatment plan, reinforce instructions you may have provided, and offer support for healthy lifestyle choices.

For UnitedHealthcare Community Plan Customers, please refer to the UHCommunityPlan.com Provider page to find your state specific Provider Administrative Manual.

Additional Care, Wellness, and Behavioral Health Programs

UnitedHealthcare offers multiple care coordination programs that may be available to our Customers depending on the structure of their health benefit plan. Many of the programs offered are focused on delivering skilled resources to assist Customers with improved self-management by assuring that they understand the provider's care plan, the medication instructions, and have support for the right lifestyle changes. In order to access these programs, please have Customers contact their UnitedHealthcare representative through the phone number listed on the back of their health care ID card.

Case Management programs

Transitional Case Management: Transitional Case Management (TCM) is the collaborative process of evaluating and coordinating post-hospitalization needs for Customers identified as being at risk of re-hospitalization or as frequent users of high-cost services. The goal of TCM is to facilitate access to services so that the Customer receives timely provider and home health services, medications, medical equipment, oxygen, therapies and other support as required.

General Condition Management: General Condition Management serves individuals with chronic conditions, those in need of longer-term support, or those who have unmet access, care plan, psycho-social, or knowledge needs.

* Limited to eligible UHC River Valley and NHP Customers

Complex Medical Conditions programs

Transplant Resource Services: Transplant Resource Services is a network access program available to certain Customers depending on their benefit plan. Customers eligible for this program have access to the OptumHealth Center of Excellence transplant network.

Women's Health Services: We offer an integrated solution to rising costs related to complexities of pregnancy and childbirth. Within women's health there are programs that focus on Infertility, Maternity and Neonatal.

Decision Support programs

NurseLine: A decision support solution that leverages a coaching call model and eSync Platform technology to proactively drive better health outcomes. Each call becomes an opportunity to not only address a symptom, but to connect Customers with the Right Care, Right Provider, Right Medication and Right Lifestyle.

Treatment Decision Support: Treatment decision support (TDS) is a shared-decision making solution that leverages a predictive model to proactively identify and engage individuals who may be seeking care for certain conditions with highly variable treatment options; for example: back surgery.

Wellness programs

Healthy Back: The Healthy Back program is a consumer-based program that provides support and guidance to navigate the health care system while improving access to superior care. It includes a phone-based coaching program enhanced with online back pain management tools to maximize outcomes and control costs.

Healthy Weight: The Healthy Weight program is an intense weight management coaching solution focused on changing behaviors and lifestyles to achieve long lasting weight loss, reduced health risks, and an improved quality of life.

Tobacco Cessation: We offer a comprehensive tobacco cessation solution integrating industry and employer best practices. The Quit Power program combines specialized tobacco coaching with nicotine replacement therapy, a combination that has been shown to increase success rates by more than 5 times compared to what individuals can attain on their own.

Wellness Coaching: Wellness Coaching is a phone or mail-based program that helps Customers identify and prioritize unhealthy behaviors, and set personalized goals that focus on positive, healthy behavior change. Our wellness coaches help Customers live healthier, more productive lives.

Behavioral Health programs

UnitedHealthcare offers specialized behavioral health benefits delivered by our affiliate company United Behavioral Health (UBH). The behavior health programs may be available to Customers depending on the structure of their health benefit plan. In order to access these programs, please have your patients contact their UnitedHealthcare representative through the phone number listed on the back of their health care ID card.

Full Care Management programs: A mental health and substance use disorder benefit helps employees and their eligible family members get help for problems, such as depression and drug or alcohol use disorder. This program is available around the clock to Customers. United Behavioral Health offers confidential, comprehensive services and arranges a wide array of treatment options from acute inpatient care to individual outpatient counseling.

When Customers call United Behavioral Health for assistance, they speak directly to a mental health benefits specialist who can answer questions related to their mental health and substance use disorder benefits. Working in strict confidence, trained professionals listen to each person carefully. Referrals are matched to specific needs using a nationwide network.

Employee Assistance programs: The challenges Customers face each day can overwhelm them. Employee Assistance Program (EAP) benefit provides confidential support for those everyday challenges. It's available around the clock anytime to those seeking help.

EAP program provides short-term counseling for individuals that may be struggling with stress at work, seeking financial or legal advice, or coping with the death of a loved one or just want to strengthen relationships with their family. EAP benefit offers assistance and support for all these concerns and more including: depression, stress and anxiety; relationship difficulties; financial and legal advice; parenting and family problems; child and elder care support; dealing with domestic violence; substance abuse and recovery; eating disorders.

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 Advantage and Medicaid 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
- Ophthalmologist

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 View360@uhc.com, or by calling (866) 270-5588.

Oncology/Hematology - UnitedHealthcare Cancer Registry

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

In support of our commitment to improving the quality of oncology care, we initiated the UnitedHealthcare Cancer Registry in 2007. The cancer registry includes clinical data such as clinical stage, date of diagnosis and current clinical status. As you identify Customers with breast, colorectal, lung and prostate cancer, we will request that you provide this clinical information, which is otherwise unavailable on claims data, to us. We will contact you prior to faxing the initial Cancer Status Form for completion. We greatly appreciate your time, effort and assistance with this important initiative.

As covered entities engaged in performing health care operations, UnitedHealthcare and physicians participating in this initiative may share this clinical information without the need to obtain patient authorizations.

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 data 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 3 conditions: breast, colorectal and lung cancer.

These reports are intended to supplement your practice, and help you identify and understand practice strengths and potential areas for improvement and are not used to rank, reward or penalize. Results thus far support our belief that oncology care in the United States follows established professional standards. To the extent the reports identified some gaps in care this should assist physicians with addressing those gaps. For more information regarding this program, go to UnitedHealthcareOnline.com → Clinician Resources → Cancer – Oncology, or contact us at unitedoncology@uhc.com.

Clinical and preventative health guidelines

UnitedHealthcare uses evidence-based clinical and preventative health 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. A list of 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 Quality Management & Performance Team at (954) 447-8818.

Important behavioral health information

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 quality of life and clinical outcomes. Screening for these disorders is critical 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	• Patient Health Questionnaire (PHQ-9) [†]	CPT 99420
Alcohol Misuse	• Alcohol Use Disorders Identification Test (AUDIT) • CAGE	CPT 99420

[†] PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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 and resources on depression and alcohol misuse disorders, Customers may access the United Behavioral Health website, www.liveandworkwell.com and you may access the United Behavioral Health clinician website, www.ubhonline.com.

To refer a Customers to a United Behavioral Health network provider for assessment and/or treatment, call United Behavioral Health at the toll free number on the back of the Customer's UnitedHealthcare health care ID card.

The UHC Preventive Medicine and Screening reimbursement policy 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 and Guides → Medical & Drug Policies and Coverage Determination Guidelines (*for Commercial Customers*). For information on coverage of mental health services and preventive health services for Medicare Advantage Customers, see the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures and the Medicare Advantage Coverage Summary for Mental Health Services and Procedures, both available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries.

Depression, Alcohol 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 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; 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 medical 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.

* Reference: Jiang W, Davidson JRT. Antidepressant therapy in patients with ischemic heart disease. *American Heart Journal*, November 2005. 150(5):871-881.

** Reference: <http://diabetes.webmd.com/coping-depression>

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 want 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 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 plans to your patients — and our Customers — and, together, help them live healthier lives.

UnitedHealthcare is committed to providing quality health care products for our Customers. From the time your patient enrolls in one of our plans, our quality initiatives touch all aspects of the health plan experience, from claims, to phone calls to physician visits. Our evidence-based wellness and care management programs are designed to help your patients achieve the best possible health, in coordination with physicians like you and with the support of our own clinicians. We have 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 of our 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 or access to such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax.
- Use of practitioner performance data.

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 4 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](https://www.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 or federal regulations may require more stringent standards. Contact your Network Management representative for assistance with determining your 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 participation agreement terminates for any reason, you may be 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, per your participation agreement and any applicable laws. Our Customer Care staff is available to help you and our Customers with the transition. We will notify affected Customers at least 30 calendar days prior to the effective date of termination of your participation agreement, or as required under applicable laws.

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 the influenza vaccine or pneumococcal vaccine or certain other preventive services. For additional information, please refer to the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries.
- 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 only make available or distribute plan marketing materials to Customers in accordance with CMS requirements.

- 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.

Medicare Compliance Expectations and Fraud, Waste and Abuse Training

As part of an effective Compliance Program, the Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including UnitedHealthcare, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their “first tier, downstream, and related entities” (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as vendors, contractors, and related parties.

The required education, training, and screening requirements to which we – and you – are subject include the following:

Standards of Conduct Awareness: FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group’s (UHG’s) Code of Conduct to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter.

What You Need to Do: Provide your own or the UHG’s Code of Conduct as outlined above and maintain records of distribution standards (i.e., in an email, fax blast, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste and Abuse Training: FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, governing body members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

The training can come from UnitedHealthcare or from another source, subject to certain requirements. FDRs 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. To facilitate that, we are providing training materials through [UnitedHealthcareOnline.com](http://www.unitedhealthcare.com) → Quick Links → Training and Education → Additional Learning → Compliance and Fraud, Waste and Abuse Training. CMS has also developed a web-based training module that can be used to satisfy the FWA training requirements. The CMS FWA training is available on CMS' Medicare Learning Network® at <http://www.cms.gov/MLNProducts>.

What You Need to Do: Administer FWA training materials as outlined above and maintain a record of completion (i.e., method, training materials, employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Exclusion Checks: FDRs must review federal exclusion lists (HHS-OIG and GSA) at the time of hiring/contracting with employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded from participating in Federal health care programs. FDRs must continue to review the federal exclusion lists on a **monthly** basis thereafter. 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 **OIG List of Excluded Individuals and Entities (LEIE)** at <http://oig.hhs.gov/exclusions/index.asp>
- General Services Administration (GSA) list of **Excluded Parties List System (EPLS)** at System for Award Management at <http://www.sam.gov.com>.

What You Need to Do: Review applicable exclusion lists as outlined above and maintain record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

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 credential physicians and other health care professionals who seek to participate in our network and get listed in our provider directory, and then recredential them at least every 36 months thereafter 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 current UnitedHealthcare Credentialing Plan at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → 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;
- 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 provider opt-out policy. Providers who opt-out of Medicare (this may include providers 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 provider who opts-out of Medicare may treat a Medicare Advantage beneficiary with whom he or she does not have a private contract and bill for such treatment. In such a situation, the provider may not charge the beneficiary more than what a non-participating provider would be permitted to charge and must submit a claim to UnitedHealthcare 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 provider.

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 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 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 web page. You can also submit your change by: (a) completing the 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 inpatient facility admission; follow the Admission Notification requirements on page 29 of the Guide.
Benefits and Eligibility	Call the number on the back of the Insured’s health care ID card or (800) 657-8205 or go to www.myuhone.com/provider .	To inquire about an Insured’s plan benefits or eligibility.
Pharmacy Services	www.myuhone.com/provider	To review the Prescription Drug List.
	Call the pharmacy number on the back of the Insured’s health care ID card or for Medco (800) 922-1557. Please refer to the Commercial Pharmacy Benefit Manager Transition in 2013 section of this Guide for information on OptumRx.	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 2 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 (OptumRx) Prescription Solutions is now OptumRx™, part of Optum—a leading health services business	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.

Resource	Where to go	What you can do there
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 2 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	www.myallsavers.com	To review the Prescription Drug List or to compare medication costs, click on the Network Tab and then the line under Pharmacy Network.
	Call the pharmacy number on the back of the Insured's health care ID card or for Medco (800) 922- 1557. Please refer to the Commercial Pharmacy Benefit Manager Transition in 2013 section of this Guide for information on OptumRx.	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 below).

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

<p>Golden Rule[®] A UnitedHealthcare Company</p> <p>UnitedHealthcare[®] Choice Plus Network</p> <p>RxBin: 610014 RxGrp: UGR16104 Issuer: Medco ID Number: 000 000 000 Primary Insured: John A Doe</p> <p>Office exam copay \$35</p> <p>Effective Date: Illness: MM/DD/YY Injury: MM/DD/YY Group Number: 705214</p> <p>00090293</p>	<p>Notification is required for hospital stays that exceed 3 days. Call 1-800-999-3404. Notification does not guarantee payment (Not required for CA, CO, CT, KY, MO, NM, OK or TX residents).</p> <hr/> <p>Send medical claims to: Golden Rule Insurance Company PO Box 31374 Salt Lake City, UT 84131-0374 Electronic Submission: 37602</p> <p>For Customer Service and To Find Network Providers: www.MyUHOne.com (800) 667-8205</p> <hr/> <p>Pharmacists: Submit claims via the Telepaid System. Pharmacy Service Help Desk: 1-800-922-1557 or www.medco.com/rph.</p> <hr/> <p>To find a pharmacy, call Member Services at 1-877-884-3256 or go to www.MyUHOne.com. Mail pharmacy claims to: Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512</p> <p><i>medco</i> </p>
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ASIC sample ID card

ALL SAVERS™
INSURANCE
A UnitedHealth Group Company

Health Plan (80840) 911-81400-00
Insured ID: 999999999999 Group Number: 5400-000949

Insured:
00 DALE BROWN

Dependents:
02 GARRETT BROWN
03 DYLAN BROWN
04 ALEC BROWN

Copay: Office: \$20
ER: \$100
HOSP: \$200

medco
Rx BIN: 610014
Rx GRP: UGR16104

UnitedHealthcare®
Choice Plus Network
Effective Date: 09/01/2012
Underwritten by All Savers Insurance Company

3010

Issued: 09/23/2012



Notification is required for inpatient stays that exceed 3 days and is required 5 days before a transplant evaluation and selected medical services. Call the customer service number to avoid potential penalty. Notification does not guarantee coverage or payment.

For Insureds: 800-232-5432

For Providers: 800-232-5432
CLAIMS: EDI # 81400, AMS PO Box 31375, Salt Lake City, UT 84131-0375

MultiPlan

Pharmacy Claims: Medco PO Box 14711, Lexington, KY 40512
Pharmacists: 800-922-1557 Insureds: 800-232-5432

AMSLIC sample ID card

American Medical Security
A UnitedHealth Group Company

Medical, Drug

Health Plan (80840) 911-81400-00
Insured ID: 999999999999 ID Number: 1200-132190

Insured:
00 CRIS BROWN

Dependents:
01 CAROL BROWN
03 BRIAN BROWN

Copay: HOSP: \$1000

Prescription Solutions
Rx BIN: 610494
Rx PCN: 9999
Rx GRP: AMS
Preferred Pricing Card

UnitedHealthcare®
Choice Plus Network
Effective Date: 12/01/2003
Underwritten by American Medical Security Life Insurance Company

3010

Issued: 09/05/2012



Notification is required for inpatient stays that exceed 3 days. Call the customer service number to avoid potential penalty. Notification does not guarantee coverage or payment.

For Insureds: www.eAMS.com 800-232-5432

For Providers: www.eAMS.com 800-232-5432
CLAIMS: EDI # 81400, AMS PO Box 31375, Salt Lake City, UT 84131-0375

MultiPlan

Pharmacy Claims: AMS PO Box 19032, Green Bay, WI 54307-9032
Pharmacists: 800-797-9791 Insureds: 800-232-5432

PLHIC sample ID cards

PacifiCare®
A UnitedHealthcare Company

Health Plan (80840) 911-81400-00
Insured ID: 999999999999 ID Number: 7500-002929

Insured:
00 DIANNE BROWN

Dependents:
01 TOM BROWN
02 ISAAC BROWN
03 ELIJAH BROWN

Copay: ER: \$200

Prescription Solutions
Rx BIN: 610494
Rx PCN: 9999
Rx GRP: AMS

UnitedHealthcare®
Choice Plus Network
Effective Date: 03/01/2006
Underwritten by PacifiCare Life and Health Insurance Company

3010

Issued: 09/05/2012



Notification is required for inpatient stays that exceed 3 days. Call the customer service number to avoid potential penalty. Notification does not guarantee coverage or payment.

For Insureds: www.eAMS.com 800-232-5432

For Providers: www.eAMS.com 800-232-5432
CLAIMS: EDI # 81400, AMS PO Box 31375, Salt Lake City, UT 84131-0375

MultiPlan

Pharmacy Claims: Prescription Solutions PO Box 29044 Hot Springs AR 71903
Pharmacists: 800-797-9791 Insureds: 800-232-5432

Notification requirements

Notify GRIC at the number listed on the Customer's healthcare ID card for any inpatient facility admission, following the *Admission Notification* procedures of this Guide.

Notify AMSLIC and PLHIC 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 prior to:

Procedures and services	Explanation
Inpatient facility admissions	Inpatient admissions. Refer to the Admission Notification requirements section of this Guide.
Transplant services	Proposed transplant services including evaluations.

Notify AMSLIC and PLHIC 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 evaluation.
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 and Guides.

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 2011 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 2011 and enter Year: 2011; 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 UnitedHealthcare’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, 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 Customers enrolled in Medical Doctor’s Practice Association, Inc. (“M.D. IPA”) or Optimum Choice, Inc. (“Optimum Choice”). 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. Information regarding OneNet PPO LLC can be found at the end of this Supplement and at UnitedHealthcareOnline.com → Manuals → OneNet PPO.

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 Customer access physicians and health care professionals?	Customers 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: Customers 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: Customers 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.

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.

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.

		MDIPA	
Health Plan (80840) 911-87726-04			
Member ID: 123456311	Group Number: 123456		
Member: SUBSCRIBER A WHITEAACA		ABC COMPANY, INC. Mockup for 2011	
PCP: JOHNDOCTOR		Payer ID 87726	
PCP Phone: (703) 999-9999			
LAB LABCORP	RAD NOVA		
Office:\$25	ER: \$50		
UrgCare:\$50	Spec:\$35		
DOI-0501		MDIPA Underwritten by MD-Individual Practice Association, Inc.	

Printed: 08/10/11	
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites of call. Referrals or authorizations are required for certain services.	
For Members:	www.myuhc.com 800-603-3923
For Providers: www.unitedhealthcareonline.com 877-842-3210	
Medical Claims: PO Box 740825, Atlanta GA 30374-0825	
Pharmacy Claims: PO BOX 14711, LEXINGTON KY 40512	For Pharmacists: 800-922-1557
Members: 800-842-2038	

Optimum Choice

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

		Optimum Choice Preferred	
Health Plan (80840) 911-87726-04			
Member ID: 123456882	Group Number: 123456		
Member: CHILDTWO A WHITEAADA		ABC COMPANY, INC. Mockup for 2011	
PCP: JOANDOCTOR		Payer ID 87726	
PCP Phone: (443) 999-9999			
LAB LABCORP	RAD BALT		
Office: \$10	ER: \$25		
UrgCare: \$15			
DOI-0501		Optimum Choice Preferred Underwritten by Optimum Choice, Inc.	

Printed: 07/18/11	
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites of call. Referrals or authorizations may be required for certain services.	
For Members:	www.myuhc.com 800-603-3923
For Providers: www.unitedhealthcareonline.com 877-842-3210	
Medical Claims: PO Box 740825, Atlanta, GA 30374-0825	
Pharmacy Claims: PO BOX 14711, LEXINGTON KY 40512	For Pharmacists: 800-922-1557
Members: 800-842-2038	

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 and Guides → 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 → Policies, Protocols and Guides → Protocols → Mid-Atlantic Region Protocols → Mid-Atlantic – Radiology Services.

Referrals and Authorizations

Most specialist services require a referral from the Customer's PCP. Referrals should be submitted by the PCP and reviewed by the specialist online. Referrals are not required when M.D. IPA or Optimum Choice is the secondary carrier. Please refer to the Referral Process Policy which can be located at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Policies, Protocols and Guides → Protocols → Mid-Atlantic Region Protocols → Mid-Atlantic - Referral Process.

1. Customers with M.D. IPA and Optimum Choice benefits must obtain a referral from their Primary Care Physician (PCP) for most specialty services.
2. Customers do not need a referral for routine eye refraction exams, OB/GYN visits and emergency/urgent care services.
3. Customers with M.D. IPA Preferred or Optimum Choice Preferred benefits do not need a referral when using their Point of Service level of benefits.
4. The referral must be:
 - › Written (paper or electronic) to a network physician or health care professional; and
 - › Signed and dated by the PCP (**Note:** electronic referrals do not require signatures).
5. The referral is valid only:
 - › When it is signed and dated on or prior to the service date (paper referrals).
 - › When it is created and submitted on or prior to the service date (electronic referrals).

For 4 visits except for those services listed below. If the PCP does not indicate number of visits, the referral is valid for 1 visit only; for a maximum of 6 months from the date it is signed or electronically filed.

6. Retroactive referrals are not valid.
7. The Customer may present the referral form or the electronic referral number to the specialist at the time of the visit, or the PCP's office can mail or fax the written paper referral.
8. Exceptions to the Referral Rules: There are exceptions to the general referral rules. Some services require Pre-certification before the PCP may issue the referral. Some referrals are for more than 4 visits. These exceptions are as follows:
 - › **Allergy Consultation and Shots:** Referrals to a specialist for an initial allergy consultation cover the initial office visit, skin testing, any allergy antigen, and one follow-up visit within 30 days. A second referral marked "Allergy Shots." may be issued which is valid for 6 months from the date of the referral for any number of visits.
 - › **Behavioral Health:** A referral must be written for the first visit to a behavioral health provider. Authorizations are required after the first visit.
 - › **Chemotherapy:** A referral is valid for any number of chemotherapy visits up to 6 months from the date of the referral.
 - › **Chiropractic Care:** For Customers with a fixed-dollar benefit limitation, a referral is required for the first visit to chiropractic provider. No further referrals or authorizations are required. For Customers without a fixed-dollar limit, the initial referral for chiropractic care is valid for up to 8 visits per condition within 6 months from the referral date. If the referral does not indicate the number of visits, the referral will only be valid for 1 visit. Additional visits after the first 8 require pre-authorization.
 - › **Dialysis:** A referral is valid for any number of dialysis visits up to 6 months from the date of the referral. Dialysis facilities require an authorization.
 - › **Fracture Care:** A referral for fracture care is global and is valid for 6 months from the date of the referral.

- › **Laboratory Services:** No referral is required. Either the PCP or the specialist may order services utilizing a commercial laboratory requisition. For information regarding which outpatient commercial medical laboratory to use, please refer to the Customer's health care ID card.

For additional information on the Laboratory protocol, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Region Protocols → Mid-Atlantic –Laboratory.
- › **Routine Obstetrical and Gynecological Care:** Referrals are not necessary.
- › **Physical Therapy, Occupational Therapy and Speech Therapy:** The initial referral for physical or occupational therapy is valid for up to 8 visits per condition within 6 months from the referral date. If the referral does not indicate the number of visits, the referral will only be valid for 1 visit. Additional visits after the first 8 require pre-authorization. For facilities, an authorization must be obtained for these services prior to the first visit.
- › **Post-Operative Care:** Referrals are not required for services related to a surgical procedure during the post-operative period included in the Global Fee if performed by the same physician practice. The PCP must write a new referral if the Customer needs to be seen by the same physician for a new issue or for a new physician for services related to the surgical procedure.
- › **Psychiatric Medication Management:** A referral must be written for the first visit to a behavioral health provider. Authorizations are required after the first visit.
- › **PUBA, PUVA and PAUB:** Referrals for these services are valid for any number of visits up to 6 months from the date of the referral.
- › **Radiology Services:** A referral is not needed for routine radiology services. Either the PCP or specialist can order these services on a prescription or requisition form. If the PCP is referring a Customer to a specialist for non-routine radiology services (e.g., a carotid ultrasound performed by a cardiologist who is a Participating Physician) a referral is needed. For additional information on the Radiology protocol, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Region Protocols → Mid-Atlantic – Radiology.

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 Clinical 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.

***Note:** Preauthorization and precertification requirements still apply when M.D. IPA or Optimum Choice is the secondary payer.

A list of the most current procedure codes associated with the services defined below can be found at: <http://www.UnitedHealthcareOnline.com> → Clinician Resources → Care Management → Advance & Admission Notification.

Procedures & services	Explanation
Bariatric Surgery	Bariatric Surgery and specific obesity-related whether scheduled as inpatient or outpatient. As a reminder, bariatric surgery and other obesity services are not covered in some benefit.
Behavioral Health Services	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.
Bone Growth Stimulator	Use of either electronic stimulation or ultrasound to heal fractures.
BRCA Genetic Testing Program	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 a Prior Authorization 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. 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 Prior Authorization 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. For services listed in this section, fax to (866) 255-0959.
Breast Reconstruction (Non Mastectomy)	Reconstruction of the breast other than following mastectomy.
Cardiology Services	Cardiac Angioplasty and Coronary Artery Bypass Graft are required to be prior authorized. UnitedHealthcare's Radiology and Cardiology Notification Programs do NOT apply to M.D IPA or Optimum Choice Customers. Please follow the precertification and preauthorization requirements listed above.
Capsule Endoscopy	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	Manipulative treatment, also known as mobilization therapy or "adjustment," refers to manual therapy employed to soft or osseous tissues for therapeutic purposes. Some benefit plans provide coverage for chiropractic services while others do not. Therefore, it is important for you to call the number on the Customer's health care ID card for any chiropractic services.
Clinical Trial	A rigorously controlled study of a new drug or a new medical device or other treatment on eligible human subjects, subject to oversight by an external Institutional Review Board (IRB) of the facility performing the clinical trial.
Cochlear Implants and Other Auditory Implants	A medical device (including a portion that is surgically implanted) within the inner ear and an external portion, to help persons with profound sensorineural deafness to achieve conversational speech.
Congenital Heart Disease	Congenital Heart Disease-related services: For questions related services listed in this section, call 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.
Cosmetic & Reconstructive	Cosmetic procedures that change or improve physical appearance, without significantly improving or restoring physiological function. Reconstructive procedures that either treat a medical condition or improve or restore physiologic function. We require Prior Authorization for such services whether scheduled as inpatient or outpatient.
Durable Medical Equipment (DME) – greater than \$1,000	DME with a retail purchase cost or a cumulative rental cost over \$1,000.00. Prosthetics are not DME (see separate <i>Prosthetics and Orthotics notification requirement</i> in this grid). 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).

Procedures & services	Explanation
End Stage Renal Disease/ Dialysis Services	<p>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 Prior Authorization.</p> <p>CPT:</p> <p>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</p> <p>Revenue Codes:</p> <p>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</p> <p>For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to UnitedHealthcareOnline .com or call us at (877) 842-3210 and select option for pre-certification for OCI and MD IPA. In an effort to maximize Customer benefit coverage, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible.</p> <p>Note that your agreement with us may include restrictions on referring Customers outside the UnitedHealthcare network.</p>
Home Health Care – Nutritional & Private Duty Nursing, Skilled Nursing	<p>The following services based in the home required Prior Authorization or Advance Notification:</p> <ul style="list-style-type: none"> • Enteral Formula/Pumps • Skilled Nursing in the home • Private Duty Nursing
Hyperbaric Oxygen Treatment (Outpatient)	Non-emergent hyperbaric oxygen treatments.
Hysterectomy	Surgical removal of the uterus (inpatient or outpatient).
Intensity Modulated Radiation Therapy (IMRT)	Fax the completed UnitedHealthcare IMRT Data Collection form and all supporting information to (866) 255-0959. The UnitedHealthcare IMRT Data collection form can be found at: UnitedHealthcareOnline.com
Infertility	Diagnostic and treatment services related to inability to achieve pregnancy.
Injectable Medication	<p>A drug capable of being injected intravenously, through an intravenous infusion, subcutaneously or intramuscularly.</p> <p>Excludes chemo therapy drugs.</p> <p>Refer to the Injectable medications section in this Supplement for a list of drugs requiring preauthorization.</p>
Inpatient Admissions	All inpatient admissions require Prior Authorization.
Joint Replacement	Outpatient and inpatient joint replacement procedures in addition to total hip and knee.
MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroid	<p>MR-guided focused ultrasound procedures and treatments, as defined by but not limited to:</p> <p>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:</p> <ul style="list-style-type: none"> • 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 and Guides → Medical & Drug Policies and coverage Determination Guidelines. • The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare. <p>The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.</p>

Procedures & services	Explanation
Muscle Flap Procedure	A muscle or portion of muscle that can be transferred with its blood supply to another part of the body for reconstructive purposes.
Non Emergency Transport – Air, Land, Other	Non-urgent ambulance transportation (by air, land, other) between specified locations.
Orthognathic Surgery	Treatment of maxillofacial (jaw) functional impairment.
Orthotics – greater than \$1,000	Orthotics with a retail purchase cost or a cumulative rental cost over \$1000. Some of our Customers have benefit plans may have different requirements. Please refer to the benefit documentation for the list of covered services.
Out-of-Network Services	A referral from a network physician, or health care provider to a hospital, physician, or other health care provider who is not contracted with UnitedHealthcare. Please note that your agreement with UnitedHealthcare may include restrictions on directing Customers outside the health plan service area. Your patients who use non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses or no coverage. Prior Authorization 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.
Physical Therapy/ Occupational Therapy (PT/OT)	Required when services are performed at an outpatient clinic. Since the member's benefit plan may require a pre-service coverage review, please call number on the Customer's health care ID card to fulfill the advance notification requirement. Physical Therapy (after 8 visits) or if performed at a hospital outpatient facility, authorization required from the 1st visit.
Potentially Unproven Services	Services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
Prosthetics – greater than \$1,000	Prosthetics with a retail purchase cost or a cumulative rental cost over \$1000.
Proton Beam Therapy	Focused radiation therapy that uses beams of protons (tiny particles with a positive charge).
Radiology Services	Includes the following services: <ul style="list-style-type: none"> • CT - Brain, Chest, Musculoskeletal, Colonography • MRI - Brain, Heart, Chest, Musculoskeletal • PET Scans (non-cancer diagnoses) • Virtual procedures UnitedHealthcare's Radiology and Cardiology Notification Programs do NOT apply to M.D IPA or Optimum Choice Customers. Please follow the precertification and preauthorization requirements listed above.
Septoplasty/ Rhinoplasty	Treatment of nasal functional impairment and septal deviation.
Sleep Apnea Procedures & Surgeries	Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea. Applies to inpatient or outpatient, including but not limited to: Palatopharyngoplasty - oral pharyngeal reconstructive surgery, includes laser-assisted uvulopalatoplasty (laup).
Sleep Studies	Sleep laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders. Excludes sleep studies performed in the home.
Specific Medications as Indicated on the Prescription Drug List (PDL)	Effective January 1st, 2013, some groups will have prescriptions managed through OptumRx. Please refer to the Customer's ID card for the Customer service number. Call (877) 842-1435 when prescribing medications that require Prior Authorization. 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.
Speech Therapy Services	Required when services are performed at an outpatient clinic. Since the member's benefit plan may require a pre-service coverage review, please call number on the Customer's health care ID card to fulfill the advance notification requirement. Physical Therapy (after 8 visits) or if performed at a hospital outpatient facility, authorization required from the 1st visit.

Procedures & services	Explanation
Spinal Stimulator for Pain Management	Spinal cord stimulators when implanted for pain management.
Spinal Surgery	Inpatient and outpatient spinal surgeries.
Transplant of tissue or organs	Organ or tissue transplant or transplant related services prior to pre-treatment or evaluation.
Vagus Nerve Stimulation	Implantation of a device that sends electrical impulses into one of the cranial nerves.
Vein Procedures	Removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins of the extremities.
Ventricular Assist Devices	A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow.

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 nonparticipating physician, health care practitioner or facility.

Precertification/preauthorization is required for the listed elective outpatient services. It is the physician's responsibility to obtain relevant preauthorization or precertification. However, the facility should verify that Preauthorization has been obtained prior to the service. Payment may be denied to the facility for services rendered in the absence of preauthorization. All final decisions concerning coverage and payment are based upon Customer eligibility, benefits and applicable state law.

Inpatient admission notification

Preauthorization/precertification is required for all elective inpatient admissions for all M.D. IPA and Optimum Choice members; it is the physician's responsibility to obtain the relevant preauthorization or precertification. However, the facility should verify that Pre-authorization has been obtained prior to the Admission. Payment may be denied to the facility for services rendered in the absence of Preauthorization. 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.

It is the responsibility of the facility to notify UnitedHealthcare 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 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.

State-Specific Variations from the Standard Notification Requirements For Maryland Facilities (For Commercial and Medicare Advantage)

If Prior Authorization is required for the requested elective inpatient procedure, it is the physician's responsibility to obtain the relevant approval. It is the responsibility of the facility to Notify UnitedHealthcare within 24 hours (or the first business day if the admission occurs on a weekend or holiday) of the elective admission. If the physician has obtained prior authorization, the initial day of the inpatient admission will be paid unless:

- The information submitted to UnitedHealthcare regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

- Critical information requested by UnitedHealthcare regarding the service to be delivered to the patient was omitted such that UnitedHealthcare's determination would have been different had it known the critical information;
- A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or
- On the date the preauthorized or approved service issued through Preauthorization was delivered the Customer was not covered by UnitedHealthcare and the provider could have verified the Customer's eligibility status by utilizing UnitedHealthcare's automated eligibility verification system (VETTS) or by accessing UnitedHealthcareOnline.com 24 hours a day, 7 days a week. Note that the online verification must indicate that the Customer is not covered by UnitedHealthcare.

If prior authorization is obtained and admission notification is not made by the facility in a timely manner, payment reductions will be limited to hospital room and board charges when applicable.

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 the 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. 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 Customers 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

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

This protocol applies to the acquisition, including prescription ordering and purchase of these specialty medications by physicians and other healthcare professionals. You must acquire these specialty medications from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. The specialty pharmacy will bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for 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 the collection of any amount prior to dispensing of the medication to the physician office.

For a listing of participating specialty pharmacy provider(s), please refer to UnitedHealthcareonline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → UnitedHealthcare Participating Specialty Pharmacy Provider List for the 2013 UnitedHealthcare Administrative Guide.

- 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)
- Orthovisc (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 is available at: [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) → Tools & Resources → Pharmacy Resources, or call (866) 429-8177.

Drugs that require preauthorization:

- Avastin (Bevacizumab)
- Euflexxa (Sodium Hyaluronate)
- Gel-One (Sodium Hyaluronate)
- H.P.Acthar Gel (repositorty corticotrophin injection)
- Immune Globulin
- Makena (17-hydroprogesterone brand name)
- Orenzia (Abatacept)
- 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](https://www.unitedhealthcareonline.com) or call contact numbers below.

Information on our medical evidence-based policies is available at: [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) → Tools & Resources → Policies, Protocols and Guides → 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 processing](#) 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](https://www.unitedhealthcareonline.com). Please refer to the Referral Process Policy, which can be found on [UnitedHealthcareOnline.com](https://www.unitedhealthcareonline.com) → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Region Protocols → 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](https://www.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 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.

Primary care physician (PCP)

The PCP is the primary provider of medical services for Customers. This includes preventive care and chronic care. The PCP is responsible for coordinating all care that Customers 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 Customers who have chosen a specific PCP is referred to as the PCP Panel. UnitedHealthcare of the Mid-Atlantic region may close any PCP panel if any Customer complains about access, or if UnitedHealthcare of the Mid-Atlantic region identifies a quality related issue.

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 30 days prior to any action. To locate your Network Account Representative, please go to UnitedHealthcareOnline.com → Contact Us tab → Network Contacts located near the bottom of the page.

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 notify the Customer Care Center to have member removed from their panel. This number is on the back of the Customer's health care ID card. Reasons for discharge include:

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

The PCP must provide adequate documentation in the Customer's medical record of the verbal and written warnings. The physician is obligated to provide emergency care to the Customer for 30 days from the Customer's receipt of the dismissal letter.

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.

Covering physicians: PCPs must arrange for coverage of their practice 24 hours a day, 7 days per week. The covering physician must be a participating physician. If the covering physician is not in your group practice, you must notify UnitedHealthcare to prevent claims payment issues. When billing services as a covering physician, modifiers Q5 (substitute physician), CP (Covering Physician) and Q6 (locum tenens) will ensure that your claim is recognized as submitted by a covering physician. A PCP copay is to be collected at the time of service.

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 Customers 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 in your agreement) times the number of Customers 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 Customers eligible on the 15th of the month.

15/30 Rule	<p>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 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.</p> <p>For purposes of capitation payments, Customers are added on the 1st day of the month or terminated on the last day of the month, with the exception of newborns, which are added on the date of their birth(s) Capitation will be paid for full months, and conversely recouped for full months if appropriate.</p> <p>As an example:</p> <p>Retroactive Add:</p> <p>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.</p> <p>To aid the provider in identifying these Customers, the Customer's standard services capitation will be reported as \$0.</p> <p>Retroactive Term:</p> <p>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.</p>
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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) offers its Clients access to a network of physicians, health care practitioners and facilities offering medical, behavioral health and workers compensation services in the Mid-Atlantic region.

Operational and administrative processes and policies for OneNet can differ from those of UnitedHealthcare, M.D. IPA and Optimum Choice. Please refer to the OneNet PPO Physician, Health Care Practitioner, Hospital and Facility Manual (OneNet Manual) for those processes and policies that are unique to services provided to OneNet Customers. These include, but are not limited to, instructions on claim submission, ID card requirements, Utilization Management requirements and who to contact with questions about claim pricing.

The OneNet Manual is a supplement to this UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (Guide). Policies and processes described in the Guide apply to OneNet participating providers unless conflicting policies or processes are presented in the OneNet Manual. The OneNet Manual supersedes this Guide in the case of conflicting provisions.

A copy of the OneNet Manual is available from:

- UnitedHealthcareOnline.com
- www.onenetppo.com
- OneNet Professional Services Department at (800) 342-3289 (Mon. - Fri. 8:00 a.m. to 8:00 p.m.)

OneNet Terminology

OneNet Client: OneNet Clients include insurance carriers, third party administrators (TPA), union health and welfare funds, workers compensation administrators, workers compensation insurance carriers, and others. OneNet Clients may be a OneNet Payer or any entity that provides administrative services to a OneNet Payer (e.g., a TPA).

OneNet Customer: A OneNet Customer is a person authorized by OneNet PPO, LLC 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. If your UnitedHealthcare contract has the definition of "Customer" or "Member", the term OneNet Customer as used by OneNet and in the OneNet Manual is intended to have the same meaning. OneNet Customers include:

- **Primary Participants:** The qualifying subscriber, employee, insured, policyholder or other person who through their direct or indirect agreement with OneNet is eligible to access network physicians, health care practitioners, hospitals and facilities.
- **Participants:** As used by OneNet and in the OneNet Manual, Participants refers to all Primary Participants and their spouses and dependents (including domestic partners, if applicable) who are authorized by OneNet to access network physicians, health care practitioners, hospitals and facilities.

OneNet Payer: 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 or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing claims payment on behalf of OneNet Payers. References in the physician, health care practitioner, hospital or facility agreement to "participating entity", "Payer" or "Payor" also apply to OneNet Payers. OneNet PPO is not a OneNet Payer.

Summary of Key OneNet Policies and Practices

Below is a summary of some of the key operational guidelines detailed in the OneNet Manual. This listing is meant as a general overview only. Additional requirements, conditions and exceptions may apply and are described in greater detail in the OneNet Manual.

- OneNet Clients print their own health plan ID cards, which are reviewed and approved by OneNet. OneNet Participants must show a health plan ID card with the OneNet name or logo at the time of service. (Note: In keeping with industry standards, ID cards are not used or required for Participants accessing OneNet's Workers Compensation Network.)
- OneNet does not maintain Participant eligibility or benefit information. This information must be obtained through the appropriate OneNet Client. The toll-free telephone number to call for verifying benefits and eligibility or initiating Utilization Management requirements, will be listed on the Participant's ID card. Individual OneNet Clients may also maintain independent Web sites for verifying benefits and eligibility of OneNet Customers. Benefits and Eligibility information for OneNet Customers is not available through UnitedHealthcareOnline.com or www.onenetppo.com.
- OneNet PPO is not a Payer and does not adjudicate or pay claims. OneNet receives claims from participating providers and applies the provider's contracted rate to the claim. Claim pricing for workers compensation claims is applied as the lesser of the billed charges, the applicable State Fee Schedule Rate, or the OneNet Fee Schedule. Only OneNet can apply OneNet's contracted rates to claims submitted by participating providers. Priced claims are sent to the applicable OneNet Client for adjudication.
- OneNet claim pricing sheets show the amount of the claim after that application of the OneNet contracted rate, and can be viewed online at UnitedHealthcareOnline. Pricing sheets do not show final claim adjudication by the OneNet Payer and may include billed charges determined to be ineligible or the OneNet Customer's responsibility. These charges will be detailed on the OneNet Payer's Explanation of Benefits (EOB) or Remittance Advice.

- The address for claims submission is included on the OneNet Customer's ID card. Claims for services provided for Workers Compensation Participants should be submitted to the injured worker's employer, workers compensation insurance carrier, or workers compensation administrator.
- OneNet Clients may use utilization management programs that are not administered by OneNet. Utilization Management contact information is included on the OneNet Customer's ID card. You are required to use your best efforts to comply with the utilization management guidelines for OneNet Clients.
- OneNet claims may be submitted by paper or through Electronic Data Interchange (EDI) using OneNet Payer Number 52149. A list of clearinghouses with established connections to OneNet is available at UnitedHealthcareOnline.com, www.onenetppo.com, or by calling OneNet Professional Services at (800) 342-3289. OneNet claims cannot be submitted through [UnitedHealthcareOnline](http://UnitedHealthcareOnline.com).
- Questions about claim payment, including overpayment, should be directed to the OneNet Client at the phone number listed on the OneNet Customer's ID card, or contact information listed on the OneNet Client's EOB or Remittance Advice.

If you need assistance or have any questions about OneNet PPO, please call the OneNet 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
Electronic Data Interchange (EDI) Support	(866) 509-1593	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Submit claims and claims attachments
Appeals	Attn: Appeals Dept P.O. Box 5210 Kingston, NY 12402-5210 Fax: (801) 994-1106	<ul style="list-style-type: none"> • Reconsiderations and appeals
Automated Referral Line (IVR System)	(877) 972-8845	<ul style="list-style-type: none"> • Request referrals to specialist • Obtain status of referrals • Obtain Eligibility & Benefits
Utilization Management	Fax: (800) 550-5568 Authorizations: (800) 731-2515 or: (800) 729- 1574 OB: (800) 731-7954 Hospital Admissions: (800) 731-2430	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Obtain information about Behavioral Care Services
Foot and Ankle Network* (*Miami Dade, Broward, Palm Beach, Martin, and Monroe Counties only)	(305) 558-0444 Fax: (305) 557-3810	<ul style="list-style-type: none"> • Obtain information about Podiatry services
OptumHealth	(800) 873-4575 Fax: (248) 733-6070	<ul style="list-style-type: none"> • Physical Therapy (PT) • Occupational Therapy (OT) • Speech Therapy (ST)
OptumHealth	(888) 936-7246 Fax: (855) 250-8157	<ul style="list-style-type: none"> • Transplant
Advocare Health Alliance	(305) 728-2747 (866) 374-4326 (outside Miami-Dade) Fax: (800) 831-4264 or (800) 722-4148	<ul style="list-style-type: none"> • Home Health Care Services • Durable Medical Equipment • Home Infusion Services
Quality Managed Healthcare, Inc.* (*Miami-Dade, Broward, Palm Beach, and Monroe Counties only)	(954) 236-3143 Fax: (954) 236-3254	<ul style="list-style-type: none"> • Obtain information about Chiropractic Services

Resource	Where to go	What you can do there
Pharmacy	Medco Rx Prior Auth (800) 753-2851 UnitedHealthcare Specialty Referral Line (866) 429-8177 OptumRx (888) 739-5820 Fax: (800) 837-0959 Please refer to the Commercial Pharmacy Benefit Manager Transition in 2013 section of this Guide for information on OptumRx.	<ul style="list-style-type: none"> • Obtain information about Pharmacy Services • Obtain Rx Authorization
CareCore National (CCN)	(866) 242-9546	• Obtain information about Precertification Services

Health care identification (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, precertifications and post-certifications.

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

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

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@uhc.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 Customer Service (877) 972-8845.

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, Oculoplasty)
- Infertility Specialists

In addition, there are services that require precertification or referral and cannot be processed through the IVR System. Please refer to the [Coverage Determinations and 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

Responsibility	PCP	Specialist Physician	Hospital or Ancillary Provider
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 a 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, 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 [NHP Precertification 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 [NHP Precertification 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
- › Date of birth
- › 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 (including diagnosis) 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 than inpatient hospital: CareCore National (866) 242-9546.
- 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.

Certifications

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
 - › Customer date of birth
 - › Specialist name, phone number, and specialty
 - › Pertinent medical information substantiating the need for additional visits › the 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 ensure 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 within 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. 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 (i.e., 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 will send a copy of the referral to the specialist and retain 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
- 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 observations and emergency admissions require post-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) 729-2430.
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 Clinical 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.

Certification 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 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • A request for suture removal follow up ER visit. 	72 hours of receipt of request.
Concurrent urgent	Any urgent request for an extension of a previously approved ongoing course of treatment over a period.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 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, 9/12

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, 1/07, 3/10, 9/12

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 semiquantitative, 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, 1-3 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 Count, 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
	87430	Infectious Agent Antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus group A
	89230	Sweat collection by iontophoresis
	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)
Rheumatology	89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
	85651	Sedimentation rate, erythrocyte: 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, pCO ₂ , pO ₂ , CO ₂ , HC0 ₃)
	82805	With oxygen saturation, by direct measurement, except pulse oximetry
	82810	Bloodgases, oxygen saturation only
	82820	Hemoglobin X oxygen affinity (pO ₂ 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

Specialty	Code	Description
All Outpatient Facilities (continued)	86904	Antigen screening for compatible blood unit using patient serum, per unit screened
	86905	RBC antigens, other than ABO or Rh (D), each
	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 reagent 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,

Revised Dates: 3/10, 9/12

- 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, 9/12

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, or observation 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
Transplant: OptumHealth: (888) 936-7246
Outpatient Therapy PT/OT/ST: OptumHealth: (800) 873-4575
Radiology/Cardiology/Nuclear Imaging Services: CareCore National (CCN): (866) 242-9546

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 than inpatient hospital. (CareCore National (866) 242-9546.
- 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.
- Sleep Study.
- MRI, MRA, CT Scans, CTA scans, PET scans: CareCore National (866) 242-9546. Fax: (866) 466-6964.
- Lung volume reduction surgery procedures, even if the inpatient admission has been authorized.
- 30 Day Event Monitor.
- Nuclear Medicine Imaging, including without limitation: CareCore National (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: (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
- Oncology Services
- 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 Vand Prescription Drug List (PDL)
- 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, 9/12

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 and/or observation stay, 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 Dates: 08/05, 04/06, 12/06, 2/08,4/09, 3/10, 11/10, 9/11, 9/12

Neighborhood Health Partnership's pharmacy benefit manager is UnitedHealthcare Pharmacy, which uses Express Scripts Medco (ESI Medco) for certain pharmacy benefit services. Please refer to the [Commercial Pharmacy Benefit Manager Transition in 2013](#) section of this Guide for information on OptumRx.

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 ESI 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 the UnitedHealthcare Online. To determine medications available through the Pharmacy benefit and any prior authorization that may be required. Please consult the NHP Prescription Drug List Consumer Reference Guide.

Outpatient Pharmacy information on [UnitedHealthcareOnline.com](#):

[UnitedHealthcareOnline.com](#) → [Tools & Resources](#) → [Pharmacy Resources](#) → [UnitedHealthcare](#) → [Clinical Programs](#).

NHP Prescription Drug List Consumer Reference Guide:

MyNHP.com → Members → Pharmacy → 2013 Prescription Drug List (PDL).

All infusions and chemotherapeutic agents administered through the medical benefit require prior authorization, regardless of the indication. In addition, the following table summarizes medical drugs requiring PA for NHP members as well as the requirements for the outpatient medications listed above.

Drug Name	Criteria
Actemra	Actemra (tocilizumab)
Alferon	Coverage is provided for intralesional treatment of refractory or recurring external condylomata acuminata inpatient 18 years of age or older.
Amevive	Coverage is provided for treatment of adults with moderate to severe plaque psoriasis.
Benlysta	Benlysta (belimumab)
Botox Dysport Myobloc Xeomin	UnitedHealthcareOnline.com→Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→Botulinum Toxin A and B.
Cerezyme	Coverage is provided for Enzyme Replacement.
Epogen* Procrit* Omontys* Aranesp*	UnitedHealthcareOnline.com → Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→Anemia Drugs: Darbepoetin Alfa and Epoetin Alfa Drug Policy.
Intravenous bisphosphonates Reclast, Boniva, Zometa	Coverage is provided for osteoporosis, Paget's disease and related disorders.
Intravenous Immune Globulin (IVIG)	UnitedHealthcareOnline.com→Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→Immune Globulin (IVIG).
Intravenous Iron Infusions Infed, Venofer, Ferrlecit, Feraheme, Dexferrum, Nulicet	Coverage is provided for treatment of patients with documented iron deficiency in whom oral administration is unsatisfactory or not possible.
Intravesicular Instalations BCG, Theracys	Bladder cancer and chronic cystitis.
Neupogen/ Neulasta*	Coverage is provided for treatment of neutropenia and in bone marrow transplantation.
Prolia	Coverage is provided for the treatment of osteoporosis.
Aralast, AralastNP, Prolastin, Prolastin C, Zemaira	Coverage is provided for a diagnosis of congenital alpha 1-antitrypsin deficiency with emphysema.
Remicade Orencia	UnitedHealthcareOnline.com → Quick Links → Policies, Protocols and Administrative Guides.Policies → Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→ Remicade (infliximab). UnitedHealthcareOnline.com → Quick Links → Policies, Protocols and Administrative Guides.Policies → Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies → Orencia (abatacept).
Rituxan	UnitedHealthcareOnline.com→Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→Rituxan (rituximab).
Sodium Hyaluronic Acid Synvisc, Synvisc-One, Euflexxa Othovisc, Hyalgan & Supartz	UnitedHealthcareOnline.com→Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→ Sodium Hyaluronate. Preferred Buy and Bill or Specialty Pharmacy. Required to obtain through Specialty Pharmacy.
Stelara	Stelara (ustekinumab)
Synagis	UnitedHealthcareOnline.com → Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→Synagis.

Drug Name	Criteria
Tysabri	UnitedHealthcareOnline.com→Quick Links→ Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→ Tysabri (natalizumab).
VEGF Inhibitors Avastin, Lucentis, Eylea, Macugen	Ophthalmologic Policy Vascular Endothelial Growth Factor (VEGF) Inhibitors.
Vivitrol	Treatment of Substance Dependence.
Xiaflex	Coverage is provided for the treatment of adult patients with Dupuytren's contracture with a palpable cord.
Xolair	UnitedHealthcareOnline.com→Quick Links→Policies, Protocols and Administrative Guides. Policies→Medical & Drug Policies and Coverage Determination Guidelines Reimbursement Policies→ Xolair (omalizumab). Obtain through Specialty Pharmacy.

*Also available through Pharmacy Benefit with Prior Authorization.

Pharmacy Drug PA Requests

Phone: (800) 753-2851

Fax: (800) 827-0959

All fax requests are responded to in 24 hours.

NHP Medical Drug PA Requests

Phone: (877) 488-5576

Fax: (800) 731-6984

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

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.

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

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 UnitedHealthcare West “Provider Manual,” other than the UnitedHealthcare West 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 2013 to the PacifiCare name with the PacifiCare companies listed below. If and when these changes occur, we will communicate with you about them.

Additionally Prescription Solutions is now OptumRx™, part of Optum—a leading health services business.

Legal Entities	Products Offered	Benefits Plans
PacifiCare of Arizona, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare Dual Complete™ • UnitedHealthcare® Group Medicare Advantage
PacifiCare of Colorado, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
PacifiCare of Nevada, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • UnitedHealthcare® MedicareComplete® • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of California	Commercial and Medicare Advantage	<p>Commercial: UnitedHealthcare SignatureValue™ family of products including, but not limited to:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue • UnitedHealthcare SignatureValue Advantage • UnitedHealthcare SignatureValue featuring • the HealthCare Partners Network Plans • UnitedHealthcare SignatureValue VEBA • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Flex <p>Medicare:</p> <ul style="list-style-type: none"> • AARP MedicareComplete® SecureHorizons® • Sharp® SecureHorizons® Plan by UnitedHealthcare® • UnitedHealthcare™ Dual Complete • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of Oklahoma, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • UnitedHealthcare Group Medicare Advantage
UnitedHealthcare of Oregon, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare Group Medicare Advantage

Legal Entities	Products Offered	Benefits Plans
UnitedHealthcare Benefits of Texas, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue <p>Medicare:</p> <ul style="list-style-type: none"> • 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	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare® SignatureValue® <p>Medicare:</p> <ul style="list-style-type: none"> • AARP MedicareComplete • UnitedHealthcare Group Medicare Advantage

Administrative services provided by the following affiliated companies: United HealthCare Services, Inc., OptumRx or OptumHealth CareSolutions, 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> › Primary Care Physician (PCP) assignment and history. › Plan codes and coverage history. • Review Customer benefits/copay detail (including benefits). <ul style="list-style-type: none"> › Medical <ul style="list-style-type: none"> · 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™ <ul style="list-style-type: none"> › 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
		<ul style="list-style-type: none"> • Use the Library/Resource Center (before and after authentication) to access the following information: <ul style="list-style-type: none"> › 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”
<p>Preauthorization (Non-delegated)</p> <p>For urgent requests</p> <p>For routine requests</p>	<p><i>Arizona:</i> Medicare Advantage Phone: (800) 746-7405</p> <p><i>California, Oregon and Washington:</i> SignatureValue, Medicare Advantage, Direct contract network and medical group/IPA carve-out Phone: (800) 762-8456</p> <p><i>Colorado:</i> Medicare Advantage Phone: (800) 746-7405 For complex radiology, contact MedSolutions - medsolutionsonline.com Phone: (888) 693-3211</p> <p><i>Nevada:</i> Medicare Advantage Phone: (800) 337-8114</p> <p><i>Texas and Oklahoma:</i> Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management Phone: (800) 668-8139</p>	<ul style="list-style-type: none"> • Request urgent preauthorization approval • Request routine preauthorization approval
<p>Hospital Inpatient Notification (Non-delegated)</p>	<p><i>Colorado only</i> (866) 822-0591 Fax: (888) 714-3991</p> <p><i>Inpatient & observation</i> (800) 799-5252 Fax: (800) 274-0569</p> <p><i>Mental health</i> Medicare Advantage: (800) 508-0088</p> <p><i>Transplant</i> (866) 300-7736 Fax: (888) 361-0502</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Eligibility • Claim Status • Capitation Reports • CMS-HHC Risk Adjustment ASM iEXCHANGE Select Provider→Library→Resource Center→Electronic Data Interchange (EDI) to access EDI information. <ul style="list-style-type: none"> • 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 /Colorado/Nevada: (888) 866-8297 Oklahoma: (877) 847-2862 Oregon: (800) 920-9202 Texas: (877) 847-2862 Washington MCO: (800) 213-7356	<ul style="list-style-type: none"> • 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 AZ, CA, CO, OK, OR, TX, and WA It is not currently available in NV).	<ul style="list-style-type: none"> • 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	<i>California, Oklahoma, Oregon, Texas, Washington</i> Mail: Mailstop CA124-0160 P.O Box 6107 Cypress, CA 90630 Fax: (866) 704-3420 CA Phone: (800) 624-8822 OK/TX Phone: (800) 825-9355 OR/WA Phone: (800) 932-3004	<ul style="list-style-type: none"> • Request a standard decision on an appeal.
Medicare Advantage Member Appeals	Mailstop CA124-0157 PO Box 6106 Cypress, CA 90630 Fax: (888) 517 7113 www.AARPMedicareComplete.com	<ul style="list-style-type: none"> • 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	<i>California Oklahoma, Oregon, Texas, Washington</i> Phone: (888) 277-4232 Fax: (800) 346-0930	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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: OptumRx.com	<ul style="list-style-type: none"> Request a prior authorization For oral medications For injectable medications
	(866) 798-8780, Option 2 (applies only to Medicare Advantage products)	<ul style="list-style-type: none"> Request information on the Medicare Part D Medication Therapy Management Program.
	See Customer's health care ID card for carrier information and contact numbers	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 → 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)

 SignatureValue
 HMO
 Health Plan (80840)

Member ID: 9999999-99 Group Number: 000011

Member:
 BROWN, SUBSCRIBER

Brown, Provider (999999-9999) Payer ID: 87726
 PCP EFFECTIVE DATE 9/9/99
 ABC Pediatric Services
 DIRECTED BY PRIMARY MD
 Office: \$25 Spec: \$35 UrgCare: \$50 ER: \$100


 RxBIN#: 610494
 Rx Grp PCCA
 RxPCN#: 9999

SignatureValue HMO
 Offered by UnitedHealthcare of California

DOI/0501

Emergency Services: Call 911 or go to the nearest emergency room. Printed 02/10/2011



This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: www.uhcwest.com 1-800-624-8822
 Spanish Phone Line: 1-800-730-7270
 Mental Health: 1-800-999-9585
 TDD: 1-800-442-8833

For Providers: www.uhcwest.com 1-800-542-8789
 Medical Claims: P.O. Box 30968, Salt Lake City, UT 84130-0968

UnitedHealthcare® shared savings WEST
 Choice Plan Network 

Pharmacy Claims: P.O. Box 6037, Cypress, CA 90630
 For Pharmacist: 1-800-788-7871

AARP MedicareComplete ID card (WEST)



Health Plan (80840) 911-87726-04

Member ID: Group Number
 Member: PLAN CODE:

PCP Name: Payer ID: 87726


PCP Phone: RxBin: 610097
 Copy: Office/ Spec/ ER RxPCN: 9999
 \$15/ \$30/ \$65 RxGrp: SHCO

AARP MedicareComplete SecureHorizons Plan 2 (HMO) w/Dental 2M
 H0609 PBP# 012

In an emergency go to the nearest emergency room or call 911. Printed 01/11

This card doesn't guarantee coverage. To verify benefits, view claims, or find a physician, visit www.myAARPMedicare.com or call customer service Monday - Sunday 8:00 am to 8:00 pm

Customer Service: 1-800-950-9355 TDD 711
 NurseLine: 1-877-365-7949 TDD 711
 Mental Health: 1-888-777-2735 TDD 711

Providers: www.uhcwest.com 1-888-866-8297
 Medical Claim Address: P.O. Box 52064 Phoenix, AZ 85072-2064

Medicare Solutions WEST

Pharmacy Claims: Rx Solutions PO Box 6082 Cypress, CA 90630-0082
 For Pharmacists: 1-877-889-6510

Our products

We offer a wide range of products and services for employer groups, families and individual Customers. Benefit 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 AZ, CA, CO, OK, OR, TX, WA; not available in NV)
- Electronic eligibility lists (upon request)

Customer's benefit plan details

Additional details regarding a specific Customer's benefit plan, 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 AZ, CA, CO, OK, OR, TX, WA; not available in 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 ANSI X12 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 X12 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 X12 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 X12 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* below 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
California	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. For Medicare Advantage Customers, we follow CMS coverage guidelines, including National Coverage Determinations and Local Coverage Determinations. If Milliman guidelines or any other UnitedHealth Care medical policies or coverage determination guidelines conflict with CMS guidelines, we will follow CMS guidelines.

Medical management may be delegated to a third party.

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/advance notification is not required for emergency services. 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 notification 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 primary care physician (PCP) or hospitalist upon a Customer's arrival for commercial 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, (see below for services requiring 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
	TX	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 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 online 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 *Precertification 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. Female Medicare Advantage Customers may self-refer to a women's health specialist who is a Participating Provider for women's routine and preventive health care services.

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 assumes responsibility for the Customer's care (either at the hospital or through transfer); 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 additional 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; and
- Requested services (e.g., 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 non-urgent/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. Prior authorization for emergent/urgent services not required for Medicare Advantage.
- 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 an 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 are not medically necessary 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 (Commercial only)

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, unless otherwise indicated in your agreement.

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 9 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 OptumRx.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 OptumRx®. OptumRx 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 OptumRx.com → Prior Authorizations.
- **Online:** OptumRx.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 OptumRx.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. Physicians can submit information that previously had to be collected by phone or fax. Also, physicians and health care professionals can use this service to check on the status of a Prior Authorization request, even if it was not submitted online. This 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 OptumRx. OptumRx will not process the request until all necessary information has been submitted. OptumRx 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, OptumRx will make the 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;
- 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, OptumRx 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. OptumRx 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 Advantage 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.

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 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.

Authorizing and dispensing injectable/infusion medications

Customers may use the OptumRx 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 OptumRx.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 OptumRx Specialty Pharmacy at (800) 711-4555, or fax requests directly to (800) 853-3844. OptumRx 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 and Arizona Commercial only)

Authorization Guarantee provides for reimbursement to the Participating Provider for covered services provided to a 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.

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 Commercial & Medicare Advantage HMO/ MCO and simply following the prompt instructions over the phone:

- California: (800) 542-8789
- Oregon: (800) 920-9202
- Oklahoma: (877) 847-2862
- Texas: (877) 847-2862
- Washington MCO: (800) 213-7356
- Arizona/Colorado/Nevada: (888)-866-8297

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 [Electronic Data Interchange](#) 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 admits 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 *Provider appeals* section of this Supplement.)

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/TPA 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 CA120-0360 P.O. Box 30968 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.
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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 52064 Phoenix, AZ 85072-2064	<p>Upon receipt of a dispute, Colorado Resolution Team will:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

- 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.
- 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.
- 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.
- 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.
- 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 a Customer or determine when a 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 identification (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 1/1/2013.

The image displays three examples of Medicare Advantage Supplement ID cards, arranged in a 3x2 grid. Each card is enclosed in a dashed border and contains the following information:

- Top Left:** UnitedHealthcare Community Plan logo.
- Health Plan (80840):** 911-06111-07
- Member ID:** 999999999-99 **Group Number:** 99999
- Member:** SUBSCRIBER BROWN
- PCP Name:** PROVIDER BROWN
- PCP Phone:** (999) 999-9999
- Copay:** Office/ Spec/ ER SXX/ SXX/ SXX
- Bottom Left:** H3307 PBP# 020 (for the first card), H3307 PBP# 012 (for the second card), and H3307 PBP# 015 (for the third card).
- Bottom Right:** A circled label indicating the network type: "UnitedHealthcare Dual Complete (HMO SNP) Oxford Medicare Network", "AARP MedicareComplete Oxford Medicare Network", and "AARP MedicareComplete Mosaic (HMO) Limited Service Area - Oxford Mosaic Network".
- Right Column:** Emergency instructions, a barcode, a disclaimer, contact numbers for Customer Service, NurseLine, and Behavioral Health, and provider/claim information.

* 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	<ul style="list-style-type: none"> • Register for UnitedHealthcareOnline.com. • Review a Customer's eligibility or benefits. • Electronic Referral System <ul style="list-style-type: none"> › 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. › 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)	<p>(800) 842-1109</p> <p>To obtain information on HIPAA Transactions code sets go to uhcnational.com → HIPAA and EDI → Transactions & Code Sets → Companion Documents.</p> <p>Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions.</p>	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 [AARP Medicare Complete Mosaic preauthorization and precertification](#) section, please fax, call or go online to:

- UnitedHealthcareOnline.com
- Submit via EDI
- Non Urgent precertification requests only fax: (800) 303-9902;
- Hospital Notification only fax: (800) 699-4712;
- General Provider Phone Number: (877) 842-3210;

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 to 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. No precertification is required for Medicare Advantage emergency hospital services.

- 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 Medicare coverage guidelines and 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 appropriate notice of non-coverage to the Customer before discharge, in accordance with Medicare guidelines; 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 (877) 843-3210.

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 faxed or mailed to:

- Fax: (866) 695-6923
- Mail: OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

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 (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
****82271	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources
****82272	Blood, occult, by peroxidase activity (e.g., 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 the 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

CPT Code	Test Description
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 (e.g., 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, pCO ₂ , pO ₂ , CO ₂ , HCO ₃ (including calculated O ₂ 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

CPT Code	Test Description
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 (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
#89261	Sperm isolation; complex prep (e.g., 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 (e.g., 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 North Carolina, 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 River Valley Entities

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/ Note: UnitedHealthcareOnline.com can also be used to check eligibility and benefits and claim status.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • To update your NPI and related information online, go to www.uhcrivervalley.com/10Provider/demographicchangeform.asp • 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	<p>Phone: Midwest: (800) 747-1446 Southeast: (800) 224-6602</p> <p>UnitedHealthcare of the River Valley 3800 Avenue of the Cities, Suite 200 Moline, Illinois 61265</p>	<ul style="list-style-type: none"> • 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)	<p>Phone: Illinois/Iowa/Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602</p>	<ul style="list-style-type: none"> • 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)	<p>Fax: (888) 242-9058</p> <p>Phone: (800) 747-1446 Ext: 65287</p> <p>Mail: UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265</p>	<ul style="list-style-type: none"> • Request preauthorization for procedures and services including DME, orthotics, prosthetics, and other supply items (may need to be obtained through a contracted vendor).
Mental health, substance abuse, vision, or transplant services	<p>Illinois/Iowa/Wisconsin: (800) 747-1446</p> <p>Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602</p>	<ul style="list-style-type: none"> • 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.

How to contact us	Where to go	What you can do there
Skilled/extended Care	<p>Phone: Midwest: (800) 747-1446 Southeast: (800) 224-6602</p> <p>Fax: Midwest: (888) 534-3258 Southeast: (800) 880-5403</p>	<ul style="list-style-type: none"> • Request preauthorization for skilled/extended care
Pharmacy services/ prescription drugs requiring preauthorization	<p>Medco Phone: (800) 903-6224 www.uhcrivervalley.com/pharmacy Please refer to the <i>Commercial Pharmacy Benefit Manager Transition in 2013</i> section of this Guide for information on OptumRx.</p>	<ul style="list-style-type: none"> • 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	<p>Phone: (800) 747-1446 Ext: 65287</p> <p>Fax: (800) 340-2184</p> <p>Mail: UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265</p>	<ul style="list-style-type: none"> • Request preauthorization for home health care services by downloading a Home Health Authorization Form: www.uhcrivervalley.com/10Provider/ → Resource Tools
Out-of-network referrals	<p>Fax: (800) 299-3779</p> <p>Phone: (800) 747-1446 Ext: 65287</p> <p>Mail: UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265</p>	<ul style="list-style-type: none"> • Request an out-of-network (OON) referral by completing an OON Request Form, at: www.uhcrivervalley.com/10Provider/ → Resource Tools
Notification of inpatient admissions	<p>Phone: Midwest: (800) 747-1446 Southeast: (800) 224-6602</p> <p>Fax: Midwest: (888) 534-3258 Southeast: (800) 880-5403</p>	<ul style="list-style-type: none"> • Notify us of inpatient admissions
Disease Management	<p>Toll-Free Phone Number: (800) 369-2704, Option # 4</p> <p>Hours: 8:00 a.m. – 4:30 p.m. Central Time</p> <p>Toll-Free Fax Number: (866) 950-7759, Attn: CMT Coordinator</p> <p>E-mail: MailWebCDM@uhc.com</p> <p>Online: uhcrivervalley.com → Providers → Health Programs</p>	<ul style="list-style-type: none"> • Request Disease Management services for your patients • Provide information to the Care Management Tool (CMT) Coordinator
Case Management	<p>Phone: (800) 369-2704, Ext 2 for Case Management</p>	<ul style="list-style-type: none"> • Request Case Management services for your patients
Outpatient Cardiac Catheterization and Inpatient/outpatient Electrophysiology Implants	<p>(866) 889-8054 CareCore National 8am-8pm, time zone specific</p>	<ul style="list-style-type: none"> • Request preauthorization for services

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/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 [Electronic Data Interchange](#) 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 you report the appropriate CPT and HCPCS codes.

Revenue codes requiring CPT® and HCPCS codes

260	IV Therapy(General Classification)	339	Other Radiology-Therapeutic	610	Magnetic Resonance Technology (General Classification)
261	Infusion Pump	340	Nuclear Medicine (General Classification)	611	MRI – Brain/Brain Stem
262	IV therapy/pharmacy services	341	Diagnostic Procedures	612	MRI -Spinal Cord/Spine
263	IV therapy/drug/supply delivery	342	Therapeutic Procedures	614	MRI - Other
264	IV Therapy/Supplies	350	CT Scan (General Classification)	615	MRA – Head and Neck
269	Other IV therapy	351	CT- Head Scan	616	MRA – Lower Extremities
290	Durable Medical Equipment (other than renal) (General Classification)	352	CT - Body Scan	618	MRA Other
291	Durable Medical Equipment/Rental	359	CT-Other	618	Other MRT
292	Purchase of new DME	360	Operating Room Services (General Classification)	623	Surgical Dressing
293	Purchase of used DME	361	Minor Surgery	624	FDA Investigational Devices
300	Laboratory(General Classification)	362	Organ Transplant- Other Than Kidney	634	Erythropoietin (EPO) < 10,000 units
301	Chemistry	367	Kidney Transplant	635	Erythropoietin (EPO) →10,000 units
302	Immunology	369	Other Operating Room Services	636	Drugs Requiring Detail Coding
303	Renal Patient(Home)	400	Other Imaging Services(General Classification)	730	EKG/ECG (Electrocardiogram) (General Classification)
304	Non-Routine Dialysis	401	Diagnostic Mammography	731	Holter Monitor
305	Hematology	402	Ultrasound	732	Telemetry
306	Bacteriology & Microbiology	403	Screening Mammography	739	Other EKG/ECG
307	Urology	404	Positron Emission Tomography	740	EEG (Electroencephalogram) (General Classification)
309	Other laboratory	409	Other Imaging Services	750	Gastro-Intestinal (GI) Services(General Classification)
310	Laboratory -Pathology(General Classification)	410	Respiratory Services(General Classification)	790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
311	Cytology	412	Inhalation Services	921	Peripheral Vascular Lab
312	Histology	419	Other Respiratory Services	922	Electromyogram
319	Other Laboratory Pathological	460	Pulmonary Function(General Classification)	923	Pap Smear
320	Radiology –diagnostic (General Classification)	469	Other-Pulmonary Function	924	Allergy Test
321	Angiocardiology	470	Audiology (General Classification)	925	Pregnancy Test
322	Arthrography	471	Audiology/Diagnostic	929	Additional Diagnostic Services
323	Arteriography	472	Audiology/Treatment	940	Other Therapeutic Services (General Classification)
324	Chest X-Ray	480	Cardiology (General Classification)	941	Recreational Therapy
329	Other Radiology -Diagnostic	481	Cardiac Cath Lab	942	Education/Training (Diabetic Education)
330	Radiology –Therapeutic and/or Chemotherapy Administration (General Classification)	482	Stress Test	949	Other Therapeutic Services (HRSA approved weight los providers)
331	Chemotherapy Administration-Injected	483	Echocardiology		
332	Chemotherapy Administration-Oral	489	Other Cardiology		
333	Radiation Therapy	490	Ambulatory Surgical Care (General Classification)		
335	Chemotherapy Administration-IV	499	Other Ambulatory Surgical Care		

Electronic Data Interchange (EDI)

You may use 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, OptumInsight, OptumInsight.com/edi. 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 OptumInsight.com/edi 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:

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, pending or denied.

* 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.

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/ → 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: UnitedHealthcare - 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.

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, Drug Policies and Coverage Determination Guidelines (also referred to as “Coverage Policies” in the River Valley Entities’ Coverage Policy Library), 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 Coverage Policies 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 Coverage Policies 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 Coverage Policies. 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/ → Resource Tools → Coverage Policy Library. Our Coverage Policies 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.

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 are indicated throughout this Supplement and are posted at www.uhcrivervalley.com/10Provider/ → Preauthorization.

As of August 1, 2012, preauthorization is required for the following procedures, devices and services and is also required for any other procedure, device, drug or service if indicated elsewhere in this Supplement. 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.

• 17-alpha-hydroxyprogesterone caproate (17P and Makena)
• Ablative Treatment for Spinal Pain
• Air Fluidized Beds (Pressure Reducing Support Surfaces - Group 3)
• Alternating Pressure and Low Air Loss Mattresses (Pressure Reducing Support Surfaces - Group 2)
• Artificial Total Disc Replacement for the Spine
• Augmentative Communicative Device/Speech Generating Device
• Autologous Chondrocyte Implantation in the Knee
• Bariatric Surgery
• Benlysta® (belimumab)
• Biologics (Infusion) for the Treatment of Skin, Joint and Gastrointestinal Conditions
• Biologics (Injection) for the Treatment of Skin, Joint and Gastrointestinal Conditions
• Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
• Bone Growth Stimulators
• Bone or Soft Tissue Healing and Fusion Enhancement Products
• Botulinum Toxin A and B
• Breast Reduction Surgery
• Breast Repair/Reconstruction (Not Following Mastectomy)

• Cimzia (certolizumab pegol)
• Clinical Trials
• Cochlear Implants
• Compounded Medications
• Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes
• Cosmetic and Reconstructive Procedures
• Custom Fabricated Wheelchair Cushions (E2609 and E2617)
• Deep Brain Stimulation
• Diagnostic Catheterizations and Electrophysiology (EP) Implant Procedures
• Elbow Replacement Surgery (Arthroplasty)
• Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
• Elemental Formulas for Eosinophilic Disorder or Short Bowel Syndrome (for Illinois members)
• Enzyme Replacement Therapy (ERT)
• Facet Injections for Spinal Pain
• Gastrointestinal Motility Disorders, Diagnosis and Treatment
• Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (HBOC)
• Growth Hormone/Growth Stimulation Products - Somatropin and Mecasermin
• Gynecomastia Treatment
• High Frequency Chest Wall Compression Devices
• Hip Replacement Surgery (Arthroplasty)
• Hip Resurfacing Arthroplasty
• Hospice
• Hospital Beds (semi-electrical and electrical)
• Human C1 Esterase Inhibitor (Cinryze, Berinert)
• Human Fibrinogen Concentrate (RiaSTAP)
• Hyperbaric Oxygen Therapy and Topical Oxygen Therapy
• Immune Globulin (IVIG)
• Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors
• Implantable Hearing Devices and Bone-Anchored Hearing Aids
• In Utero Fetal Surgery
• Intensity-Modulated Radiation Therapy
• Intrastromal Corneal Ring Segments
• Knee Replacement Surgery (Arthroplasty)
• Lanreotide Acetate Injection (Somatuline Depot) for the Treatment of Acromegaly
• Laser Therapy for Cutaneous Vascular Lesions and Pilonidal Disease
• Magnetoencephalography and Magnetic Source Imaging
• Mandibular Disorders
• Mechanical Stretching and Continuous Passive Motion Devices
• Meniscus Implant and Allograft
• Mozobil (Plerixafor Injection)
• Oncology Medication - Avastin
• Orenia® (abatacept)
• Orthognathic and Jaw Surgery
• Osteochondral Grafting of Knee
• Otoplasty

•Panniculectomy and Body Contouring Procedures
•Pectus Deformity Repair
•Plagiocephaly and Craniosynostosis Treatment
•Platelet Derived Growth Factors for Treatment of Wounds
•Polysomnography & Portable Monitoring for Sleep Related Breathing Disorders
•Power Mobility Assistive Equipment (Scooter/Power-Operated Vehicle, Power Wheelchair)
•Preimplantation Genetic Diagnosis
•Pressure Reducing Support Surfaces - Group 1 (e.g., Overlays, Pads)
•Procedures for Ablation of Varicose Veins
•Propranolol Treatment for Infantile Hemangiomas: Inpatient
•Proton Beam Radiation Therapy
•Psychiatric Medical Institute for Children (preauthorization is required for admission to and services provided by this Iowa facility in Iowa)
•Psychological Testing
•Remicade® (infliximab)
•Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis
•Rituxan® (rituximab)
•Romiplostim (Nplate)
•Seat Lift Mechanisms (lift chair)
•Shoulder Replacement Surgery (Arthroplasty)
•Sodium Hyaluronate
•Specialized, Microprocessor or Myoelectric Limbs
•Supprelin LA (histrelin acetate 50-mg once-yearly implant)
•Surgical Treatment for Spine Pain
•Surgical Treatment of Obstructive Sleep Apnea
•Synagis® (palivizumab)
•Total Ankle Replacement Surgery (Arthroplasty)
•Transcatheter Heart Valve Procedures
•Tysabri (Natalizumab)
•UVB Light Cabinet for Home Phototherapy
•Vagus Nerve Stimulation
•Vantas (histrelin implant)
•Ventavis ® with Prodose® Adaptive Aerosol Delivery System
•Wireless Capsule Endoscopy
•Xolair (omalizumab)
•Xyntha - Factor VIII (Antihemophilic Factor, recombinant)

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 Coverage Policies when determining what documentation and information you should provide.

How to request preauthorization when required

Submitting a request

Please refer to the [How to contact River Valley](#) 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 following numbers: Illinois/Iowa/ Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.

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 providers may issue a medical necessity denial for coverage.

The River Valley Entities' staff, and their delegates 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 for 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 *Provider Education – 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 River Valley* 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 River Valley](#) 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 1st 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 an 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.

Decisions will be made within 3 business days of receiving the referral request or 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.

- 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 call the following numbers if they have further questions: Illinois/Iowa/Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.
- 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 following numbers:

Illinois/Iowa/Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.

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 River Valley](#) 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 require preauthorization (for example DME, procedures, prescription drugs or other services.)

Prescription drugs

- Preauthorization is required for some prescription drugs. Please refer to the [How to contact River Valley](#) 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: "2013 4-Tier PDL", "2013 Traditional PDL", and "2013 Advantage PDL".

Please **Note:** Not all drugs on a PDL are covered under a Customer's pharmacy benefit. On www.uhcrivervalley.com/Pharmacy, you may determine whether a medication is covered by viewing the Online Pharmacy.

Sleep Studies (laboratory assisted, including polysomnography) to diagnose sleep apnea and other sleep disorders

Preauthorization is required for polysomnography treatment and for the site of service (sleep lab v. portable home monitoring).

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 River Valley](#) 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 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;

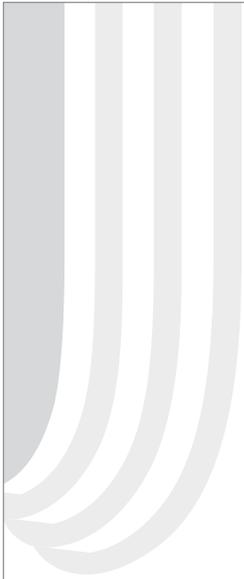
Providers who are determined to be noncompliant with required medical management processes and provision of services will notified in writing of the areas of noncompliance, including a description of all specific incidents that lead to the determination, the sanction to be imposed and the potential consequences 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.



State: Arkansas **Filing Company:** UnitedHealthcare of Arkansas, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: 100-6088 UHC Admin Guide 2013
Project Name/Number: 100-6088 UHC Admin Guide 2013/100-6088 UHC Admin Guide 2013

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	01/14/2013
Bypass Reason:	UHC Admin Guide 2012 = 56.7 readability		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/14/2013
Bypass Reason:	Not Applicable		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/14/2013
Bypass Reason:	Not Applicable		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/14/2013
Bypass Reason:	Not Applicable		
		Item Status:	Status Date:
Satisfied - Item:	100-6088 UHC ADMIN GUIDE 2013 Cover letter	Approved-Closed	01/14/2013
Comments:			
Attachment(s):			
100-6088 UHC Admin Guide 2013.AR Cover Letter.pdf			



January 3, 2013

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas, Inc.
NAIC No. 95446

2013 Administrative Guide: 100-6088 UHC Admin Guide 2013

Flesch Score: 56.7

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed 2013 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 2013) and available by print-on-demand for provider use.

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